



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT	DATE: 05/28/2014	TIME: 05:54
	2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT		
	3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT		
	4. <input checked="" type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> COST REPORT STATUS	6. DATE RECEIVED: _____	10. NPR DATE: _____
	1 -AS SUBMITTED	7. CONTRACTOR NO: _____	11. CONTRACTOR'S VENDOR CODE: _____
	2 -SETTLED WITHOUT AUDIT	8. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN	
	4 -REOPENED		
	5 -AMENDED		

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY PRESENCE COVENANT MEDICAL CENTER (14-0113) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2013 AND ENDING 12/31/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

TITLE

DATE

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
		1	PART A 2	PART B 3	4	5	
1	HOSPITAL		-119,337	141,462	-29,982		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		10,128				3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-109,209	141,462	-29,982		200

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

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



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:											
1	STREET: 1400 WEST PARK STREET		P.O. BOX:						1		
2	CITY: URBANA		STATE: IL		ZIP CODE: 61801		COUNTY: CHAMPAIGN			2	
HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:											
							PAYMENT SYSTEM (P, T, O, OR N)				
0	1	2	3	4	5	6	7	8			
COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV-IDER TYPE	DATE CERTIFIED	V	XVIII	XIX			
3	HOSPITAL	PRESENCE COVENANT MEDICAL CENTER	14-0113	16580	1	07/01/1966	O	P	O	3	
4	SUBPROVIDER - IPF									4	
5	SUBPROVIDER - IRF	COVENANT REHABILITATION UNIT	14-T113	16580	5	10/01/1983	O	P	O	5	
6	SUBPROVIDER - (OTHER)									6	
7	SWING BEDS - SNF									7	
8	SWING BEDS - NF									8	
9	HOSPITAL-BASED SNF									9	
10	HOSPITAL-BASED NF									10	
11	HOSPITAL-BASED OLTC									11	
12	HOSPITAL-BASED HHA									12	
13	SEPARATELY CERTIFIED ASC									13	
14	HOSPITAL-BASED HOSPICE									14	
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15	
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16	
17	HOSPITAL-BASED (CMHC)									17	
18	RENAL DIALYSIS									18	
19	OTHER									19	
20	COST REPORTING PERIOD (mm/dd/yyyy)		FROM: 01 / 01 / 2013		TO: 12 / 31 / 2013		20				
21	TYPE OF CONTROL (see instructions)		1		21						
INPATIENT PPS INFORMATION										1	2
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR§412.06(c)(2)(Pickle amendment hospital)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.							Y	N	22	
22.01	DID THIS HOSPITAL RECEIVE INTERIM UNCOMPENSATED CARE PAYMENTS FOR THIS COST REPORTING PERIOD? ENTER IN COLUMN 1, 'Y' FOR YES Or 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING PRIOR TO OCTOBER 1. ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING ON OR AFTER OCTOBER 1. (see instructions)							N	Y	22.01	
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.							2	N	23	
		IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	OUT-OF-STATE MEDICAID PAID DAYS	OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO DAYS	OTHER MEDICAID DAYS				
		1	2	3	4	5	6				
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	3,537	701			14	130		24		
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	133	120						25		
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			1	26						
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.			1	27						
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			35							
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		36			
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			37							
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38			
							1	2			



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

WORKSHEET S-2
PART I

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



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
TITLE V AND XIX SERVICES		1	2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	Y	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (dual certification)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS		1	2	
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	N		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	PHYSICAL N	OCCUPATIONAL SPEECH RESPIRATORY	109
MISCELLANEOUS COST REPORTING INFORMATION				
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, or E only) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98'	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE, ENTER 2 IF THE POLICY IS OCCURRENCE.	2		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:	PREMIUMS	PAID LOSSES	SELF INSURANCE
			1,379,530	1,938,044
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR HIGH COST IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121
TRANSPLANT CENTER INFORMATION				
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S)(mm/dd/yyyy) BELOW.	N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

ALL PROVIDERS			
		1	2
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	148003
			140

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

141	NAME: PRESENCE PRV HEALTH	CONTRACTOR'S NAME: NGS	CONTRACTOR'S NUMBER: 0131	141
142	STREET: 19065 HICKORY CREEK DRIVE, SUI	P.O. BOX:		142
143	CITY: MOKENA	STATE: IL	ZIP CODE: 60448	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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

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

MULTICAMPUS

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

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		167
168	IF THIS PROVIDER IS A CAH (line 105 is 'Y') AND IS A MEANINGFUL USER (line 167 is 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. (see instructions)			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (line 167 is 'Y') AND IS NOT A CAH (line 105 is 'N'), ENTER THE TRANSITIONAL FACTOR. (see instructions)	1.00		169
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)	05/02/2013	07/31/2013	170



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	Y			3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	Y	A		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y			5
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N		
		1	2		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N			6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N			7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N			8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	Y			9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N			10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N			11
BAD DEBTS			Y/N		
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		Y		12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.		N		13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.		N		14
BED COMPLEMENT			Y		
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		Y		15
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
		1	2	3	4
PS&R REPORT DATA					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		N	
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	Y	04/30/2014	Y	04/30/2014
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN RELIEVED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.		22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.		29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.		30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.		31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.		32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.		34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		35
HOME OFFICE COSTS		Y/N	DATE
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
38	IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE.		
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.		
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
COST REORT PREPARER INFORMATION			
41	FIRST NAME: ANNE	LAST NAME: LITTLE	TITLE: DIRECTOR, REIMB
42	EMPLOYER: PRESENCE HEALTH		
43	PHONE NUMBER: 217-337-2836	E-MAIL ADDRESS: ANNE.LITTLE@PRESENCEHEALTH.ORG	



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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	39,283,553		39,283,553	1,404,807.43	27.96	1
2							2
3							3
4							4
4.01							4.01
5							5
6							6
7	21						7
7.01		948,647		948,647	27,169.62	34.92	7.01
8							8
9	44						9
10		4,405,592	41,343	4,446,935	186,884.98	23.80	10
OTHER WAGES & RELATED COSTS							
11		3,064,147		3,064,147	75,061.87	40.82	11
12							12
13		262,287		262,287	1,687.60	155.42	13
14		9,691,829		9,691,829	176,351.00	54.96	14
15							15
16							16
WAGE-RELATED COSTS							
17		8,700,905		8,700,905			17
18							18
19		1,099,050		1,099,050			19
20							20
21							21
22							22
22.01							22.01
23							23
24							24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26		495,675		495,675	4,393.25	112.83	26
27		3,763,780		3,763,780	132,202.35	28.47	27
28		130,905		130,905	1,063.00	123.15	28
29							29
30		1,004,301		1,004,301	35,499.25	28.29	30
31		-3,775	3,775				31
32		932,274	-3,775	928,499	64,637.58	14.36	32
33							33
34		764,615	-450,815	313,800	23,397.93	13.41	34
35		419,562		419,562	12,140.00	34.56	35
36			450,815	450,815	33,706.00	13.37	36
37							37
38		1,452,646	-498,886	953,760	24,159.72	39.48	38
39		199,345		199,345	16,064.71	12.41	39
40		1,799,145	-17,511	1,781,634	39,706.35	44.87	40
41		979,462		979,462	41,083.08	23.84	41
42		696,878		696,878	18,511.00	37.65	42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		38,885,373		38,885,373	1,390,840.81	27.96	1
2	EXCLUDED AREA SALARIES (see instructions)		4,405,592	41,343	4,446,935	186,884.98	23.80	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		34,479,781	-41,343	34,438,438	1,203,955.83	28.60	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		13,018,263		13,018,263	253,100.47	51.44	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		8,700,905		8,700,905		25.27%	5
6	TOTAL (sum of lines 3 through 5)		56,198,949	-41,343	56,157,606	1,457,056.30	38.54	6
7	TOTAL OVERHEAD COST (see instructions)		12,634,813	-516,397	12,118,416	446,564.22	27.14	7



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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3

PART IV - WAGE RELATED COST

PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	1,766,196	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	4,022,078	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	115,748	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	49,251	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)	160,027	12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	28,414	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	555,211	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	2,785,673	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	196,513	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)	-239	21
22	DAY CARE COSTS AND ALLOWANCES	4,092	22
23	TUITION REIMBURSEMENT	116,991	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	9,799,955	24

PART B - OTHER THAN CORE RELATED COST

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

EXHIBIT 3

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

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

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



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HOSPITAL CONTRACT LABOR AND BENEFIT COST

**WORKSHEET S-3
PART V**

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

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



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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.207407	1
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MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID		4,572,126	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID			5
6	MEDICAID CHARGES		60,100,006	6
7	MEDICAID COST (line 1 times line 6)		12,465,162	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.		7,893,036	8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP			9
10	STAND-ALONE SCHIP CHARGES			10
11	STAND-ALONE SCHIP COST (line 1 times line 10)			11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.			12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)			13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)			14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)			15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.			16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE			17	
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		35,600	18	
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)		7,893,036	19	
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	21,504,421	1,197,153	22,701,574	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	4,460,167	248,298	4,708,465	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	17,262	28,317	45,579	22
23	COST OF CHARITY CARE (line 21 minus line 22)	4,442,905	219,981	4,662,886	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?		N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)			25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)		5,451,541	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)		550,079	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)		4,901,462	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)		1,016,598	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)		5,679,484	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)		13,572,520	31



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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		7,881,880	7,881,880	-1,071,264	6,810,616	-1,260,548	5,550,068	1
2	00200	CAP REL COSTS-MVBLE EQUIP				4,672,005	4,672,005	80,837	4,752,842	2
3	00300	OTHER CAP REL COSTS		148,535	148,535	-148,535			-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	495,675	9,852,041	10,347,716	147,286	10,495,002	-6,991	10,488,011	4
5.01	00540	NONPATIENT TELEPHONE	270,468	559,316	829,784		829,784	75	829,859	5.01
5.02	00550	DATA PROCESSING	130,237	285,713	415,950	48,198	464,148	6,028,562	6,492,710	5.02
5.03	00560	PURCH,RCVING,STORING	-5,192	858,583	853,391	-613,896	239,495	-1,004	238,491	5.03
5.04	00570	ADMITTING	583,843	11,448	595,291	34,932	630,223		630,223	5.04
5.05	00580	CASHIERING,A/R		996,618	996,618		996,618	1,124,987	2,121,605	5.05
5.06	00590	OTHER ADMIN & GEN	2,784,424	28,992,456	31,776,880	-2,104,187	29,672,693	-13,321,199	16,351,494	5.06
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	1,004,301	3,880,080	4,884,381		4,884,381		4,884,381	7
8	00800	LAUNDRY & LINEN SERVICE	-3,775	461,099	457,324	3,775	461,099		461,099	8
9	00900	HOUSEKEEPING	932,274	345,252	1,277,526	-3,775	1,273,751	-828	1,272,923	9
10	01000	DIETARY	764,615	1,094,910	1,859,525	-1,096,371	763,154		763,154	10
11	01100	CAFETERIA				1,096,371	1,096,371	-406,967	689,404	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	1,452,646	50,688	1,503,334	-498,886	1,004,448	-765	1,003,683	13
14	01400	CENTRAL SERVICES & SUPPLY	199,345	799,670	999,015	-584,710	414,305		414,305	14
15	01500	PHARMACY	1,799,145	2,639,633	4,438,778	-2,638,308	1,800,470		1,800,470	15
16	01600	MEDICAL RECORDS & LIBRARY	979,462	730,406	1,709,868		1,709,868	-11,107	1,698,761	16
17	01700	SOCIAL SERVICE	696,878	203,183	900,061	-130,905	769,156	-28,252	740,904	17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD				948,647	948,647		948,647	21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		1,386,148	1,386,148	-779,765	606,383		606,383	22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	8,689,792	547,222	9,237,014	261,357	9,498,371	-64,698	9,433,673	30
31	03100	INTENSIVE CARE UNIT	2,004,468	412,331	2,416,799	58,998	2,475,797	163,341	2,639,138	31
41	04100	SUBPROVIDER - IRF	1,229,077	1,607,377	2,836,454	-1,011,245	1,825,209	-52,532	1,772,677	41
43	04300	NURSERY	489,766	680,293	1,170,059	12,100	1,182,159	-628,028	554,131	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	3,068,776	10,085,320	13,154,096	-8,548,180	4,605,916	-1,667	4,604,249	50
50.01	03330	ENDOSCOPY	706,568	649,334	1,355,902	-220,680	1,135,222		1,135,222	50.01
51	05100	RECOVERY ROOM	483,203	8,843	492,046	7,120	499,166		499,166	51
52	05200	DELIVERY ROOM & LABOR ROOM	347,951	252,830	600,781	-145,470	455,311	-225	455,086	52
53	05300	ANESTHESIOLOGY		2,715,696	2,715,696	-153,979	2,561,717	-2,491,750	69,967	53
54	05400	RADIOLOGY-DIAGNOSTIC	845,023	78,557	923,580	-96,744	826,836	-2,598	824,238	54
54.01	03630	ULTRASOUND	218,715	24,284	242,999	43,716	286,715		286,715	54.01
54.02	03440	MAMMOGRAPHY	51,868	37,354	89,222	10,367	99,589		99,589	54.02
55	05500	RADIOLOGY-THERAPEUTIC	32,412	11,963	44,375	-44,375				55
55.01	03480	ONCOLOGY	-197	12,007	11,810	-11,810				55.01
56	05600	RADIOISOTOPE	106,339	144,547	250,886	21,255	272,141		272,141	56
57	05700	CT SCAN	313,209	90,687	403,896	62,603	466,499	-8,567	457,932	57
58	05800	MRI	107,104	45,834	152,938	21,408	174,346		174,346	58
59	05900	CARDIAC CATHETERIZATION	916,959	3,125,412	4,042,371	-2,907,417	1,134,954	-4,030	1,130,924	59
60	06000	LABORATORY		4,586,798	4,586,798	-113,576	4,473,222	-39,828	4,433,394	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	BLOOD STORING, PROCESSING & TRANS.		566,819	566,819		566,819		566,819	63
65	06500	RESPIRATORY THERAPY	1,061,254	228,216	1,289,470	-174,895	1,114,575	-8,112	1,106,463	65
66	06600	PHYSICAL THERAPY		464,055	464,055	395,191	859,246		859,246	66
67	06700	OCCUPATIONAL THERAPY		280,910	280,910	489,222	770,132		770,132	67
68	06800	SPEECH PATHOLOGY		76,943	76,943	160,377	237,320		237,320	68
69.01	03140	CARDIOLOGY	421,863	141,513	563,376		563,376	-86,036	477,340	69.01
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				7,650,317	7,650,317		7,650,317	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				5,643,249	5,643,249		5,643,249	72
73	07300	DRUGS CHARGED TO PATIENTS				2,984,373	2,984,373		2,984,373	73
74	07400	RENAL DIALYSIS		173,555	173,555		173,555		173,555	74
76.97	07697	CARDIAC REHABILITATION	319,468	16,350	335,818	-7,375	328,443	-5,228	323,215	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
91	09100	EMERGENCY	2,609,074	975,858	3,584,932	-93,901	3,491,031	-537,089	2,953,942	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
95	09500	AMBULANCE SERVICES	1,952,306	853,392	2,805,698	58,022	2,863,720		2,863,720	95
		SPECIAL PURPOSE COST CENTERS								
113	11300	INTEREST EXPENSE		3,249,210	3,249,210	-3,249,210				113
118		SUBTOTALS (sum of lines 1-117)	38,059,344	93,321,169	131,380,513	-1,618,570	129,761,943	-11,570,247	118,191,696	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	52,007	154,806	206,813		206,813		206,813	190



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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
192	19200	PHYSICIANS' PRIVATE OFFICES	522,203	721,058	1,243,261	14,039	1,257,300		1,257,300	192
192.01	19201	COVENANT OUTPATIENT PHARMACY	184,197	547,100	731,297	17,511	748,808		748,808	192.01
192.02	19202	REAL ESTATE		-801,485	-801,485	1,518,166	716,681		716,681	192.02
192.03	19203	FOUNDATION	264,814	331,176	595,990	68,854	664,844		664,844	192.03
192.04	19204	OUTREACH PROGRAMS	200,988	156,780	357,768		357,768		357,768	192.04
192.05	19205	UNASSIGNED								192.05
200		TOTAL (sum of lines 118-199)	39,283,553	94,430,604	133,714,157		133,714,157	-11,570,247	122,143,910	200



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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	PHARMACY	A	DRUGS CHARGED TO PATIENTS	73		2,620,797	1
500	TOTAL RECLASSIFICATIONS					2,620,797	500
	CODE LETTER - A						
1	REHAB SERVICES	B	PHYSICAL THERAPY	66		395,191	1
2	REHAB SERVICES	B	OCCUPATIONAL THERAPY	67		489,222	2
3	REHAB SERVICES	B	SPEECH PATHOLOGY	68		160,377	3
500	TOTAL RECLASSIFICATIONS					1,044,790	500
	CODE LETTER - B						
1	INTEREST EXPENSE	C	CAP REL COSTS-BLDG & FIXT	1		2,677,652	1
2	INTEREST EXPENSE	C	CAP REL COSTS-MVBLE EQUIP	2		571,558	2
3	CAPITAL LEASE INTEREST	C	CAP REL COSTS-MVBLE EQUIP	2		7,612	3
500	TOTAL RECLASSIFICATIONS					3,256,822	500
	CODE LETTER - C						
1	DEPRECIATION EXPENSE	D	CAP REL COSTS-BLDG & FIXT	1		34,226	1
2	DEPRECIATION EXPENSE	D	CAP REL COSTS-MVBLE EQUIP	2		4,020,990	2
3	DEPRECIATION EXPENSE	D					3
4	DEPRECIATION EXPENSE	D					4
5	DEPRECIATION EXPENSE	D					5
6	DEPRECIATION EXPENSE	D					6
500	TOTAL RECLASSIFICATIONS					4,055,216	500
	CODE LETTER - D						
1	PROPERTY TAXES	E	REAL ESTATE	192.02		2,396,105	1
500	TOTAL RECLASSIFICATIONS					2,396,105	500
	CODE LETTER - E						
1	MEDICAL SUPPLIES	F	MEDICAL SUPPLIES CHARGED TO P	71		113,280	1
2	MEDICAL SUPPLIES	F	MEDICAL SUPPLIES CHARGED TO P	71		7,375	2
3	MEDICAL SUPPLIES	F	MEDICAL SUPPLIES CHARGED TO P	71		1,239,486	3
4	MEDICAL SUPPLIES	F	MEDICAL SUPPLIES CHARGED TO P	71		174,895	4
5	MEDICAL SUPPLIES	F	MEDICAL SUPPLIES CHARGED TO P	71		349,186	5
6	MEDICAL SUPPLIES	F	MEDICAL SUPPLIES CHARGED TO P	71		165,523	6
7	MEDICAL SUPPLIES	F	MEDICAL SUPPLIES CHARGED TO P	71		4,563,450	7
8	MEDICAL SUPPLIES	F	MEDICAL SUPPLIES CHARGED TO P	71		43,601	8
9	MEDICAL SUPPLIES	F	MEDICAL SUPPLIES CHARGED TO P	71		225,012	9
10	MEDICAL SUPPLIES	F	MEDICAL SUPPLIES CHARGED TO P	71		291,847	10
11	MEDICAL SUPPLIES	F	MEDICAL SUPPLIES CHARGED TO P	71		148,762	11
500	TOTAL RECLASSIFICATIONS					7,322,417	500
	CODE LETTER - F						
1	AMBULANCE INSURANCE	G	AMBULANCE SERVICES	95		67,735	1
500	TOTAL RECLASSIFICATIONS					67,735	500
	CODE LETTER - G						
1	EXCUTIVE HEALTH RESOURCES	H	OTHER ADMIN & GEN	5.06		130,905	1
500	TOTAL RECLASSIFICATIONS					130,905	500
	CODE LETTER - H						
1	INTERNS & RESIDENTS	I	I&R SERVICES-SALARY & FRINGES	21		948,647	1
500	TOTAL RECLASSIFICATIONS					948,647	500
	CODE LETTER - I						
1	RADIOLOGY SHARED SERVICES	J	CT SCAN	57	62,603		1
2	RADIOLOGY SHARED SERVICES	J	ULTRASOUND	54.01	43,716		2
3	RADIOLOGY SHARED SERVICES	J	MAMMOGRAPHY	54.02	10,367		3
4	RADIOLOGY SHARED SERVICES	J	MRI	58	21,408		4
5	RADIOLOGY SHARED SERVICES	J	RADIOISOTOPE	56	21,255		5
500	TOTAL RECLASSIFICATIONS				159,349		500
	CODE LETTER - J						
1	DIRECTORS	L	ADULTS & PEDIATRICS	30	63,785		1
2	DIRECTORS	L	EMERGENCY	91	61,909		2
3	DIRECTORS	L	OPERATING ROOM	50	32,630		3
4	DIRECTORS	L	OPERATING ROOM	50	11,772		4
5	DIRECTORS	L	ENDOSCOPY	50.01	10,859		5
6	DIRECTORS	L	RECOVERY ROOM	51	7,120		6
7	DIRECTORS	L	DELIVERY ROOM & LABOR ROOM	52	8,596		7
8	DIRECTORS	L	ADULTS & PEDIATRICS	30	40,603		8
9	DIRECTORS	L	NURSERY	43	12,100		9
10	DIRECTORS	L	ADULTS & PEDIATRICS	30	26,410		10
11	DIRECTORS	L	SUBPROVIDER - IRF	41	33,545		11
12	DIRECTORS	L	ADULTS & PEDIATRICS	30	41,892		12
13	DIRECTORS	L	ADULTS & PEDIATRICS	30	38,867		13



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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
14	DIRECTORS	L	ADULTS & PEDIATRICS	30	49,800		14
15	DIRECTORS	L	INTENSIVE CARE UNIT	31	58,998		15
16	DIRECTORS	L	COVENANT OUTPATIENT PHARMACY	192.01	17,511		16
17	DIRECTORS	L	EMERGENCY	91	9,713		17
500	TOTAL RECLASSIFICATIONS				526,110		500
	CODE LETTER - L						
1	RECLASSIFICATION OF MOB EXPENSE	M	I&R SERVICES-OTHER PRGM COSTS	22		168,882	1
2	RECLASSIFICATION OF MOB EXPENSE	M	OTHER ADMIN & GEN	5.06		126,448	2
500	TOTAL RECLASSIFICATIONS					295,330	500
	CODE LETTER - M						
1	DIETARY RECLASSIFICATION	N	CAFETERIA	11	450,815	645,556	1
500	TOTAL RECLASSIFICATIONS				450,815	645,556	500
	CODE LETTER - N						
1	PYXIS RECLASSIFICATION	O	MEDICAL SUPPLIES CHARGED TO P	71		327,900	1
2	PYXIS RECLASSIFICATION	O	DRUGS CHARGED TO PATIENTS	73		363,576	2
500	TOTAL RECLASSIFICATIONS					691,476	500
	CODE LETTER - O						
1	IMPLANT SUPPLIES	P	IMPL. DEV. CHARGED TO PATIENT	72		40,786	1
2	IMPLANT SUPPLIES	P	IMPL. DEV. CHARGED TO PATIENT	72		1,661,511	2
3	IMPLANT SUPPLIES	P	IMPL. DEV. CHARGED TO PATIENT	72		235,524	3
4	IMPLANT SUPPLIES	P	IMPL. DEV. CHARGED TO PATIENT	72		3,693,330	4
5	IMPLANT SUPPLIES	P	IMPL. DEV. CHARGED TO PATIENT	72		354	5
6	IMPLANT SUPPLIES	P	IMPL. DEV. CHARGED TO PATIENT	72		6,527	6
7	IMPLANT SUPPLIES	P	IMPL. DEV. CHARGED TO PATIENT	72		5,217	7
500	TOTAL RECLASSIFICATIONS					5,643,249	500
	CODE LETTER - P						
1	CLOSED DEPARTMENT	Q	RADIOLOGY-DIAGNOSTIC	54	32,412	11,963	1
2	CLOSED DEPARTMENT	Q	RADIOLOGY-DIAGNOSTIC	54		12,007	2
3	CLOSED DEPARTMENT	Q	ONCOLOGY	55.01	197		3
4	SYSTEM DEPARTMENT	Q	PURCH.RCVING.STORING	5.03	5,192		4
5	PURCHASED SERVICE	Q	LAUNDRY & LINEN SERVICE	8	3,775		5
6	CLOSED DEPARTMENT	Q	RADIOLOGY-DIAGNOSTIC	54		6,420	6
500	TOTAL RECLASSIFICATIONS				41,576	30,390	500
	CODE LETTER - Q						
1	COUNTY PLAZA LEASE	R	EMPLOYEE BENEFITS DEPARTMENT	4		147,576	1
2	COUNTY PLAZA LEASE	R	DATA PROCESSING	5.02		48,198	2
3	COUNTY PLAZA LEASE	R	PURCH.RCVING.STORING	5.03		72,388	3
4	COUNTY PLAZA LEASE	R	ADMITTING	5.04		34,932	4
5	COUNTY PLAZA LEASE	R	OTHER ADMIN & GEN	5.06		147,255	5
6	COUNTY PLAZA LEASE	R	LABORATORY	60		5,508	6
7	COUNTY PLAZA LEASE	R	PHYSICIANS' PRIVATE OFFICES	192		14,643	7
8	COUNTY PLAZA LEASE	R	FOUNDATION	192.03		68,854	8
500	TOTAL RECLASSIFICATIONS					539,354	500
	CODE LETTER - R						
	GRAND TOTAL (INCREASES)				1,177,850	29,688,789	

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



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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				WKST A-7 REF.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	PHARMACY	A	PHARMACY	15		2,620,797		1
500	TOTAL RECLASSIFICATIONS					2,620,797		500
	CODE LETTER - A							
1	REHAB SERVICES	B	SUBPROVIDER - IRF	41		395,191		1
2	REHAB SERVICES	B	SUBPROVIDER - IRF	41		489,222		2
3	REHAB SERVICES	B	SUBPROVIDER - IRF	41		160,377		3
500	TOTAL RECLASSIFICATIONS					1,044,790		500
	CODE LETTER - B							
1	INTEREST EXPENSE	C	INTEREST EXPENSE	113		2,677,652	11	1
2	INTEREST EXPENSE	C	INTEREST EXPENSE	113		571,558	11	2
3	CAPITAL LEASE INTEREST	C	REAL ESTATE	192.02		7,612	11	3
500	TOTAL RECLASSIFICATIONS					3,256,822		500
	CODE LETTER - C							
1	DEPRECIATION EXPENSE	D	CAP REL COSTS-BLDG & FIXT	1		3,859,832	9	1
2	DEPRECIATION EXPENSE	D	PHYSICIANS' PRIVATE OFFICES	192		604	9	2
3	DEPRECIATION EXPENSE	D	LABORATORY	60		119,084	9	3
4	DEPRECIATION EXPENSE	D	REAL ESTATE	192.02		35,643	9	4
5	DEPRECIATION EXPENSE	D	OTHER ADMIN & GEN	5.06		39,763	9	5
6	DEPRECIATION EXPENSE	D	EMPLOYEE BENEFITS DEPARTMENT	4		290	9	6
500	TOTAL RECLASSIFICATIONS					4,055,216		500
	CODE LETTER - D							
1	PROPERTY TAXES	E	OTHER ADMIN & GEN	5.06		2,396,105		1
500	TOTAL RECLASSIFICATIONS					2,396,105		500
	CODE LETTER - E							
1	MEDICAL SUPPLIES	F	DELIVERY ROOM & LABOR ROOM	52		113,280		1
2	MEDICAL SUPPLIES	F	CARDIAC REHABILITATION	76.97		7,375		2
3	MEDICAL SUPPLIES	F	CARDIAC CATHETERIZATION	59		1,239,486		3
4	MEDICAL SUPPLIES	F	RESPIRATORY THERAPY	65		174,895		4
5	MEDICAL SUPPLIES	F	CENTRAL SERVICES & SUPPLY	14		349,186		5
6	MEDICAL SUPPLIES	F	EMERGENCY	91		165,523		6
7	MEDICAL SUPPLIES	F	OPERATING ROOM	50		4,563,450		7
8	MEDICAL SUPPLIES	F	OPERATING ROOM	50		43,601		8
9	MEDICAL SUPPLIES	F	ENDOSCOPY	50.01		225,012		9
10	MEDICAL SUPPLIES	F	OPERATING ROOM	50		291,847		10
11	MEDICAL SUPPLIES	F	ANESTHESIOLOGY	53		148,762		11
500	TOTAL RECLASSIFICATIONS					7,322,417		500
	CODE LETTER - F							
1	AMBULANCE INSURANCE	G	OTHER ADMIN & GEN	5.06		67,735		1
500	TOTAL RECLASSIFICATIONS					67,735		500
	CODE LETTER - G							
1	EXECUTIVE HEALTH RESOURCES	H	SOCIAL SERVICE	17		130,905		1
500	TOTAL RECLASSIFICATIONS					130,905		500
	CODE LETTER - H							
1	INTERNS & RESIDENTS	I	I&R SERVICES-OTHER PRGM COSTS	22		948,647		1
500	TOTAL RECLASSIFICATIONS					948,647		500
	CODE LETTER - I							
1	RADIOLOGY SHARED SERVICES	J	RADIOLOGY-DIAGNOSTIC	54	62,603			1
2	RADIOLOGY SHARED SERVICES	J	RADIOLOGY-DIAGNOSTIC	54	43,716			2
3	RADIOLOGY SHARED SERVICES	J	RADIOLOGY-DIAGNOSTIC	54	10,367			3
4	RADIOLOGY SHARED SERVICES	J	RADIOLOGY-DIAGNOSTIC	54	21,408			4
5	RADIOLOGY SHARED SERVICES	J	RADIOLOGY-DIAGNOSTIC	54	21,255			5
500	TOTAL RECLASSIFICATIONS				159,349			500
	CODE LETTER - J							
1	DIRECTORS	L	NURSING ADMINISTRATION	13	63,785			1
2	DIRECTORS	L	NURSING ADMINISTRATION	13	61,909			2
3	DIRECTORS	L	NURSING ADMINISTRATION	13	32,630			3
4	DIRECTORS	L	NURSING ADMINISTRATION	13	11,772			4
5	DIRECTORS	L	NURSING ADMINISTRATION	13	10,859			5
6	DIRECTORS	L	NURSING ADMINISTRATION	13	7,120			6
7	DIRECTORS	L	NURSING ADMINISTRATION	13	8,596			7
8	DIRECTORS	L	NURSING ADMINISTRATION	13	40,603			8
9	DIRECTORS	L	NURSING ADMINISTRATION	13	12,100			9
10	DIRECTORS	L	NURSING ADMINISTRATION	13	26,410			10
11	DIRECTORS	L	NURSING ADMINISTRATION	13	33,545			11
12	DIRECTORS	L	NURSING ADMINISTRATION	13	41,892			12



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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				WKST A-7 REF.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
13	DIRECTORS	L	NURSING ADMINISTRATION	13	38,867			13
14	DIRECTORS	L	NURSING ADMINISTRATION	13	49,800			14
15	DIRECTORS	L	NURSING ADMINISTRATION	13	58,998			15
16	DIRECTORS	L	PHARMACY	15	17,511			16
17	DIRECTORS	L	AMBULANCE SERVICES	95	9,713			17
500	TOTAL RECLASSIFICATIONS				526,110			500
	CODE LETTER - L							
1	RECLASSIFICATION OF MOB EXPENSE	M	REAL ESTATE	192.02		168,882		1
2	RECLASSIFICATION OF MOB EXPENSE	M	REAL ESTATE	192.02		126,448		2
500	TOTAL RECLASSIFICATIONS					295,330		500
	CODE LETTER - M							
1	DIETARY RECLASSIFICATION	N	DIETARY	10	450,815	645,556		1
500	TOTAL RECLASSIFICATIONS				450,815	645,556		500
	CODE LETTER - N							
1	PYXIS RECLASSIFICATION	O	PURCH,RCVING,STORING	5.03		327,900		1
2	PYXIS RECLASSIFICATION	O	PURCH,RCVING,STORING	5.03		363,576		2
500	TOTAL RECLASSIFICATIONS					691,476		500
	CODE LETTER - O							
1	IMPLANT SUPPLIES	P	DELIVERY ROOM & LABOR ROOM	52		40,786		1
2	IMPLANT SUPPLIES	P	CARDIAC CATHETERIZATION	59		1,661,511		2
3	IMPLANT SUPPLIES	P	CENTRAL SERVICES & SUPPLY	14		235,524		3
4	IMPLANT SUPPLIES	P	OPERATING ROOM	50		3,693,330		4
5	IMPLANT SUPPLIES	P	OPERATING ROOM	50		354		5
6	IMPLANT SUPPLIES	P	ENDOSCOPY	50.01		6,527		6
7	IMPLANT SUPPLIES	P	ANESTHESIOLOGY	53		5,217		7
500	TOTAL RECLASSIFICATIONS					5,643,249		500
	CODE LETTER - P							
1	CLOSED DEPARTMENT	Q	RADIOLOGY-THERAPEUTIC	55	32,412	11,963		1
2	CLOSED DEPARTMENT	Q	ONCOLOGY	55.01		12,007		2
3	CLOSED DEPARTMENT	Q	RADIOLOGY-DIAGNOSTIC	54	197			3
4	SYSTEM DEPARTMENT	Q	OTHER ADMIN & GEN	5.06	5,192			4
5	PURCHASED SERVICE	Q	HOUSEKEEPING	9	3,775			5
6	CLOSED DEPARTMENT	Q	CARDIAC CATHETERIZATION	59		6,420		6
500	TOTAL RECLASSIFICATIONS				41,576	30,390		500
	CODE LETTER - Q							
1	COUNTY PLAZA LEASE	R	REAL ESTATE	192.02		147,576		1
2	COUNTY PLAZA LEASE	R	REAL ESTATE	192.02		48,198		2
3	COUNTY PLAZA LEASE	R	REAL ESTATE	192.02		72,388		3
4	COUNTY PLAZA LEASE	R	REAL ESTATE	192.02		34,932		4
5	COUNTY PLAZA LEASE	R	REAL ESTATE	192.02		147,255		5
6	COUNTY PLAZA LEASE	R	REAL ESTATE	192.02		5,508		6
7	COUNTY PLAZA LEASE	R	REAL ESTATE	192.02		14,643		7
8	COUNTY PLAZA LEASE	R	REAL ESTATE	192.02		68,854		8
500	TOTAL RECLASSIFICATIONS					539,354		500
	CODE LETTER - R							
	GRAND TOTAL (DECREASES)				1,177,850	29,688,789		

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



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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS	
			PURCHASES	DONATION	TOTAL				
		1	2	3	4	5	6	7	
1	LAND	6,156,757				88,190	6,068,567		1
2	LAND IMPROVEMENTS	4,865,252				1,682	4,863,570	2,491,413	2
3	BUILDINGS AND FIXTURES	62,708,331	398,637		398,637	366,992	62,739,976	9,332,774	3
4	BUILDING IMPROVEMENTS	68,508					68,508		4
5	FIXED EQUIPMENT	3,081,850	148,271		148,271		3,230,121	1,741,825	5
6	MOVABLE EQUIPMENT	69,463,481	3,045,685		3,045,685	400,902	72,108,264	45,100,447	6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	146,344,179	3,592,593		3,592,593	857,766	149,079,006	58,666,459	8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	146,344,179	3,592,593		3,592,593	857,766	149,079,006	58,666,459	10

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

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(1) (Sum of (cols. 9 through 14)	
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	7,881,880							7,881,880	1
2	CAP REL COSTS-MVBLE EQUIP									2
3	TOTAL (sum of lines 1-2)	7,881,880							7,881,880	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	76,970,742		76,970,742	0.516308			76,690	76,690	1
2	CAP REL COSTS-MVBLE EQU	72,108,264		72,108,264	0.483692			71,845	71,845	2
3	TOTAL (sum of lines 1-2)	149,079,006		149,079,006	1.000000			148,535	148,535	3

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(2) (sum of (cols. 9 through 14)	
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	4,056,274		1,417,104			76,690	5,550,068	1	
2	CAP REL COSTS-MVBLE EQUIP	4,370,896		310,101			71,845	4,752,842	2	
3	TOTAL (sum of lines 1-2)	8,427,170		1,727,205			148,535	10,302,910	3	

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



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF.
				COST CENTER	LINE#	
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3	INVESTMENT INCOME-OTHER (chapter 2)					3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)	B	-1,004	PURCH.RCVING.STORING	5.03	4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)					5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)					6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)	B	75	NONPATIENT TELEPHONE	5.01	7
8	TELEVISION AND RADIO SERVICE (chapter 21)					8
9	PARKING LOT (chapter 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-4,154,584			10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	-3,537,363			12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-406,967	CAFETERIA	11	14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17	SALE OF DRUGS TO OTHER THAN PATIENTS					17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-11,107	MEDICAL RECORDS & LIBRARY	16	18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20	VENDING MACHINES					20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)	B	1,033	OTHER ADMIN & GEN	5.06	21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS					22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114	25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29	PHYSICIANS' ASSISTANT					29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32	CAH HIT ADJ FOR DEPRECIATION AND					32
33	MUSCLR SKEL CLINIC REV	B	-6,366	OTHER ADMIN & GEN	5.06	33
34	MEDICAL STAFF MISC INCOME	B	-68,430	OTHER ADMIN & GEN	5.06	34
35	CARDIO PULM REHAB FITNESS	B	-5,228	CARDIAC REHABILITATION	76.97	35
36	ADMINISTRATION MISC INCOME	B	-150,000	OTHER ADMIN & GEN	5.06	36
37	OB/GYN MISC INCOME	B	50	ADULTS & PEDIATRICS	30	37
38	LABOR & DELIVERY MISC INCOME	B	-225	DELIVERY ROOM & LABOR ROOM	52	38
39	EMS RESOURCE HOSP MISC	B	-83,050	EMERGENCY	91	39
40	EMPLOYEE HEALTH MISC INCOME	B	-929	EMPLOYEE BENEFITS DEPARTMENT	4	40
41						41
42	LABORATORY MISC INCOME	B	-1,530	LABORATORY	60	42
43	CLINICAL EDUCATION	B	-765	NURSING ADMINISTRATION	13	43
44	OTHER OPER REV	B	-59,729	OTHER ADMIN & GEN	5.06	44
45	DONATIONS	A	-22,600	OTHER ADMIN & GEN	5.06	45
46	ENVIRONMENT SERV MISC INCOME	B	-828	HOUSEKEEPING	9	46
47	NON-INVASIVE CARDIO COMMITT TO POO	B	-510	CARDIOLOGY	69.01	47
48	EMP ACTIVITY EOMM MISC INCOME	B	-6,062	EMPLOYEE BENEFITS DEPARTMENT	4	48
49						49
49.02	PAT ACCT INV INCOME	B	-848,287	CASHIERING,A/R	5.05	49.02
49.03	INCOME TAX ON UNRELATED INCOME	A	-7,167	OTHER ADMIN & GEN	5.06	49.03
49.04	COMMIT TO POOR-CASE MANAGEMENT	A	-28,252	SOCIAL SERVICE	17	49.04
49.05	COMMIT TO POOR-SPONSERSHIPS	A	-150	OTHER ADMIN & GEN	5.06	49.05
49.07	ADMIN NON ALLOWABLE EXPENSE	A	-3,230	OTHER ADMIN & GEN	5.06	49.07
49.09	LOBBYING COSTS	A	-38,975	OTHER ADMIN & GEN	5.06	49.09
49.10	PHYSICIAN HOSPITALIST SUBSIDY	A	-2,128,055	OTHER ADMIN & GEN	5.06	49.10
49.11	REHAB UNIT COMMITT TO POOR	A	-12	SUBPROVIDER - IRF	41	49.11
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-11,570,247			50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (see instructions)



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

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

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

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

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



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PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	5.06	OTHER ADMIN & GEN	ADMINISTRATIVE FEE	2,378,276	13,215,806	-10,837,530		1
2	5.02	DATA PROCESSING	ADMINISTRATIVE FEE	6,028,562		6,028,562		2
3	5.05	CASHIERING,A/R	ADMINISTRATIVE FEE	1,973,274		1,973,274		3
3.01	31	INTENSIVE CARE UNIT	EICU	478,042		478,042		3.01
3.02	2	CAP REL COSTS-MVBLE EQUIP	DEPRECIATION ALLOCATION	2,291,535	1,941,629	349,906	9	3.02
3.03	1	CAP REL COSTS-BLDG & FIXT	INTEREST ALLOCATION	1,417,104	2,677,652	-1,260,548	11	3.03
3.04	2	CAP REL COSTS-MVBLE EQUIP	INTEREST ALLOCATION	302,488	571,557	-269,069	11	3.04
3.05	60	LABORATORY	ALVERNO LAB FEES	4,395,681	4,395,681			3.05
3.06	5.06	OTHER ADMIN & GEN	SELF INS TRUST	1,938,044	1,938,044			3.06
3.07	4	EMPLOYEE BENEFITS DEPARTMENT	WORKERS COMP	542,746	542,746			3.07
4								4
5		TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12		21,745,752	25,283,115	-3,537,363		5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.

Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

RELATED ORGANIZATION(S) AND/OR HOME OFFICE						
	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
	1	2	3	4	5	6
6	B			PRESENCE HEALTH PRV		HEALTH MANAGEMENT
7	G			APHL LABS		LAB SERVICE
8						
9						
10						

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

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



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	30	ADULTS & PEDIATRICS DR S	78,450	58,450	20,000	142,500	200	13,702	685	1
2	31	INTENSIVE CARE UNIT DR C	334,700	300,248	34,452	231,100	180	19,999	1,000	2
3	41	SUBPROVIDER - IRF DR R	52,520	52,520		171,400				3
4	43	NURSERY DR O	628,028	628,028		171,400				4
5	50	OPERATING ROOM DR S	6,000		6,000	231,100	39	4,333	217	5
6	53	ANESTHESIOLOGY DR C	2,491,750	2,491,750		200,300				6
7	54	RADIOLOGY-DIAGNOSTIC DR L	23,375		23,375	231,100	187	20,777	1,039	7
8	57	CT SCAN DR L	8,567	8,567		231,100				8
9	60	LABORATORY DR C	63,625		63,625	219,500	240	25,327	1,266	9
10	65	RESPIRATORY THERAPY DR C	18,000		18,000	171,400	120	9,888	494	10
11	69.01	CARDIOLOGY DR V	85,526	85,526		171,400				11
12	91	EMERGENCY DR ER	454,039	454,039		171,400				12
13	59	CARDIAC CATHETERIZAT DR C	19,585		19,585	231,100	140	15,555	778	13
200		TOTAL	4,264,165	4,079,128	185,037		1,106	109,581	5,479	200



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	30	ADULTS & PEDIATRICS DR S					13,702	6,298	64,748	1
2	31	INTENSIVE CARE UNIT DR C					19,999	14,453	314,701	2
3	41	SUBPROVIDER - IRF DR R							52,520	3
4	43	NURSERY DR O							628,028	4
5	50	OPERATING ROOM DR S					4,333	1,667	1,667	5
6	53	ANESTHESIOLOGY DR C							2,491,750	6
7	54	RADIOLOGY-DIAGNOSTIC DR L					20,777	2,598	2,598	7
8	57	CT SCAN DR L							8,567	8
9	60	LABORATORY DR C					25,327	38,298	38,298	9
10	65	RESPIRATORY THERAPY DR C					9,888	8,112	8,112	10
11	69.01	CARDIOLOGY DR V							85,526	11
12	91	EMERGENCY DR ER							454,039	12
13	59	CARDIAC CATHETERIZAT DR C					15,555	4,030	4,030	13
200		TOTAL					109,581	75,456	4,154,584	200



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A. col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE	DATA PROCESSING	
		0	1	2	4	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT	5,550,068	5,550,068					1
2	CAP REL COSTS-MVBLE EQUIP	4,752,842		4,752,842				2
4	EMPLOYEE BENEFITS DEPARTMENT	10,488,011	2,853	489	10,491,353			4
5.01	NONPATIENT TELEPHONE	829,859	10,719	3,887	73,156	917,621		5.01
5.02	DATA PROCESSING	6,492,710	40,347	1,409,449	35,227	32,000	8,009,733	5.02
5.03	PURCH.RCVING.STORING	238,491		50,046		8,649	56,307	5.03
5.04	ADMITTING	630,223	31,569	27,508	157,918	44,973	239,307	5.04
5.05	CASHIERING.A/R	2,121,605	4,220	78,456		3,459	98,538	5.05
5.06	OTHER ADMIN & GEN	16,351,494	274,149	587,462	751,727	140,973	1,112,072	5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	4,884,381	1,171,881	483,126	271,643	19,027	154,845	7
8	LAUNDRY & LINEN SERVICE	461,099	14,307	291		1,730		8
9	HOUSEKEEPING	1,272,923	65,064	1,096	251,140	6,919	56,307	9
10	DIETARY	763,154	169,063	3,866	84,877	15,568	70,384	10
11	CAFETERIA	689,404	37,921	5,554	121,936	22,486	84,461	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,003,683	7,028	87,435	257,973	5,189		13
14	CENTRAL SERVICES & SUPPLY	414,305	194,309	38,281	53,919	7,784	84,461	14
15	PHARMACY	1,800,470	50,198	5,353	481,896	21,622	182,999	15
16	MEDICAL RECORDS & LIBRARY	1,698,761	122,128	273	264,925	28,541	492,690	16
17	SOCIAL SERVICE	740,904	9,234	34	188,492	10,378	84,461	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	948,647						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	606,383				1,730		22
23	PARAMED ED PRGM-(SPECIFY)							23
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	9,433,673	927,124	25,722	2,421,112	140,973	1,449,917	30
31	INTENSIVE CARE UNIT	2,639,138	149,360	15,646	558,126	16,432	182,999	31
41	SUBPROVIDER - IRF	1,772,677	194,544	5,803	341,514	40,649	394,152	41
43	NURSERY	554,131	56,388	5,711	135,745	10,378	70,384	43
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	4,604,249	405,056	384,142	842,052	49,297	802,381	50
50.01	ENDOSCOPY	1,135,222	64,843	14,359	194,050	16,432	239,307	50.01
51	RECOVERY ROOM	499,166	35,142		132,623	16,432		51
52	DELIVERY ROOM & LABOR ROOM	455,086	141,611	88,077	96,439	17,297	126,692	52
53	ANESTHESIOLOGY	69,967	5,940	6,683		3,459		53
54	RADIOLOGY-DIAGNOSTIC	824,238	126,069	113,168	194,175	19,892	126,692	54
54.01	ULTRASOUND	286,715	33,451	20,981	70,982	6,919	56,307	54.01
54.02	MAMMOGRAPHY	99,589	47,507	24,180	16,833	865	14,077	54.02
55	RADIOLOGY-THERAPEUTIC							55
55.01	ONCOLOGY							55.01
56	RADIOISOTOPE	272,141	18,306	1,796	34,512	6,054	28,154	56
57	CT SCAN	457,932	34,745	83,522	101,650	12,973	70,384	57
58	MRI	174,346	23,246	182,079	34,760	8,649	28,154	58
59	CARDIAC CATHETERIZATION	1,130,924	123,011	625,305	248,019	12,973	197,076	59
60	LABORATORY	4,433,394	171,386	84,402		43,243	436,383	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	566,819						63
65	RESPIRATORY THERAPY	1,106,463	90,177	15,509	287,048	23,351	140,769	65
66	PHYSICAL THERAPY	859,246	52,786	1,610		1,730		66
67	OCCUPATIONAL THERAPY	770,132	34,230			1,730		67
68	SPEECH PATHOLOGY	237,320	2,794			865		68
69.01	CARDIOLOGY	477,340	37,759	91,225	114,106	14,703	112,615	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,650,317						71
72	IMPL. DEV. CHARGED TO PATIENTS	5,643,249						72
73	DRUGS CHARGED TO PATIENTS	2,984,373						73
74	RENAL DIALYSIS	173,555	6,249	1,430		2,595	28,154	74
76.97	CARDIAC REHABILITATION	323,215	45,537	13,254	86,410	3,459	84,461	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	2,953,942	162,975	55,337	725,075	46,703	323,768	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	2,863,720		74,953	525,433		295,614	95
SPECIAL PURPOSE COST CENTERS								
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	118,191,696	5,195,226	4,717,500	10,155,493	889,081	7,925,272	118
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	206,813	24,687	5,300	14,067			190
192	PHYSICIANS' PRIVATE OFFICES	1,257,300	34,274	2,585	141,245	12,108		192
192.01	COVENANT OUTPATIENT PHARMACY	748,808	10,895	194	54,558	4,324		192.01
192.02	REAL ESTATE	716,681						192.02



COMPU-MAX

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE	DATA PROCESSING	
		0	1	2	4	5.01	5.02	
192.03	FOUNDATION	664,844		21,411	71,627	5,189	84,461	192.03
192.04	OUTREACH PROGRAMS	357,768	121,379	5,852	54,363	6,919		192.04
192.05	UNASSIGNED		163,607					192.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	122,143,910	5,550,068	4,752,842	10,491,353	917,621	8,009,733	202



COMPU-MAX

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PURCH RCVING STORING	ADMITTING	CASHIERING A/R	SUBTOTAL (cols.0-4)	OTHER ADMIN GEN	OPERATION OF PLANT	
		5.03	5.04	5.05	4A	5.06	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONE							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCH.RCVING.STORING	353,493						5.03
5.04	ADMITTING	204	1,131,702					5.04
5.05	CASHIERING.A/R	2		2,306,280				5.05
5.06	OTHER ADMIN & GEN	1,576			19,219,453	19,219,453		5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	3,654			6,988,557	1,305,001	8,293,558	7
8	LAUNDRY & LINEN SERVICE	963			478,390	89,332	29,557	8
9	HOUSEKEEPING	2,179			1,655,628	309,162	134,421	9
10	DIETARY	992			1,107,904	206,883	349,281	10
11	CAFETERIA	1,426			963,188	179,860	78,344	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	216			1,361,524	254,243	14,520	13
14	CENTRAL SERVICES & SUPPLY	298			793,357	148,147	401,439	14
15	PHARMACY				2,542,538	474,778	103,709	15
16	MEDICAL RECORDS & LIBRARY	1,387			2,608,705	487,134	252,316	16
17	SOCIAL SERVICE	9			1,033,512	192,992	19,077	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD				948,647	177,145		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD				608,113	113,555		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICES	5,545	153,326	187,139	14,744,531	2,753,259	1,915,426	30
31	INTENSIVE CARE UNIT	1,428	44,436	47,542	3,655,107	682,533	308,575	31
41	SUBPROVIDER - IRF	731	28,361	30,343	2,808,774	524,494	401,925	41
43	NURSERY	336	14,592	15,611	863,276	161,203	116,498	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	10,295	110,065	303,357	7,510,894	1,402,539	836,841	50
50.01	ENDOSCOPY	470	6,926	78,417	1,750,026	326,789	133,965	50.01
51	RECOVERY ROOM	182	14,206	38,305	736,056	137,447	72,602	51
52	DELIVERY ROOM & LABOR ROOM	1,096	23,060	25,614	974,972	182,060	292,566	52
53	ANESTHESIOLOGY	98	36,585	111,141	233,873	43,672	12,273	53
54	RADIOLOGY-DIAGNOSTIC	513	15,041	43,309	1,463,097	273,210	260,457	54
54.01	ULTRASOUND	527	6,894	18,105	500,881	93,532	69,109	54.01
54.02	MAMMOGRAPHY	589	2	3,748	207,390	38,727	98,150	54.02
55	RADIOLOGY-THERAPEUTIC							55
55.01	ONCOLOGY							55.01
56	RADIOISOTOPE	3,035	3,835	14,068	381,901	71,314	37,820	56
57	CT SCAN	1,623	25,411	86,082	874,322	163,266	71,782	57
58	MRI	886	14,609	35,600	502,329	93,802	48,027	58
59	CARDIAC CATHETERIZATION	402	30,921	86,215	2,454,846	458,403	254,139	59
60	LABORATORY	7	120,717	260,770	5,550,302	1,036,430	354,081	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	12,781	6,231	9,634	595,465	111,194		63
65	RESPIRATORY THERAPY	104	93,485	111,012	1,867,918	348,804	186,306	65
66	PHYSICAL THERAPY	208	16,171	24,646	956,397	178,592	109,055	66
67	OCCUPATIONAL THERAPY	10	13,444	18,142	837,688	156,425	70,719	67
68	SPEECH PATHOLOGY		3,267	4,173	248,419	46,388	5,772	68
69.01	CARDIOLOGY	1,006	15,436	34,611	898,801	167,837	78,010	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	165,096	48,788	98,869	7,963,070	1,486,976		71
72	IMPL. DEV. CHARGED TO PATIENTS	127,244	62,296	108,283	5,941,072	1,109,400		72
73	DRUGS CHARGED TO PATIENTS		181,749	280,878	3,447,000	643,672		73
74	RENAL DIALYSIS		2,392	2,622	216,997	40,521	12,910	74
76.97	CARDIAC REHABILITATION	152	1,825	6,232	564,545	105,420	94,079	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	1,792	37,631	178,932	4,486,155	837,718	336,705	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	1,608		42,880	3,804,208	710,375		95
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	350,670	1,131,702	2,306,280	117,349,828	18,324,234	7,560,456	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,108			252,975	47,239	51,004	190
192	PHYSICIANS' PRIVATE OFFICES	113			1,447,625	270,321	70,810	192
192.01	COVENANT OUTPATIENT PHARMACY	19			818,798	152,897	22,510	192.01
192.02	REAL ESTATE				716,681	133,829		192.02



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	PURCH RCVING STORING	ADMITTING	CASHIERING A/R	SUBTOTAL (cols.0-4) 4A	OTHER ADMIN GEN 5.06	OPERATION OF PLANT 7	
192.03	FOUNDATION	212	5.04	5.05	847,744	158,303		192.03
192.04	OUTREACH PROGRAMS	371			546,652	102,079	250,767	192.04
192.05	UNASSIGNED				163,607	30,551	338,011	192.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	353,493	1,131,702	2,306,280	122,143,910	19,219,453	8,293,558	202



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
192.03	FOUNDATION				7,243			192.03
192.04	OUTREACH PROGRAMS	6,208	64,753		7,661		1,033	192.04
192.05	UNASSIGNED		87,281					192.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	597,279	2,099,211	1,754,259	1,241,622	1,661,129	1,497,342	202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	
		15	16	17	21	22	24	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONE							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCH.RCVING.STORING							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING.A/R							5.05
5.06	OTHER ADMIN & GEN							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	3,266,817						15
16	MEDICAL RECORDS & LIBRARY		3,459,185					16
17	SOCIAL SERVICE			1,271,239				17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD				1,125,792			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					721,668		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	10,875	2,284,446	830,627	946,678	606,851	27,023,682	30
31	INTENSIVE CARE UNIT	5,740	331,736	120,641	44,469	28,506	5,648,320	31
41	SUBPROVIDER - IRF	664	495,701	180,262			4,953,392	41
43	NURSERY	1,517	174,343	63,435			1,573,497	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	72,366					10,450,336	50
50.01	ENDOSCOPY	25,032			66,309	42,506	2,461,574	50.01
51	RECOVERY ROOM	442					1,014,547	51
52	DELIVERY ROOM & LABOR ROOM	13,814					1,598,439	52
53	ANESTHESIOLOGY	13,922					306,909	53
54	RADIOLOGY-DIAGNOSTIC	496					2,148,964	54
54.01	ULTRASOUND						702,739	54.01
54.02	MAMMOGRAPHY	2					379,391	54.02
55	RADIOLOGY-THERAPEUTIC							55
55.01	ONCOLOGY							55.01
56	RADIOISOTOPE	822					526,409	56
57	CT SCAN	4,061					1,185,076	57
58	MRI	404					671,813	58
59	CARDIAC CATHETERIZATION	9,242					3,339,030	59
60	LABORATORY						7,033,317	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.						706,659	63
65	RESPIRATORY THERAPY	137					2,563,971	65
66	PHYSICAL THERAPY						1,275,444	66
67	OCCUPATIONAL THERAPY						1,085,732	67
68	SPEECH PATHOLOGY						303,364	68
69.01	CARDIOLOGY	2,266			68,336	43,805	1,326,862	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	90,676					10,345,109	71
72	IMPL. DEV. CHARGED TO PATIENTS						7,670,394	72
73	DRUGS CHARGED TO PATIENTS	2,951,549					7,042,221	73
74	RENAL DIALYSIS	39					274,903	74
76.97	CARDIAC REHABILITATION	7					817,076	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	40,545	172,959	76,274			6,389,294	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	12,280					4,660,547	95
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	3,256,898	3,459,185	1,271,239	1,125,792	721,668	115,479,011	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						368,265	190
192	PHYSICIANS' PRIVATE OFFICES	9,919					1,828,934	192
192.01	COVENANT OUTPATIENT PHARMACY						1,005,297	192.01
192.02	REAL ESTATE						850,510	192.02



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	
		15	16	17	21	22	24	
192.03	FOUNDATION						1,013,290	192.03
192.04	OUTREACH PROGRAMS						979,153	192.04
192.05	UNASSIGNED						619,450	192.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	3,266,817	3,459,185	1,271,239	1,125,792	721,668	122,143,910	202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	NONPATIENT TELEPHONE						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCH.RCVING.STORING						5.03
5.04	ADMITTING						5.04
5.05	CASHIERING.A/R						5.05
5.06	OTHER ADMIN & GEN						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	-1,553,529	25,470,153				30
31	INTENSIVE CARE UNIT	-72,975	5,575,345				31
41	SUBPROVIDER - IRF		4,953,392				41
43	NURSERY		1,573,497				43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		10,450,336				50
50.01	ENDOSCOPY	-108,815	2,352,759				50.01
51	RECOVERY ROOM		1,014,547				51
52	DELIVERY ROOM & LABOR ROOM		1,598,439				52
53	ANESTHESIOLOGY		306,909				53
54	RADIOLOGY-DIAGNOSTIC		2,148,964				54
54.01	ULTRASOUND		702,739				54.01
54.02	MAMMOGRAPHY		379,391				54.02
55	RADIOLOGY-THERAPEUTIC						55
55.01	ONCOLOGY						55.01
56	RADIOISOTOPE		526,409				56
57	CT SCAN		1,185,076				57
58	MRI		671,813				58
59	CARDIAC CATHETERIZATION		3,339,030				59
60	LABORATORY		7,033,317				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.		706,659				63
65	RESPIRATORY THERAPY		2,563,971				65
66	PHYSICAL THERAPY		1,275,444				66
67	OCCUPATIONAL THERAPY		1,085,732				67
68	SPEECH PATHOLOGY		303,364				68
69.01	CARDIOLOGY	-112,141	1,214,721				69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		10,345,109				71
72	IMPL. DEV. CHARGED TO PATIENTS		7,670,394				72
73	DRUGS CHARGED TO PATIENTS		7,042,221				73
74	RENAL DIALYSIS		274,903				74
76.97	CARDIAC REHABILITATION		817,076				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY		6,389,294				91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES		4,660,547				95
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)	-1,847,460	113,631,551				118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		368,265				190
192	PHYSICIANS' PRIVATE OFFICES		1,828,934				192
192.01	COVENANT OUTPATIENT PHARMACY		1,005,297				192.01
192.02	REAL ESTATE		850,510				192.02



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
192.03	FOUNDATION		1,013,290				192.03
192.04	OUTREACH PROGRAMS		979,153				192.04
192.05	UNASSIGNED		619,450				192.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	-1,847,460	120,296,450				202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT	142,878	2,853	489	146,220	146,220		4
5.01	NONPATIENT TELEPHONE		10,719	3,887	14,606	1,020	15,626	5.01
5.02	DATA PROCESSING	46,663	40,347	1,409,449	1,496,459	491	545	5.02
5.03	PURCH.RCVING.STORING	90,740		50,046	140,786		147	5.03
5.04	ADMITTING	33,820	31,569	27,508	92,897	2,201	766	5.04
5.05	CASHIERING.A/R		4,220	78,456	82,676		59	5.05
5.06	OTHER ADMIN & GEN	269,015	274,149	587,462	1,130,626	10,478	2,401	5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	5,633	1,171,881	483,126	1,660,640	3,786	324	7
8	LAUNDRY & LINEN SERVICE		14,307	291	14,598		29	8
9	HOUSEKEEPING		65,064	1,096	66,160	3,500	118	9
10	DIETARY		169,063	3,866	172,929	1,183	265	10
11	CAFETERIA		37,921	5,554	43,475	1,700	383	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		7,028	87,435	94,463	3,596	88	13
14	CENTRAL SERVICES & SUPPLY	10,695	194,309	38,281	243,285	752	133	14
15	PHARMACY		50,198	5,353	55,551	6,717	368	15
16	MEDICAL RECORDS & LIBRARY		122,128	273	122,401	3,693	486	16
17	SOCIAL SERVICE		9,234	34	9,268	2,627	177	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	168,882			168,882		29	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	30,394	927,124	25,722	983,240	33,735	2,401	30
31	INTENSIVE CARE UNIT	46	149,360	15,646	165,052	7,779	280	31
41	SUBPROVIDER - IRF	17,427	194,544	5,803	217,774	4,760	692	41
43	NURSERY		56,388	5,711	62,099	1,892	177	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	5,176	405,056	384,142	794,374	11,737	839	50
50.01	ENDOSCOPY	363,636	64,843	14,359	442,838	2,705	280	50.01
51	RECOVERY ROOM		35,142		35,142	1,849	280	51
52	DELIVERY ROOM & LABOR ROOM		141,611	88,077	229,688	1,344	295	52
53	ANESTHESIOLOGY		5,940	6,683	12,623		59	53
54	RADIOLOGY-DIAGNOSTIC		126,069	113,168	239,237	2,706	339	54
54.01	ULTRASOUND		33,451	20,981	54,432	989	118	54.01
54.02	MAMMOGRAPHY		47,507	24,180	71,687	235	15	54.02
55	RADIOLOGY-THERAPEUTIC							55
55.01	ONCOLOGY							55.01
56	RADIOISOTOPE		18,306	1,796	20,102	481	103	56
57	CT SCAN		34,745	83,522	118,267	1,417	221	57
58	MRI		23,246	182,079	205,325	484	147	58
59	CARDIAC CATHETERIZATION		123,011	625,305	748,316	3,457	221	59
60	LABORATORY	5,333	171,386	84,402	261,121		736	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY		90,177	15,509	105,686	4,001	398	65
66	PHYSICAL THERAPY	4,948	52,786	1,610	59,344		29	66
67	OCCUPATIONAL THERAPY		34,230		34,230		29	67
68	SPEECH PATHOLOGY		2,794		2,794		15	68
69.01	CARDIOLOGY		37,759	91,225	128,984	1,590	250	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	327,900			327,900			71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS	363,576			363,576			73
74	RENAL DIALYSIS		6,249	1,430	7,679		44	74
76.97	CARDIAC REHABILITATION		45,537	13,254	58,791	1,204	59	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	528	162,975	55,337	218,840	10,106	795	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	153,666		74,953	228,619	7,324		95
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	2,040,956	5,195,226	4,717,500	11,953,682	141,539	15,140	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		24,687	5,300	29,987	196		190
192	PHYSICIANS' PRIVATE OFFICES	49,457	34,274	2,585	86,316	1,969	206	192
192.01	COVENANT OUTPATIENT PHARMACY		10,895	194	11,089	760	74	192.01
192.02	REAL ESTATE	497,960			497,960			192.02



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE	
		0	1	2	2A	4	5.01	
192.03	FOUNDATION	66,661		21,411	88,072	998	88	192.03
192.04	OUTREACH PROGRAMS	64,960	121,379	5,852	192,191	758	118	192.04
192.05	UNASSIGNED		163,607		163,607			192.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,719,994	5,550,068	4,752,842	13,022,904	146,220	15,626	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DATA PROCESSING	PURCH RCVING STORING	ADMITTING	CASHIERING A/R	OTHER ADMIN GEN	OPERATION OF PLANT	
		5.02	5.03	5.04	5.05	5.06	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONE							5.01
5.02	DATA PROCESSING	1,497,495						5.02
5.03	PURCH.RCVING.STORING	10,527	151,460					5.03
5.04	ADMITTING	44,741	87	140,692				5.04
5.05	CASHIERING.A/R	18,423	1		101,159			5.05
5.06	OTHER ADMIN & GEN	207,912	675			1,352,092		5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	28,950	1,565			91,809	1,787,074	7
8	LAUNDRY & LINEN SERVICE		413			6,285	6,369	8
9	HOUSEKEEPING	10,527	934			21,750	28,965	9
10	DIETARY	13,159	425			14,555	75,262	10
11	CAFETERIA	15,791	611			12,653	16,881	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		93			17,886	3,129	13
14	CENTRAL SERVICES & SUPPLY	15,791	127			10,422	86,501	14
15	PHARMACY	34,213				33,401	22,347	15
16	MEDICAL RECORDS & LIBRARY	92,113	594			34,271	54,368	16
17	SOCIAL SERVICE	15,791	4			13,577	4,111	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD					12,462		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					7,989		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	271,075	2,376	19,054	8,223	193,673	412,733	30
31	INTENSIVE CARE UNIT	34,213	612	5,522	2,089	48,017	66,491	31
41	SUBPROVIDER - IRF	73,690	313	3,524	1,333	36,899	86,606	41
43	NURSERY	13,159	144	1,813	686	11,341	25,103	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	150,013	4,411	13,678	13,145	98,671	180,320	50
50.01	ENDOSCOPY	44,741	201	861	3,446	22,990	28,866	50.01
51	RECOVERY ROOM		78	1,765	1,683	9,670	15,644	51
52	DELIVERY ROOM & LABOR ROOM	23,686	470	2,866	1,126	12,808	63,041	52
53	ANESTHESIOLOGY		42	4,546	4,884	3,072	2,644	53
54	RADIOLOGY-DIAGNOSTIC	23,686	220	1,869	1,903	19,221	56,123	54
54.01	ULTRASOUND	10,527	226	857	796	6,580	14,891	54.01
54.02	MAMMOGRAPHY	2,632	252		165	2,724	21,149	54.02
55	RADIOLOGY-THERAPEUTIC							55
55.01	ONCOLOGY							55.01
56	RADIOISOTOPE	5,264	1,300	477	618	5,017	8,149	56
57	CT SCAN	13,159	696	3,158	3,783	11,486	15,467	57
58	MRI	5,264	379	1,815	1,564	6,599	10,349	58
59	CARDIAC CATHETERIZATION	36,845	172	3,842	3,789	32,249	54,761	59
60	LABORATORY	81,586	3	15,001	11,459	72,914	76,296	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.		5,476	774	423	7,823		63
65	RESPIRATORY THERAPY	26,318	45	11,617	4,878	24,539	40,145	65
66	PHYSICAL THERAPY		89	2,010	1,083	12,564	23,499	66
67	OCCUPATIONAL THERAPY		4	1,671	797	11,005	15,238	67
68	SPEECH PATHOLOGY			406	183	3,263	1,244	68
69.01	CARDIOLOGY	21,054	431	1,918	1,521	11,808	16,809	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		70,740	6,063	4,345	104,611		71
72	IMPL. DEV. CHARGED TO PATIENTS		54,519	7,742	4,758	78,048		72
73	DRUGS CHARGED TO PATIENTS			22,643	12,343	45,283		73
74	RENAL DIALYSIS	5,264		297	115	2,851	2,782	74
76.97	CARDIAC REHABILITATION	15,791	65	227	274	7,416	20,272	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	60,531	768	4,676	7,863	58,935	72,552	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	55,268	689		1,884	49,976		95
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	1,481,704	150,250	140,692	101,159	1,289,113	1,629,107	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		903			3,323	10,990	190
192	PHYSICIANS' PRIVATE OFFICES		49			19,017	15,258	192
192.01	COVENANT OUTPATIENT PHARMACY		8			10,757	4,850	192.01
192.02	REAL ESTATE					9,415		192.02



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DATA PROCESSING	PURCH RCVING STORING	ADMITTING	CASHIERING A/R	OTHER ADMIN GEN	OPERATION OF PLANT	
		5.02	5.03	5.04	5.05	5.06	7	
192.03	FOUNDATION	15,791	91			11,137		192.03
192.04	OUTREACH PROGRAMS		159			7,181	54,035	192.04
192.05	UNASSIGNED					2,149	72,834	192.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,497,495	151,460	140,692	101,159	1,352,092	1,787,074	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
192.03	FOUNDATION				541			192.03
192.04	OUTREACH PROGRAMS	288	4,070		572		253	192.04
192.05	UNASSIGNED		5,486					192.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	27,694	131,954	283,447	92,766	121,515	367,198	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	
		15	16	17	21	22	24	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONE							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCH,RCVING,STORING							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING,A/R							5.05
5.06	OTHER ADMIN & GEN							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	163,094						15
16	MEDICAL RECORDS & LIBRARY		315,448					16
17	SOCIAL SERVICE			47,414				17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD				12,462			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					176,900		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	543	208,322	30,980			2,481,401	30
31	INTENSIVE CARE UNIT	287	30,251	4,500			414,368	31
41	SUBPROVIDER - IRF	33	45,204	6,723			535,694	41
43	NURSERY	76	15,899	2,366			158,674	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	3,613					1,312,791	50
50.01	ENDOSCOPY	1,250					555,952	50.01
51	RECOVERY ROOM	22					70,772	51
52	DELIVERY ROOM & LABOR ROOM	690					344,497	52
53	ANESTHESIOLOGY	695					28,764	53
54	RADIOLOGY-DIAGNOSTIC	25					355,951	54
54.01	ULTRASOUND						92,526	54.01
54.02	MAMMOGRAPHY						101,588	54.02
55	RADIOLOGY-THERAPEUTIC							55
55.01	ONCOLOGY							55.01
56	RADIOISOTOPE	41					46,479	56
57	CT SCAN	203					174,016	57
58	MRI	20					234,555	58
59	CARDIAC CATHETERIZATION	461					895,640	59
60	LABORATORY						524,913	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.						14,496	63
65	RESPIRATORY THERAPY	7					228,970	65
66	PHYSICAL THERAPY						100,667	66
67	OCCUPATIONAL THERAPY						64,254	67
68	SPEECH PATHOLOGY						8,059	68
69.01	CARDIOLOGY	113					189,943	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,527					715,452	71
72	IMPL. DEV. CHARGED TO PATIENTS						297,090	72
73	DRUGS CHARGED TO PATIENTS	147,354					591,199	73
74	RENAL DIALYSIS	2					19,296	74
76.97	CARDIAC REHABILITATION						107,744	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	2,024	15,772	2,845			484,981	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	613					354,847	95
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	162,599	315,448	47,414			11,505,579	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						46,517	190
192	PHYSICIANS' PRIVATE OFFICES	495					125,345	192
192.01	COVENANT OUTPATIENT PHARMACY						28,307	192.01
192.02	REAL ESTATE						507,375	192.02



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	
		15	16	17	21	22	24	
192.03	FOUNDATION						116,718	192.03
192.04	OUTREACH PROGRAMS						259,625	192.04
192.05	UNASSIGNED						244,076	192.05
200	CROSS FOOT ADJUSTMENTS				12,462	176,900	189,362	200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	163,094	315,448	47,414	12,462	176,900	13,022,904	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	NONPATIENT TELEPHONE						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCH.RCVING.STORING						5.03
5.04	ADMITTING						5.04
5.05	CASHIERING.A/R						5.05
5.06	OTHER ADMIN & GEN						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		2,481,401				30
31	INTENSIVE CARE UNIT		414,368				31
41	SUBPROVIDER - IRF		535,694				41
43	NURSERY		158,674				43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		1,312,791				50
50.01	ENDOSCOPY		555,952				50.01
51	RECOVERY ROOM		70,772				51
52	DELIVERY ROOM & LABOR ROOM		344,497				52
53	ANESTHESIOLOGY		28,764				53
54	RADIOLOGY-DIAGNOSTIC		355,951				54
54.01	ULTRASOUND		92,526				54.01
54.02	MAMMOGRAPHY		101,588				54.02
55	RADIOLOGY-THERAPEUTIC						55
55.01	ONCOLOGY						55.01
56	RADIOISOTOPE		46,479				56
57	CT SCAN		174,016				57
58	MRI		234,555				58
59	CARDIAC CATHETERIZATION		895,640				59
60	LABORATORY		524,913				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.		14,496				63
65	RESPIRATORY THERAPY		228,970				65
66	PHYSICAL THERAPY		100,667				66
67	OCCUPATIONAL THERAPY		64,254				67
68	SPEECH PATHOLOGY		8,059				68
69.01	CARDIOLOGY		189,943				69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		715,452				71
72	IMPL. DEV. CHARGED TO PATIENTS		297,090				72
73	DRUGS CHARGED TO PATIENTS		591,199				73
74	RENAL DIALYSIS		19,296				74
76.97	CARDIAC REHABILITATION		107,744				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY		484,981				91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES		354,847				95
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)		11,505,579				118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		46,517				190
192	PHYSICIANS' PRIVATE OFFICES		125,345				192
192.01	COVENANT OUTPATIENT PHARMACY		28,307				192.01
192.02	REAL ESTATE		507,375				192.02



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
192.03	FOUNDATION		116,718				192.03
192.04	OUTREACH PROGRAMS		259,625				192.04
192.05	UNASSIGNED		244,076				192.05
200	CROSS FOOT ADJUSTMENTS		189,362				200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)		13,022,904				202



COMPU-MAX

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NONPATIENT TELEPHONE N LINES	DATA PROCESSING N DEVICES	PURCH RCVING STORING SUPPLIES \$	
		1	2	4	5.01	5.02	5.03	
192.03	FOUNDATION		30,285	264,814	6	6	9,399	192.03
192.04	OUTREACH PROGRAMS	8,255	8,277	200,988	8		16,462	192.04
192.05	UNASSIGNED	11,127						192.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	5,550,068	4,752,842	10,491,353	917,621	8,009,733	353,493	202
203	UNIT COST MULT-WS B PT I	14.703647	0.706988	0.270480	864.864279	14,076.859402	0.022548	203
204	COST TO BE ALLOC PER B PT II			146,220	15,626	1,497,495	151,460	204
205	UNIT COST MULT-WS B PT II			0.003770	14.727615	2,631.801406	0.009661	205



COMPU-MAX

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	ADMITTING	CASHIERING	RECON- CILIATION	OTHER	OPERATION	LAUNDRY	
		INPATIENT REVENUE	A/R GROSS REVENUE		ADMIN GEN ACCUM COST	OF PLANT SQUARE FEET	& LINEN SERVICE POUNDS OF LAUNDRY	
		5.04	5.05	5A.06	5.06	7	8	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONE							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCH.RCVING.STORING							5.03
5.04	ADMITTING	287,566,312						5.04
5.05	CASHIERING,A/R		547,867,393					5.05
5.06	OTHER ADMIN & GEN			-19,219,453	102,924,457			5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT					6,988,557	273,016	7
8	LAUNDRY & LINEN SERVICE					478,390	973	8
9	HOUSEKEEPING					1,655,628	4,425	9
10	DIETARY					1,107,904	11,498	10
11	CAFETERIA					963,188	2,579	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION					1,361,524	478	13
14	CENTRAL SERVICES & SUPPLY					793,357	13,215	14
15	PHARMACY					2,542,538	3,414	15
16	MEDICAL RECORDS & LIBRARY					2,608,705	8,306	16
17	SOCIAL SERVICE					1,033,512	628	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD					948,647		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					608,113		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	38,964,636	44,451,019		14,744,531	63,054	388,973	30
31	INTENSIVE CARE UNIT	11,292,560	11,292,560		3,655,107	10,158	59,698	31
41	SUBPROVIDER - IRF	7,207,472	7,207,472		2,808,774	13,231	114,016	41
43	NURSERY	3,708,191	3,708,191		863,276	3,835	9,750	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	27,970,724	72,113,333		7,510,894	27,548	138,895	50
50.01	ENDOSCOPY	1,760,168	18,626,464		1,750,026	4,410	30,382	50.01
51	RECOVERY ROOM	3,610,292	9,098,673		736,056	2,390	14,648	51
52	DELIVERY ROOM & LABOR ROOM	5,860,311	6,084,099		974,972	9,631	42,017	52
53	ANESTHESIOLOGY	9,297,206	26,399,302		233,873	404		53
54	RADIOLOGY-DIAGNOSTIC	3,822,485	10,287,228		1,463,097	8,574	10,135	54
54.01	ULTRASOUND	1,752,084	4,300,535		500,881	2,275		54.01
54.02	MAMMOGRAPHY	404	890,168		207,390	3,231	2,292	54.02
55	RADIOLOGY-THERAPEUTIC							55
55.01	ONCOLOGY							55.01
56	RADIOISOTOPE	974,477	3,341,518		381,901	1,245	3,160	56
57	CT SCAN	6,457,568	20,447,127		874,322	2,363	17,568	57
58	MRI	3,712,605	8,455,962		502,329	1,581		58
59	CARDIAC CATHETERIZATION	7,857,821	20,478,635		2,454,846	8,366	28,080	59
60	LABORATORY	30,677,789	61,940,577		5,550,302	11,656	1,893	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	1,583,408	2,288,405		595,465			63
65	RESPIRATORY THERAPY	23,757,194	26,368,591		1,867,918	6,133		65
66	PHYSICAL THERAPY	4,109,570	5,854,160		956,397	3,590	4,564	66
67	OCCUPATIONAL THERAPY	3,416,508	4,309,338		837,688	2,328	4,564	67
68	SPEECH PATHOLOGY	830,211	991,235		248,419	190	2,282	68
69.01	CARDIOLOGY	3,922,684	8,221,063		898,801	2,568	5,416	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,398,495	23,484,284		7,963,070			71
72	IMPL. DEV. CHARGED TO PATIENTS	15,831,304	25,720,476		5,941,072			72
73	DRUGS CHARGED TO PATIENTS	46,155,419	66,716,794		3,447,000			73
74	RENAL DIALYSIS	607,802	622,849		216,997	425	1,939	74
76.97	CARDIAC REHABILITATION	463,725	1,480,287		564,545	3,097		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	9,563,199	42,501,747		4,486,155	11,084	143,837	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES		10,185,301		3,804,208		10,437	95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	287,566,312	547,867,393	-19,219,453	98,130,375	248,883	1,039,138	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				252,975	1,679		190
192	PHYSICIANS' PRIVATE OFFICES				1,447,625	2,331	2,349	192
192.01	COVENANT OUTPATIENT PHARMACY				818,798	741		192.01
192.02	REAL ESTATE				716,681			192.02



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	ADMITTING INPATIENT REVENUE	CASHIERING A/R GROSS REVENUE	RECON- CILIATION	OTHER ADMIN GEN ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	
		5.04	5.05	5A.06	5.06	7	8	
192.03	FOUNDATION				847,744			192.03
192.04	OUTREACH PROGRAMS				546,652	8,255	10,938	192.04
192.05	UNASSIGNED				163,607	11,127		192.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,131,702	2,306,280		19,219,453	8,293,558	597,279	202
203	UNIT COST MULT-WS B PT I	0.003935	0.004210		0.186734	30.377553	0.567526	203
204	COST TO BE ALLOC PER B PT II	140,692	101,159		1,352,092	1,787,074	27,694	204
205	UNIT COST MULT-WS B PT II	0.000489	0.000185		0.013137	6.545675	0.026314	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY TOTAL MEALS	CAFETERIA TOTAL EMPL FTE	NURSING ADMINISTRATION TOTAL REV EMP	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	
		9	10	11	13	14	15	
192.03	FOUNDATION			312				192.03
192.04	OUTREACH PROGRAMS	8,255		330		9,408		192.04
192.05	UNASSIGNED	11,127						192.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	2,099,211	1,754,259	1,241,622	1,661,129	1,497,342	3,266,817	202
203	UNIT COST MULT-WS B PT I	7.844058	10.509642	23.216133	38.973511	0.109852	0.888444	203
204	COST TO BE ALLOC PER B PT II	131,954	283,447	92,766	121,515	367,198	163,094	204
205	UNIT COST MULT-WS B PT II	0.493068	1.698111	1.734560	2.850992	0.026939	0.044355	205



COMPU-MAX

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

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

GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	NONPATIENT TELEPHONE						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCH.RCVING.STORING						5.03
5.04	ADMITTING						5.04
5.05	CASHIERING.A/R						5.05
5.06	OTHER ADMIN & GEN						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	10,000					16
17	SOCIAL SERVICE		10,000				17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD			10,000			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD				10,000		22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	6,604	6,534	8,409	8,409		30
31	INTENSIVE CARE UNIT	959	949	395	395		31
41	SUBPROVIDER - IRF	1,433	1,418				41
43	NURSERY	504	499				43
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM						50
50.01	ENDOSCOPY			589	589		50.01
51	RECOVERY ROOM						51
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
54.01	ULTRASOUND						54.01
54.02	MAMMOGRAPHY						54.02
55	RADIOLOGY-THERAPEUTIC						55
55.01	ONCOLOGY						55.01
56	RADIOISOTOPE						56
57	CT SCAN						57
58	MRI						58
59	CARDIAC CATHETERIZATION						59
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.						63
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69.01	CARDIOLOGY			607	607		69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	500	600				91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES						95
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,000	10,000	10,000	10,000		118
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192	PHYSICIANS' PRIVATE OFFICES						192



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME			
		16	17	21	22			
192.01	COVENANT OUTPATIENT PHARMACY							192.01
192.02	REAL ESTATE							192.02
192.03	FOUNDATION							192.03
192.04	OUTREACH PROGRAMS							192.04
192.05	UNASSIGNED							192.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	3,459,185	1,271,239	1,125,792	721,668			202
203	UNIT COST MULT-WS B PT I	345.918500	127.123900	112.579200	72.166800			203
204	COST TO BE ALLOC PER B PT II	315.448	47,414	12,462	176,900			204
205	UNIT COST MULT-WS B PT II	31.544800	4.741400	1.246200	17.690000			205



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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4



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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	25,470,153		25,470,153	6,298	25,476,451	30
31	INTENSIVE CARE UNIT	5,575,345		5,575,345	14,453	5,589,798	31
41	SUBPROVIDER - IRF	4,953,392		4,953,392		4,953,392	41
43	NURSERY	1,573,497		1,573,497		1,573,497	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	10,450,336		10,450,336	1,667	10,452,003	50
50.01	ENDOSCOPY	2,352,759		2,352,759		2,352,759	50.01
51	RECOVERY ROOM	1,014,547		1,014,547		1,014,547	51
52	DELIVERY ROOM & LABOR ROOM	1,598,439		1,598,439		1,598,439	52
53	ANESTHESIOLOGY	306,909		306,909		306,909	53
54	RADIOLOGY-DIAGNOSTIC	2,148,964		2,148,964	2,598	2,151,562	54
54.01	ULTRASOUND	702,739		702,739		702,739	54.01
54.02	MAMMOGRAPHY	379,391		379,391		379,391	54.02
55	RADIOLOGY-THERAPEUTIC						55
55.01	ONCOLOGY						55.01
56	RADIOISOTOPE	526,409		526,409		526,409	56
57	CT SCAN	1,185,076		1,185,076		1,185,076	57
58	MRI	671,813		671,813		671,813	58
59	CARDIAC CATHETERIZATION	3,339,030		3,339,030	4,030	3,343,060	59
60	LABORATORY	7,033,317		7,033,317	38,298	7,071,615	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	706,659		706,659		706,659	63
65	RESPIRATORY THERAPY	2,563,971		2,563,971	8,112	2,572,083	65
66	PHYSICAL THERAPY	1,275,444		1,275,444		1,275,444	66
67	OCCUPATIONAL THERAPY	1,085,732		1,085,732		1,085,732	67
68	SPEECH PATHOLOGY	303,364		303,364		303,364	68
69.01	CARDIOLOGY	1,214,721		1,214,721		1,214,721	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,345,109		10,345,109		10,345,109	71
72	IMPL. DEV. CHARGED TO PATIENTS	7,670,394		7,670,394		7,670,394	72
73	DRUGS CHARGED TO PATIENTS	7,042,221		7,042,221		7,042,221	73
74	RENAL DIALYSIS	274,903		274,903		274,903	74
76.97	CARDIAC REHABILITATION	817,076		817,076		817,076	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	6,389,294		6,389,294		6,389,294	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,422,639		3,422,639		3,422,639	92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	4,660,547		4,660,547		4,660,547	95
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	117,054,190		117,054,190	75,456	117,129,646	200
201	LESS OBSERVATION BEDS	3,422,639		3,422,639		3,422,639	201
202	TOTAL (SEE INSTRUCTIONS)	113,631,551		113,631,551		113,707,007	202



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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	38,964,636		38,964,636				30
31	INTENSIVE CARE UNIT	11,292,560		11,292,560				31
41	SUBPROVIDER - IRF	7,207,472		7,207,472				41
43	NURSERY	3,708,191		3,708,191				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	27,970,724	44,142,609	72,113,333	0.144915	0.144915	0.144939	50
50.01	ENDOSCOPY	1,760,168	16,866,296	18,626,464	0.126313	0.126313	0.126313	50.01
51	RECOVERY ROOM	3,610,292	5,488,381	9,098,673	0.111505	0.111505	0.111505	51
52	DELIVERY ROOM & LABOR ROOM	5,860,311	223,788	6,084,099	0.262724	0.262724	0.262724	52
53	ANESTHESIOLOGY	9,297,206	17,102,096	26,399,302	0.011626	0.011626	0.011626	53
54	RADIOLOGY-DIAGNOSTIC	3,822,485	6,464,743	10,287,228	0.208896	0.208896	0.209149	54
54.01	ULTRASOUND	1,752,084	2,548,451	4,300,535	0.163407	0.163407	0.163407	54.01
54.02	MAMMOGRAPHY	404	889,764	890,168	0.426202	0.426202	0.426202	54.02
55	RADIOLOGY-THERAPEUTIC							55
55.01	ONCOLOGY							55.01
56	RADIOISOTOPE	974,477	2,367,041	3,341,518	0.157536	0.157536	0.157536	56
57	CT SCAN	6,457,568	13,989,559	20,447,127	0.057958	0.057958	0.057958	57
58	MRI	3,712,605	4,743,357	8,455,962	0.079448	0.079448	0.079448	58
59	CARDIAC CATHETERIZATION	7,857,821	12,620,814	20,478,635	0.163049	0.163049	0.163246	59
60	LABORATORY	30,677,789	31,262,788	61,940,577	0.113549	0.113549	0.114168	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	1,583,408	704,997	2,288,405	0.308800	0.308800	0.308800	63
65	RESPIRATORY THERAPY	23,757,194	2,611,397	26,368,591	0.097236	0.097236	0.097543	65
66	PHYSICAL THERAPY	4,109,570	1,744,590	5,854,160	0.217870	0.217870	0.217870	66
67	OCCUPATIONAL THERAPY	3,416,508	892,830	4,309,338	0.251949	0.251949	0.251949	67
68	SPEECH PATHOLOGY	830,211	161,024	991,235	0.306046	0.306046	0.306046	68
69.01	CARDIOLOGY	3,922,684	4,298,379	8,221,063	0.147757	0.147757	0.147757	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,398,495	11,085,789	23,484,284	0.440512	0.440512	0.440512	71
72	IMPL. DEV. CHARGED TO PATIENTS	15,831,304	9,889,172	25,720,476	0.298221	0.298221	0.298221	72
73	DRUGS CHARGED TO PATIENTS	46,155,419	20,561,375	66,716,794	0.105554	0.105554	0.105554	73
74	RENAL DIALYSIS	607,802	15,047	622,849	0.441364	0.441364	0.441364	74
76.97	CARDIAC REHABILITATION	463,725	1,016,562	1,480,287	0.551971	0.551971	0.551971	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	9,563,199	32,938,548	42,501,747	0.150330	0.150330	0.150330	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,179,319	4,307,064	5,486,383	0.623843	0.623843	0.623843	92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES		10,185,301	10,185,301	0.457576	0.457576	0.457576	95
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	288,745,631	259,121,762	547,867,393				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	288,745,631	259,121,762	547,867,393				202



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
	INPATIENT ROUTINE SERV COST CENTERS	1	2	3	4	5	6	7	
30	ADULTS & PEDIATRICS (General Routine Care)	2,481,401		2,481,401	24,638	100.71			30
31	INTENSIVE CARE UNIT	414,368		414,368	3,080	134.54			31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF	535,694		535,694	4,259	125.78			41
42	SUBPROVIDER I								42
43	NURSERY	158,674		158,674	2,005	79.14			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	3,590,137		3,590,137	33,982				200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0113

WORKSHEET D
PART II

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)
		1	2	3	4	5
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	1,312,791	72,113,333	0.018205		50
50.01	ENDOSCOPY	555,952	18,626,464	0.029847		50.01
51	RECOVERY ROOM	70,772	9,098,673	0.007778		51
52	DELIVERY ROOM & LABOR ROOM	344,497	6,084,099	0.056623		52
53	ANESTHESIOLOGY	28,764	26,399,302	0.001090		53
54	RADIOLOGY-DIAGNOSTIC	355,951	10,287,228	0.034601		54
54.01	ULTRASOUND	92,526	4,300,535	0.021515		54.01
54.02	MAMMOGRAPHY	101,588	890,168	0.114122		54.02
55	RADIOLOGY-THERAPEUTIC					55
55.01	ONCOLOGY					55.01
56	RADIOISOTOPE	46,479	3,341,518	0.013910		56
57	CT SCAN	174,016	20,447,127	0.008511		57
58	MRI	234,555	8,455,962	0.027738		58
59	CARDIAC CATHETERIZATION	895,640	20,478,635	0.043735		59
60	LABORATORY	524,913	61,940,577	0.008474		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63	BLOOD STORING, PROCESSING & TRANS.	14,496	2,288,405	0.006335		63
65	RESPIRATORY THERAPY	228,970	26,368,591	0.008683		65
66	PHYSICAL THERAPY	100,667	5,854,160	0.017196		66
67	OCCUPATIONAL THERAPY	64,254	4,309,338	0.014910		67
68	SPEECH PATHOLOGY	8,059	991,235	0.008130		68
69.01	CARDIOLOGY	189,943	8,221,063	0.023104		69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	715,452	23,484,284	0.030465		71
72	IMPL. DEV. CHARGED TO PATIENTS	297,090	25,720,476	0.011551		72
73	DRUGS CHARGED TO PATIENTS	591,199	66,716,794	0.008861		73
74	RENAL DIALYSIS	19,296	622,849	0.030980		74
76.97	CARDIAC REHABILITATION	107,744	1,480,287	0.072786		76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
91	EMERGENCY	484,981	42,501,747	0.011411		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	333,365	5,486,383	0.060762		92
	OTHER REIMBURSABLE COST CENTERS					
95	AMBULANCE SERVICES					95
200	TOTAL (sum of lines 50-199)	7,893,960	476,509,233			200

(A) Worksheet A line numbers



PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers



PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	24,638				30
31	INTENSIVE CARE UNIT	3,080				31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF	4,259				41
42	SUBPROVIDER I					42
43	NURSERY	2,005				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	33,982				200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0113

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
50.01	ENDOSCOPY							50.01
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
54.02	MAMMOGRAPHY							54.02
55	RADIOLOGY-THERAPEUTIC							55
55.01	ONCOLOGY							55.01
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69.01	CARDIOLOGY							69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0113

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5 ÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6 ÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
7	8	9	10	11	12	13		
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	72,113,333						50
50.01	ENDOSCOPY	18,626,464						50.01
51	RECOVERY ROOM	9,098,673						51
52	DELIVERY ROOM & LABOR ROOM	6,084,099						52
53	ANESTHESIOLOGY	26,399,302						53
54	RADIOLOGY-DIAGNOSTIC	10,287,228						54
54.01	ULTRASOUND	4,300,535						54.01
54.02	MAMMOGRAPHY	890,168						54.02
55	RADIOLOGY-THERAPEUTIC							55
55.01	ONCOLOGY							55.01
56	RADIOISOTOPE	3,341,518						56
57	CT SCAN	20,447,127						57
58	MRI	8,455,962						58
59	CARDIAC CATHETERIZATION	20,478,635						59
60	LABORATORY	61,940,577						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	2,288,405						63
65	RESPIRATORY THERAPY	26,368,591						65
66	PHYSICAL THERAPY	5,854,160						66
67	OCCUPATIONAL THERAPY	4,309,338						67
68	SPEECH PATHOLOGY	991,235						68
69.01	CARDIOLOGY	8,221,063						69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,484,284						71
72	IMPL. DEV. CHARGED TO PATIENTS	25,720,476						72
73	DRUGS CHARGED TO PATIENTS	66,716,794						73
74	RENAL DIALYSIS	622,849						74
76.97	CARDIAC REHABILITATION	1,480,287						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	42,501,747						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	5,486,383						92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)	476,509,233						200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0113

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST		
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.144915						50
50.01	ENDOSCOPY	0.126313						50.01
51	RECOVERY ROOM	0.111505						51
52	DELIVERY ROOM & LABOR ROOM	0.262724						52
53	ANESTHESIOLOGY	0.011626						53
54	RADIOLOGY-DIAGNOSTIC	0.208896						54
54.01	ULTRASOUND	0.163407						54.01
54.02	MAMMOGRAPHY	0.426202						54.02
55	RADIOLOGY-THERAPEUTIC							55
55.01	ONCOLOGY							55.01
56	RADIOISOTOPE	0.157536						56
57	CT SCAN	0.057958						57
58	MRI	0.079448						58
59	CARDIAC CATHETERIZATION	0.163049						59
60	LABORATORY	0.113549						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.308800						63
65	RESPIRATORY THERAPY	0.097236						65
66	PHYSICAL THERAPY	0.217870						66
67	OCCUPATIONAL THERAPY	0.251949						67
68	SPEECH PATHOLOGY	0.306046						68
69.01	CARDIOLOGY	0.147757						69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440512						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.298221						72
73	DRUGS CHARGED TO PATIENTS	0.105554						73
74	RENAL DIALYSIS	0.441364						74
76.97	CARDIAC REHABILITATION	0.551971						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	0.150330						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.623843						92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	0.457576						95
200	SUBTOTAL (see instructions)							200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)							202

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-T113

WORKSHEET D
PART II

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)
		1	2	3	4	5
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	1,312,791	72,113,333	0.018205		50
50.01	ENDOSCOPY	555,952	18,626,464	0.029847		50.01
51	RECOVERY ROOM	70,772	9,098,673	0.007778		51
52	DELIVERY ROOM & LABOR ROOM	344,497	6,084,099	0.056623		52
53	ANESTHESIOLOGY	28,764	26,399,302	0.001090		53
54	RADIOLOGY-DIAGNOSTIC	355,951	10,287,228	0.034601		54
54.01	ULTRASOUND	92,526	4,300,535	0.021515		54.01
54.02	MAMMOGRAPHY	101,588	890,168	0.114122		54.02
55	RADIOLOGY-THERAPEUTIC					55
55.01	ONCOLOGY					55.01
56	RADIOISOTOPE	46,479	3,341,518	0.013910		56
57	CT SCAN	174,016	20,447,127	0.008511		57
58	MRI	234,555	8,455,962	0.027738		58
59	CARDIAC CATHETERIZATION	895,640	20,478,635	0.043735		59
60	LABORATORY	524,913	61,940,577	0.008474		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63	BLOOD STORING, PROCESSING & TRANS.	14,496	2,288,405	0.006335		63
65	RESPIRATORY THERAPY	228,970	26,368,591	0.008683		65
66	PHYSICAL THERAPY	100,667	5,854,160	0.017196		66
67	OCCUPATIONAL THERAPY	64,254	4,309,338	0.014910		67
68	SPEECH PATHOLOGY	8,059	991,235	0.008130		68
69.01	CARDIOLOGY	189,943	8,221,063	0.023104		69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	715,452	23,484,284	0.030465		71
72	IMPL. DEV. CHARGED TO PATIENTS	297,090	25,720,476	0.011551		72
73	DRUGS CHARGED TO PATIENTS	591,199	66,716,794	0.008861		73
74	RENAL DIALYSIS	19,296	622,849	0.030980		74
76.97	CARDIAC REHABILITATION	107,744	1,480,287	0.072786		76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
91	EMERGENCY	484,981	42,501,747	0.011411		91
92	OBSERVATION BEDS (NON-DISTINCT PART)		5,486,383			92
	OTHER REIMBURSABLE COST CENTERS					
95	AMBULANCE SERVICES					95
200	TOTAL (sum of lines 50-199)	7,560,595	476,509,233			200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T113

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
50.01	ENDOSCOPY							50.01
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
54.02	MAMMOGRAPHY							54.02
55	RADIOLOGY-THERAPEUTIC							55
55.01	ONCOLOGY							55.01
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69.01	CARDIOLOGY							69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T113

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5 ÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6 ÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
7		8		9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	72,113,333							50
50.01	ENDOSCOPY	18,626,464							50.01
51	RECOVERY ROOM	9,098,673							51
52	DELIVERY ROOM & LABOR ROOM	6,084,099							52
53	ANESTHESIOLOGY	26,399,302							53
54	RADIOLOGY-DIAGNOSTIC	10,287,228							54
54.01	ULTRASOUND	4,300,535							54.01
54.02	MAMMOGRAPHY	890,168							54.02
55	RADIOLOGY-THERAPEUTIC								55
55.01	ONCOLOGY								55.01
56	RADIOISOTOPE	3,341,518							56
57	CT SCAN	20,447,127							57
58	MRI	8,455,962							58
59	CARDIAC CATHETERIZATION	20,478,635							59
60	LABORATORY	61,940,577							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	2,288,405							63
65	RESPIRATORY THERAPY	26,368,591							65
66	PHYSICAL THERAPY	5,854,160							66
67	OCCUPATIONAL THERAPY	4,309,338							67
68	SPEECH PATHOLOGY	991,235							68
69.01	CARDIOLOGY	8,221,063							69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,484,284							71
72	IMPL. DEV. CHARGED TO PATIENTS	25,720,476							72
73	DRUGS CHARGED TO PATIENTS	66,716,794							73
74	RENAL DIALYSIS	622,849							74
76.97	CARDIAC REHABILITATION	1,480,287							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	42,501,747							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	5,486,383							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES								95
200	TOTAL (sum of lines 50-199)	476,509,233							200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-T113

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST		
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.144915						50
50.01	ENDOSCOPY	0.126313						50.01
51	RECOVERY ROOM	0.111505						51
52	DELIVERY ROOM & LABOR ROOM	0.262724						52
53	ANESTHESIOLOGY	0.011626						53
54	RADIOLOGY-DIAGNOSTIC	0.208896						54
54.01	ULTRASOUND	0.163407						54.01
54.02	MAMMOGRAPHY	0.426202						54.02
55	RADIOLOGY-THERAPEUTIC							55
55.01	ONCOLOGY							55.01
56	RADIOISOTOPE	0.157536						56
57	CT SCAN	0.057958						57
58	MRI	0.079448						58
59	CARDIAC CATHETERIZATION	0.163049						59
60	LABORATORY	0.113549						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.308800						63
65	RESPIRATORY THERAPY	0.097236						65
66	PHYSICAL THERAPY	0.217870						66
67	OCCUPATIONAL THERAPY	0.251949						67
68	SPEECH PATHOLOGY	0.306046						68
69.01	CARDIOLOGY	0.147757						69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440512						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.298221						72
73	DRUGS CHARGED TO PATIENTS	0.105554						73
74	RENAL DIALYSIS	0.441364						74
76.97	CARDIAC REHABILITATION	0.551971						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	0.150330						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.623843						92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	0.457576						95
200	SUBTOTAL (see instructions)							200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)							202

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
	INPATIENT ROUTINE SERV COST CENTERS	1	2	3	4	5	6	7	
30	ADULTS & PEDIATRICS (General Routine Care)	2,481,401		2,481,401	24,638	100.71	9,802	987,159	30
31	INTENSIVE CARE UNIT	414,368		414,368	3,080	134.54	1,850	248,899	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF	535,694		535,694	4,259	125.78	3,069	386,019	41
42	SUBPROVIDER I								42
43	NURSERY	158,674		158,674	2,005	79.14			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	3,590,137		3,590,137	33,982		14,721	1,622,077	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0113

WORKSHEET D
PART II

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,312,791	72,113,333	0.018205	11,789,848	214,634	50
50.01	ENDOSCOPY	555,952	18,626,464	0.029847	934,193	27,883	50.01
51	RECOVERY ROOM	70,772	9,098,673	0.007778	1,558,087	12,119	51
52	DELIVERY ROOM & LABOR ROOM	344,497	6,084,099	0.056623	60,336	3,416	52
53	ANESTHESIOLOGY	28,764	26,399,302	0.001090	3,525,531	3,843	53
54	RADIOLOGY-DIAGNOSTIC	355,951	10,287,228	0.034601	2,311,164	79,969	54
54.01	ULTRASOUND	92,526	4,300,535	0.021515	939,134	20,205	54.01
54.02	MAMMOGRAPHY	101,588	890,168	0.114122	389	44	54.02
55	RADIOLOGY-THERAPEUTIC						55
55.01	ONCOLOGY						55.01
56	RADIOISOTOPE	46,479	3,341,518	0.013910	637,426	8,867	56
57	CT SCAN	174,016	20,447,127	0.008511	3,758,039	31,985	57
58	MRI	234,555	8,455,962	0.027738	1,865,381	51,742	58
59	CARDIAC CATHETERIZATION	895,640	20,478,635	0.043735	3,513,155	153,648	59
60	LABORATORY	524,913	61,940,577	0.008474	15,256,040	129,280	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	14,496	2,288,405	0.006335	988,696	6,263	63
65	RESPIRATORY THERAPY	228,970	26,368,591	0.008683	14,041,138	121,919	65
66	PHYSICAL THERAPY	100,667	5,854,160	0.017196	1,093,285	18,800	66
67	OCCUPATIONAL THERAPY	64,254	4,309,338	0.014910	677,245	10,098	67
68	SPEECH PATHOLOGY	8,059	991,235	0.008130	150,118	1,220	68
69.01	CARDIOLOGY	189,943	8,221,063	0.023104	2,302,152	53,189	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	715,452	23,484,284	0.030465	6,586,612	200,661	71
72	IMPL. DEV. CHARGED TO PATIENTS	297,090	25,720,476	0.011551	7,188,548	83,035	72
73	DRUGS CHARGED TO PATIENTS	591,199	66,716,794	0.008861	23,376,235	207,137	73
74	RENAL DIALYSIS	19,296	622,849	0.030980	445,870	13,813	74
76.97	CARDIAC REHABILITATION	107,744	1,480,287	0.072786	113,916	8,291	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	484,981	42,501,747	0.011411	3,729,530	42,558	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	333,365	5,486,383	0.060762	720,053	43,752	92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (sum of lines 50-199)	7,893,960	476,509,233		107,562,121	1,548,371	200

(A) Worksheet A line numbers



PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	24,638		9,802		30
31	INTENSIVE CARE UNIT	3,080		1,850		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF	4,259		3,069		41
42	SUBPROVIDER I					42
43	NURSERY	2,005				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	33,982		14,721		200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0113

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6
		NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
50.01	ENDOSCOPY						50.01
51	RECOVERY ROOM						51
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
54.01	ULTRASOUND						54.01
54.02	MAMMOGRAPHY						54.02
55	RADIOLOGY-THERAPEUTIC						55
55.01	ONCOLOGY						55.01
56	RADIOISOTOPE						56
57	CT SCAN						57
58	MRI						58
59	CARDIAC CATHETERIZATION						59
60	LABORATORY						60
62.30	BLOOD CLOTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.						63
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69.01	CARDIOLOGY						69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (sum of lines 50-199)						200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0113

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
7	8	9	10	11	12	13		
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	72,113,333			11,789,848		10,380,106	50
50.01	ENDOSCOPY	18,626,464			934,193		4,644,886	50.01
51	RECOVERY ROOM	9,098,673			1,558,087		1,072,783	51
52	DELIVERY ROOM & LABOR ROOM	6,084,099			60,336		1,589	52
53	ANESTHESIOLOGY	26,399,302			3,525,531		3,901,176	53
54	RADIOLOGY-DIAGNOSTIC	10,287,228			2,311,164		1,687,967	54
54.01	ULTRASOUND	4,300,535			939,134		750,650	54.01
54.02	MAMMOGRAPHY	890,168			389		96,526	54.02
55	RADIOLOGY-THERAPEUTIC							55
55.01	ONCOLOGY							55.01
56	RADIOISOTOPE	3,341,518			637,426		865,999	56
57	CT SCAN	20,447,127			3,758,039		3,472,916	57
58	MRI	8,455,962			1,865,381		1,342,461	58
59	CARDIAC CATHETERIZATION	20,478,635			3,513,155		4,772,154	59
60	LABORATORY	61,940,577			15,256,040		3,346,544	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	2,288,405			988,696		388,035	63
65	RESPIRATORY THERAPY	26,368,591			14,041,138		531,523	65
66	PHYSICAL THERAPY	5,854,160			1,093,285			66
67	OCCUPATIONAL THERAPY	4,309,338			677,245			67
68	SPEECH PATHOLOGY	991,235			150,118			68
69.01	CARDIOLOGY	8,221,063			2,302,152		1,530,803	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,484,284			6,586,612		2,807,635	71
72	IMPL. DEV. CHARGED TO PATIENTS	25,720,476			7,188,548		3,806,227	72
73	DRUGS CHARGED TO PATIENTS	66,716,794			23,376,235		5,624,575	73
74	RENAL DIALYSIS	622,849			445,870		13,649	74
76.97	CARDIAC REHABILITATION	1,480,287			113,916		384,856	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	42,501,747			3,729,530		6,517,120	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	5,486,383			720,053		1,632,381	92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)	476,509,233			107,562,121		59,572,561	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0113

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.144915	10,380,106			1,504,233			50
50.01	ENDOSCOPY	0.126313	4,644,886			586,709			50.01
51	RECOVERY ROOM	0.111505	1,072,783			119,621			51
52	DELIVERY ROOM & LABOR ROOM	0.262724	1,589			417			52
53	ANESTHESIOLOGY	0.011626	3,901,176			45,355			53
54	RADIOLOGY-DIAGNOSTIC	0.208896	1,687,967			352,610			54
54.01	ULTRASOUND	0.163407	750,650			122,661			54.01
54.02	MAMMOGRAPHY	0.426202	96,526			41,140			54.02
55	RADIOLOGY-THERAPEUTIC								55
55.01	ONCOLOGY								55.01
56	RADIOISOTOPE	0.157536	865,999			136,426			56
57	CT SCAN	0.057958	3,472,916			201,283			57
58	MRI	0.079448	1,342,461			106,656			58
59	CARDIAC CATHETERIZATION	0.163049	4,772,154			778,095			59
60	LABORATORY	0.113549	3,346,544			379,997			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.308800	388,035			119,825			63
65	RESPIRATORY THERAPY	0.097236	531,523			51,683			65
66	PHYSICAL THERAPY	0.217870							66
67	OCCUPATIONAL THERAPY	0.251949							67
68	SPEECH PATHOLOGY	0.306046							68
69.01	CARDIOLOGY	0.147757	1,530,803			226,187			69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440512	2,807,635			1,236,797			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.298221	3,806,227			1,135,097			72
73	DRUGS CHARGED TO PATIENTS	0.105554	5,624,575		137,270	593,696		14,489	73
74	RENAL DIALYSIS	0.441364	13,649			6,024			74
76.97	CARDIAC REHABILITATION	0.551971	384,856			212,429			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.150330	6,517,120			979,719			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.623843	1,632,381			1,018,349			92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	0.457576							95
200	SUBTOTAL (see instructions)		59,572,561		137,270	9,955,009		14,489	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		59,572,561		137,270	9,955,009		14,489	202

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-T113

WORKSHEET D
PART II

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,312,791	72,113,333	0.018205	53,205	969	50
50.01	ENDOSCOPY	555,952	18,626,464	0.029847	56,880	1,698	50.01
51	RECOVERY ROOM	70,772	9,098,673	0.007778	18,068	141	51
52	DELIVERY ROOM & LABOR ROOM	344,497	6,084,099	0.056623			52
53	ANESTHESIOLOGY	28,764	26,399,302	0.001090	25,853	28	53
54	RADIOLOGY-DIAGNOSTIC	355,951	10,287,228	0.034601	107,018	3,703	54
54.01	ULTRASOUND	92,526	4,300,535	0.021515	40,539	872	54.01
54.02	MAMMOGRAPHY	101,588	890,168	0.114122			54.02
55	RADIOLOGY-THERAPEUTIC						55
55.01	ONCOLOGY						55.01
56	RADIOISOTOPE	46,479	3,341,518	0.013910	13,325	185	56
57	CT SCAN	174,016	20,447,127	0.008511	136,597	1,163	57
58	MRI	234,555	8,455,962	0.027738	119,379	3,311	58
59	CARDIAC CATHETERIZATION	895,640	20,478,635	0.043735			59
60	LABORATORY	524,913	61,940,577	0.008474	1,329,889	11,269	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	14,496	2,288,405	0.006335	96,796	613	63
65	RESPIRATORY THERAPY	228,970	26,368,591	0.008683	424,962	3,690	65
66	PHYSICAL THERAPY	100,667	5,854,160	0.017196	1,895,936	32,603	66
67	OCCUPATIONAL THERAPY	64,254	4,309,338	0.014910	1,725,770	25,731	67
68	SPEECH PATHOLOGY	8,059	991,235	0.008130	415,766	3,380	68
69.01	CARDIOLOGY	189,943	8,221,063	0.023104	43,136	997	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	715,452	23,484,284	0.030465	374,841	11,420	71
72	IMPL. DEV. CHARGED TO PATIENTS	297,090	25,720,476	0.011551	9,561	110	72
73	DRUGS CHARGED TO PATIENTS	591,199	66,716,794	0.008861	1,607,594	14,245	73
74	RENAL DIALYSIS	19,296	622,849	0.030980	38,861	1,204	74
76.97	CARDIAC REHABILITATION	107,744	1,480,287	0.072786			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	484,981	42,501,747	0.011411	18,080	206	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		5,486,383				92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (sum of lines 50-199)	7,560,595	476,509,233		8,552,056	117,538	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T113

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
50.01	ENDOSCOPY							50.01
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
54.02	MAMMOGRAPHY							54.02
55	RADIOLOGY-THERAPEUTIC							55
55.01	ONCOLOGY							55.01
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69.01	CARDIOLOGY							69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T113

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
7	8	9	10	11	12	13		
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	72,113,333			53,205			50
50.01	ENDOSCOPY	18,626,464			56,880			50.01
51	RECOVERY ROOM	9,098,673			18,068			51
52	DELIVERY ROOM & LABOR ROOM	6,084,099						52
53	ANESTHESIOLOGY	26,399,302			25,853			53
54	RADIOLOGY-DIAGNOSTIC	10,287,228			107,018			54
54.01	ULTRASOUND	4,300,535			40,539			54.01
54.02	MAMMOGRAPHY	890,168						54.02
55	RADIOLOGY-THERAPEUTIC							55
55.01	ONCOLOGY							55.01
56	RADIOISOTOPE	3,341,518			13,325			56
57	CT SCAN	20,447,127			136,597			57
58	MRI	8,455,962			119,379			58
59	CARDIAC CATHETERIZATION	20,478,635						59
60	LABORATORY	61,940,577			1,329,889			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	2,288,405			96,796			63
65	RESPIRATORY THERAPY	26,368,591			424,962			65
66	PHYSICAL THERAPY	5,854,160			1,895,936			66
67	OCCUPATIONAL THERAPY	4,309,338			1,725,770			67
68	SPEECH PATHOLOGY	991,235			415,766			68
69.01	CARDIOLOGY	8,221,063			43,136			69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,484,284			374,841			71
72	IMPL. DEV. CHARGED TO PATIENTS	25,720,476			9,561			72
73	DRUGS CHARGED TO PATIENTS	66,716,794			1,607,594			73
74	RENAL DIALYSIS	622,849			38,861			74
76.97	CARDIAC REHABILITATION	1,480,287						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	42,501,747			18,080			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	5,486,383						92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)	476,509,233			8,552,056			200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-T113

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST		
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.144915						50
50.01	ENDOSCOPY	0.126313						50.01
51	RECOVERY ROOM	0.111505						51
52	DELIVERY ROOM & LABOR ROOM	0.262724						52
53	ANESTHESIOLOGY	0.011626						53
54	RADIOLOGY-DIAGNOSTIC	0.208896						54
54.01	ULTRASOUND	0.163407						54.01
54.02	MAMMOGRAPHY	0.426202						54.02
55	RADIOLOGY-THERAPEUTIC							55
55.01	ONCOLOGY							55.01
56	RADIOISOTOPE	0.157536						56
57	CT SCAN	0.057958						57
58	MRI	0.079448						58
59	CARDIAC CATHETERIZATION	0.163049						59
60	LABORATORY	0.113549						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.308800						63
65	RESPIRATORY THERAPY	0.097236						65
66	PHYSICAL THERAPY	0.217870						66
67	OCCUPATIONAL THERAPY	0.251949						67
68	SPEECH PATHOLOGY	0.306046						68
69.01	CARDIOLOGY	0.147757						69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440512						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.298221						72
73	DRUGS CHARGED TO PATIENTS	0.105554						73
74	RENAL DIALYSIS	0.441364						74
76.97	CARDIAC REHABILITATION	0.551971						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	0.150330						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.623843						92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	0.457576						95
200	SUBTOTAL (see instructions)							200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)							202

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0113

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	24,638	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	24,638	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	21,328	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)		9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)	2,005	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	25,470,153	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	25,470,153	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	25,470,153	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0113

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,033.78	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)						39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)						41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)	1,573,497	2,005	784.79			42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	5,575,345	3,080	1,810.18			43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

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

PASS-THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0113

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					3,310	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T113

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	4,259	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	4,259	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	4,259	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)		9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	4,953,392	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,953,392	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	4,953,392	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T113

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	1,163.04	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)		39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)		41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)		48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)		49

PASS-THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0113

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	24,638	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	24,638	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	21,328	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	9,802	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	25,476,451	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	25,476,451	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	25,476,451	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0113

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)			
	1	2	3	4	5			
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)						1,034.03	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)						10,135,562	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)							40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)						10,135,562	41
42	NURSERY (Titles V and XIX only)							42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS							
43	5,589,798	3,080	1,814.87	1,850	3,357,510		43	
44							44	
45							45	
46							46	
47							47	

							1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						16,728,170	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)						30,221,242	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)						1,236,058	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						1,548,371	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)						2,784,429	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						27,436,813	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0113

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					3,310	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,034.03	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					3,422,639	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	2,481,401	25,476,451	0.097400	3,422,639	333,365	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T113

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	4,259	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	4,259	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	4,259	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	3,069	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	4,953,392	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,953,392	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	4,953,392	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T113

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	1,163.04	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	3,569,370	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	3,569,370	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	1,627,916	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	5,197,286	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	386,019	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	117,538	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	503,557	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	4,693,729	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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



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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0113

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
41	SUBPROVIDER - IRF				41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.144915			50
50.01	ENDOSCOPY	0.126313			50.01
51	RECOVERY ROOM	0.111505			51
52	DELIVERY ROOM & LABOR ROOM	0.262724			52
53	ANESTHESIOLOGY	0.011626			53
54	RADIOLOGY-DIAGNOSTIC	0.208896			54
54.01	ULTRASOUND	0.163407			54.01
54.02	MAMMOGRAPHY	0.426202			54.02
55	RADIOLOGY-THERAPEUTIC				55
55.01	ONCOLOGY				55.01
56	RADIOISOTOPE	0.157536			56
57	CT SCAN	0.057958			57
58	MRI	0.079448			58
59	CARDIAC CATHETERIZATION	0.163049			59
60	LABORATORY	0.113549			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.308800			63
65	RESPIRATORY THERAPY	0.097236			65
66	PHYSICAL THERAPY	0.217870			66
67	OCCUPATIONAL THERAPY	0.251949			67
68	SPEECH PATHOLOGY	0.306046			68
69.01	CARDIOLOGY	0.147757			69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440512			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.298221			72
73	DRUGS CHARGED TO PATIENTS	0.105554			73
74	RENAL DIALYSIS	0.441364			74
76.97	CARDIAC REHABILITATION	0.551971			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.150330			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.623843			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers



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PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-T113

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
41	SUBPROVIDER - IRF				41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.144915			50
50.01	ENDOSCOPY	0.126313			50.01
51	RECOVERY ROOM	0.111505			51
52	DELIVERY ROOM & LABOR ROOM	0.262724			52
53	ANESTHESIOLOGY	0.011626			53
54	RADIOLOGY-DIAGNOSTIC	0.208896			54
54.01	ULTRASOUND	0.163407			54.01
54.02	MAMMOGRAPHY	0.426202			54.02
55	RADIOLOGY-THERAPEUTIC				55
55.01	ONCOLOGY				55.01
56	RADIOISOTOPE	0.157536			56
57	CT SCAN	0.057958			57
58	MRI	0.079448			58
59	CARDIAC CATHETERIZATION	0.163049			59
60	LABORATORY	0.113549			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.308800			63
65	RESPIRATORY THERAPY	0.097236			65
66	PHYSICAL THERAPY	0.217870			66
67	OCCUPATIONAL THERAPY	0.251949			67
68	SPEECH PATHOLOGY	0.306046			68
69.01	CARDIOLOGY	0.147757			69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440512			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.298221			72
73	DRUGS CHARGED TO PATIENTS	0.105554			73
74	RENAL DIALYSIS	0.441364			74
76.97	CARDIAC REHABILITATION	0.551971			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.150330			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.623843			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE COVENANT MEDICAL CENTER Provider CCN: 14-0113	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 05:54 Version: 2014.03
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0113

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		18,165,457		30
31	INTENSIVE CARE UNIT		6,686,239		31
41	SUBPROVIDER - IRF				41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.144939	11,789,848	1,708,809	50
50.01	ENDOSCOPY	0.126313	934,193	118,001	50.01
51	RECOVERY ROOM	0.111505	1,558,087	173,734	51
52	DELIVERY ROOM & LABOR ROOM	0.262724	60,336	15,852	52
53	ANESTHESIOLOGY	0.011626	3,525,531	40,988	53
54	RADIOLOGY-DIAGNOSTIC	0.209149	2,311,164	483,378	54
54.01	ULTRASOUND	0.163407	939,134	153,461	54.01
54.02	MAMMOGRAPHY	0.426202	389	166	54.02
55	RADIOLOGY-THERAPEUTIC				55
55.01	ONCOLOGY				55.01
56	RADIOISOTOPE	0.157536	637,426	100,418	56
57	CT SCAN	0.057958	3,758,039	217,808	57
58	MRI	0.079448	1,865,381	148,201	58
59	CARDIAC CATHETERIZATION	0.163246	3,513,155	573,509	59
60	LABORATORY	0.114168	15,256,040	1,741,752	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.308800	988,696	305,309	63
65	RESPIRATORY THERAPY	0.097543	14,041,138	1,369,615	65
66	PHYSICAL THERAPY	0.217870	1,093,285	238,194	66
67	OCCUPATIONAL THERAPY	0.251949	677,245	170,631	67
68	SPEECH PATHOLOGY	0.306046	150,118	45,943	68
69.01	CARDIOLOGY	0.147757	2,302,152	340,159	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440512	6,586,612	2,901,482	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.298221	7,188,548	2,143,776	72
73	DRUGS CHARGED TO PATIENTS	0.105554	23,376,235	2,467,455	73
74	RENAL DIALYSIS	0.441364	445,870	196,791	74
76.97	CARDIAC REHABILITATION	0.551971	113,916	62,878	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.150330	3,729,530	560,660	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.623843	720,053	449,200	92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)		107,562,121	16,728,170	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		107,562,121		202

(A) Worksheet A line numbers



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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-T113

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
41	SUBPROVIDER - IRF		5,979,003		41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.144939	53,205	7,711	50
50.01	ENDOSCOPY	0.126313	56,880	7,185	50.01
51	RECOVERY ROOM	0.111505	18,068	2,015	51
52	DELIVERY ROOM & LABOR ROOM	0.262724			52
53	ANESTHESIOLOGY	0.011626	25,853	301	53
54	RADIOLOGY-DIAGNOSTIC	0.209149	107,018	22,383	54
54.01	ULTRASOUND	0.163407	40,539	6,624	54.01
54.02	MAMMOGRAPHY	0.426202			54.02
55	RADIOLOGY-THERAPEUTIC				55
55.01	ONCOLOGY				55.01
56	RADIOISOTOPE	0.157536	13,325	2,099	56
57	CT SCAN	0.057958	136,597	7,917	57
58	MRI	0.079448	119,379	9,484	58
59	CARDIAC CATHETERIZATION	0.163246			59
60	LABORATORY	0.114168	1,329,889	151,831	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.308800	96,796	29,891	63
65	RESPIRATORY THERAPY	0.097543	424,962	41,452	65
66	PHYSICAL THERAPY	0.217870	1,895,936	413,068	66
67	OCCUPATIONAL THERAPY	0.251949	1,725,770	434,806	67
68	SPEECH PATHOLOGY	0.306046	415,766	127,244	68
69.01	CARDIOLOGY	0.147757	43,136	6,374	69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440512	374,841	165,122	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.298221	9,561	2,851	72
73	DRUGS CHARGED TO PATIENTS	0.105554	1,607,594	169,688	73
74	RENAL DIALYSIS	0.441364	38,861	17,152	74
76.97	CARDIAC REHABILITATION	0.551971			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.150330	18,080	2,718	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.623843			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)		8,552,056	1,627,916	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		8,552,056		202

(A) Worksheet A line numbers



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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS				1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)	17,297,696			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	5,842,490			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	300,850			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	3,275,268			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	165.11			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)	9.59			5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)				6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(1)	0.09			7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS				7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2)(iv) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002				8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)	9.50			9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	11.87			10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)	9.50			12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	9.50			13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	9.50			14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	9.50			15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT	9.50			18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)	0.057537			19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)	0.062229			20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)	0.057537			21
22	IME PAYMENT ADJUSTMENT (see instructions)	817,162			22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)	1.19			23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)	2.37			24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)	1.19			25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)	0.007207			26
27	IME PAYMENTS ADJUSTMENT (see instructions)	0.001923			27
28	IME ADJUSTMENT (see instructions)	50,797			28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)	867,959			29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0668			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.1615			31
32	SUM OF LINES 30 AND 31	0.2283			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0805			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	1,510,045			34
		PRIOR TO	ON OR AFTER		
		OCTOBER 1	OCTOBER 1		
	UNCOMPENSATED CARE ADJUSTMENT				
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		1,682,147		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		423,994		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	423,994			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART 1 EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40



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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41)				46
47	SUBTOTAL (see instructions)	26,243,034			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	26,243,034			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	2,070,655			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)	456,312			52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	28,770,001			59
60	PRIMARY PAYER PAYMENTS	35,513			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	28,734,488			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	2,297,472			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	38,776			63
64	ALLOWABLE BAD DEBTS (see instructions)	395,339			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	256,970			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	359,809			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	26,655,210			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	-59,608			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-63,808			70.94
71	AMOUNT DUE PROVIDER (see instructions)	26,531,794			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	400,630			71.01
72	INTERIM PAYMENTS	26,250,501			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	-119,337			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2				75

TO BE COMPLETED BY CONTRACTOR

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



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0113

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	14,489			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)	9,955,009			2
3	PPS PAYMENTS	9,098,063			3
4	OUTLIER PAYMENT (see instructions)	31,214			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	14,489			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	137,270			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	137,270			14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)	137,270			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))	122,781			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	14,489			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	9,129,277			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	1,978,142			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	7,165,624			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)	128,527			28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	7,294,151			30
31	PRIMARY PAYER PAYMENTS	3,418			31
32	SUBTOTAL (line 30 minus line 31)	7,290,733			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)	445,182			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	289,368			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	414,406			36
37	SUBTOTAL (see instructions)	7,580,101			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	7,580,101			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	114,460			40.01
41	INTERIM PAYMENTS	7,324,179			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	141,462			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

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



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T113

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

	1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)			2
3	PPS PAYMENTS			3
4	OUTLIER PAYMENT (see instructions)			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)			5
6	LINE 2 TIMES LINE 5			6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6			7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)			8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200			9
10	ORGAN ACQUISITION			10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)			11
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
12	ANCILLARY SERVICE CHARGES			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)			13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)			14
	CUSTOMARY CHARGES			
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000		17
18	TOTAL CUSTOMARY CHARGES (see instructions)			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))			20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)			21
22	INTERNS AND RESIDENTS (see instructions)			22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)			23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25	DEDUCTIBLES AND COINSURANCE (see instructions)			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)			28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)			29
30	SUBTOTAL (sum of lines 27 through 29)			30
31	PRIMARY PAYER PAYMENTS			31
32	SUBTOTAL (line 30 minus line 31)			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			36
37	SUBTOTAL (see instructions)			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R			38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			39
40	SUBTOTAL (see instructions)			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)			40.01
41	INTERIM PAYMENTS			41
42	TENTATIVE SETTLEMENT (for contractor use only)			42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			44

TO BE COMPLETED BY CONTRACTOR

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



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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0113

WORKSHEET E-1
PART I

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

		INPATIENT PART A		PART B		
DESCRIPTION		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
		1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		26,525,156		7,362,464	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT					
		.01				3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	.02	12/20/2013	23,104	12/20/2013	35,325
		.03				3.03
		.04				3.04
		.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51	06/12/2013	297,759	06/12/2013	73,610
		.52				3.52
		.53				3.53
		.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		-274,655		-38,285
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			26,250,501		7,324,179
						4
	TO BE COMPLETED BY CONTRACTOR					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	.01				5.01
		.02				5.02
		.03				5.03
		.04				5.04
		.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
		.52				5.52
		.53				5.53
		.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01		281,293		255,922
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			26,531,794		7,580,101
8	NAME OF CONTRACTOR		CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)	8

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



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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-T113

WORKSHEET E-1
PART I

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

		INPATIENT PART A		PART B	
DESCRIPTION		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		4,743,906		1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO				2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT				3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)				3.02
	PROGRAM TO PROVIDER	12/20/2013	32,154		3.03
					3.04
					3.05
					3.06
					3.07
					3.08
					3.09
					3.10
					3.50
		06/12/2013	51,904		3.51
	PROVIDER TO PROGRAM				3.52
					3.53
					3.54
					3.55
					3.56
					3.57
					3.58
					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-19,750		3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,724,156		4
TO BE COMPLETED BY CONTRACTOR					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)				5.01
	PROGRAM TO PROVIDER				5.02
					5.03
					5.04
					5.05
					5.06
					5.07
					5.08
					5.09
					5.10
					5.50
					5.51
					5.52
					5.53
					5.54
					5.55
					5.56
					5.57
					5.58
					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)		82,712		6.01
					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		4,806,868		7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)	
					8

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



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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK HOSPITAL CAH
 APPLICABLE BOX:

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	6,975	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	11,652	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	1,544	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	24,408	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	547,867,393	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	22,701,574	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	1,785,173	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	35,703	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	1,749,470	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,779,452	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-29,982	32



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T113

WORKSHEET E-3
PART III

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	NET FEDERAL PPS PAYMENT (see instructions)	3,270,057	1,340,793	1
2	MEDICARE SSI RATIO (see instructions)	0.054400		2
3	INPATIENT REHABILITATION LIP PAYMENTS (see instructions)	166,773	46,660	3
4	OUTLIER PAYMENTS	44,824		4
5	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR PRIOR TO NOVEMBER 15, 2004 (see instructions)			5
5.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)			5.01
6	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)			6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)			7
8	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)			8
9	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)			9
10	AVERAGE DAILY CENSUS (see instructions)	11.668493		10
11	TEACHING ADJUSTMENT FACTOR (see instructions)			11
12	TEACHING ADJUSTMENT (see instructions)			12
13	TOTAL PPS PAYMENT (see instructions)	4,869,107		13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (see instructions)			14
15	ORGAN ACQUISITION			15
16	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)			16
17	SUBTOTAL (see instructions)	4,869,107		17
18	PRIMARY PAYER PAYMENTS			18
19	SUBTOTAL (line 17 less line 18)	4,869,107		19
20	DEDUCTIBLES	56,804		20
21	SUBTOTAL (line 19 minus line 20)	4,812,303		21
22	COINSURANCE	9,176		22
23	SUBTOTAL (line 21 minus line 22)	4,803,127		23
24	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	5,756		24
25	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	3,741		25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			26
27	SUBTOTAL (sum of lines 23 and 25)	4,806,868		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IRF only)			28
29	OTHER PASS THROUGH COSTS (see instructions)			29
30	OUTLIER PAYMENTS RECONCILIATION			30
31	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	4,806,868		32
32.01	SEQUESTRATION ADJUSTMENT (see instructions)	72,584		32.01
33	INTERIM PAYMENTS	4,724,156		33
34	TENTATIVE SETTLEMENT (for contractor use only)			34
35	BALANCE DUE PROVIDER/PROGRAM (line 32 minus lines 32.01, 33 and 34)	10,128		35
36	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			36

TO BE COMPLETED BY CONTRACTOR

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



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0113

WORKSHEET E-3
PART VII

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

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

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



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T113

WORKSHEET E-3
PART VII

CHECK TITLE V
 APPLICABLE TITLE XIX
 BOXES:

PPS
 TEFRA
 OTHER

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

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



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

WORKSHEET E-4

CHECK TITLE V
 APPLICABLE TITLE XVIII
 BOX: TITLE XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
		PRIMARY CARE	OTHER	TOTAL
		1	2	3
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)			2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA			3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			3.01
4	ADJUSTMENT (plus or minus) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) and §413.79(f))			4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (see instructions for cost reporting periods straddling 7/1/2011)			4.02
5	FTE ADJUSTED CAP (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)			6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			7
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	0.00	0.00	0.00
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	0.00	0.00	0.00
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		0.00	
11	TOTAL WEIGHTED FTE COUNT	0.00	0.00	
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	0.00	0.00	
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	0.00	0.00	
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	0.00	0.00	
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00	
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00	
17	ADJUSTED ROLLING AVERAGE FTE COUNT	0.00	0.00	
18	PER RESIDENT AMOUNT	0.00	0.00	
19	APPROVED AMOUNT FOR RESIDENT COSTS			
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)			
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)			
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (see instructions)			
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (see instructions)			
24	MULTIPLY LINE 22 TIMES LINE 23			
25	TOTAL DIRECT GME AMOUNT (sum of lines 19 and 24)			
COMPUTATION OF PROGRAM PATIENT LOAD				
		INPATIENT PART A	MANAGED CARE	
26	INPATIENT DAYS			
27	TOTAL INPATIENT DAYS (see instructions)	28,667		
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.000000	0.000000	
29	PROGRAM DIRECT GME AMOUNT			
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE			
31	NET PROGRAM DIRECT GME AMOUNT			
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)			
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)			
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (line 32 ÷ line 33)			
35	MEDICARE OUTPATIENT ESRD CHARGES (see instructions)			
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (line 34 x line 35)			
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
PART A REASONABLE COST				
37	REASONABLE COST (see instructions)			
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)			
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)			
40	PRIMARY PAYER PAYMENTS (see instructions)			
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)			
PART B REASONABLE COST				
42	REASONABLE COST (see instructions)			
43	PRIMARY PAYER PAYMENTS (see instructions)			
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)			
45	TOTAL REASONABLE COST (sum of lines 41 and 44)			
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)			
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)			
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (line 31)			
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)			
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)			



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

WORKSHEET E-4

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

COMPUTATION OF TOTAL DIRECT GME AMOUNT					
		PRIMARY CARE	OTHER	TOTAL	
		1	2	3	
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			8.70	1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA				3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	ADJUSTMENT (plus or minus) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (see instructions for cost reporting periods straddling 7/1/2011)				4.02
5	FTE ADJUSTED CAP (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			8.70	5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)			11.87	6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			8.70	7
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	11.87	0.00	11.87	8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	8.70	0.00	8.70	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		0.00		10
11	TOTAL WEIGHTED FTE COUNT	8.70	0.00		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	8.70	0.00		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	8.70	0.00		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	8.70	0.00		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	8.70	0.00		17
18	PER RESIDENT AMOUNT	96,972.04	91,823.97		18
19	APPROVED AMOUNT FOR RESIDENT COSTS	843,657		843,657	19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)			1.99	20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)			3.17	21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (see instructions)			1.99	22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (see instructions)			93,840.62	23
24	MULTIPLY LINE 22 TIMES LINE 23			186,743	24
25	TOTAL DIRECT GME AMOUNT (sum of lines 19 and 24)			1,030,400	25
COMPUTATION OF PROGRAM PATIENT LOAD					
26	INPATIENT DAYS	14,721	1,805		26
27	TOTAL INPATIENT DAYS (see instructions)	28,667	28,667		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.513517	0.062964		28
29	PROGRAM DIRECT GME AMOUNT	529,128	64,878		29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE		9,167		30
31	NET PROGRAM DIRECT GME AMOUNT			584,839	31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)					
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)			622,849	33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (line 32 ÷ line 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (see instructions)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (line 34 x line 35)				36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME					
PART A REASONABLE COST					
37	REASONABLE COST (see instructions)			35,418,528	37
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)				38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)				39
40	PRIMARY PAYER PAYMENTS (see instructions)			35,513	40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)			35,383,015	41
PART B REASONABLE COST					
42	REASONABLE COST (see instructions)			9,969,498	42
43	PRIMARY PAYER PAYMENTS (see instructions)			3,418	43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)			9,966,080	44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)			45,349,095	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)			0.780236	46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)			0.219764	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	TOTAL PROGRAM GME PAYMENT (line 31)			584,839	48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)			456,312	49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)			128,527	50



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BALANCE SHEET

WORKSHEET G

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

ASSETS (Omit Cents)		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
CURRENT ASSETS						
1	CASH ON HAND AND IN BANKS	9,650,159				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	31,114,608				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-5,486,797				6
7	INVENTORY	3,906,132				7
8	PREPAID EXPENSES	734,692				8
9	OTHER CURRENT ASSETS	4,071,969				9
10	DUE FROM OTHER FUNDS	338,609				10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	44,329,372				11
FIXED ASSETS						
12	LAND	6,068,568				12
13	LAND IMPROVEMENTS	4,863,570				13
14	ACCUMULATED DEPRECIATION	-5,162,268				14
15	BUILDINGS	62,739,976				15
16	ACCUMULATED DEPRECIATION	-41,997,733				16
17	LEASEHOLD IMPROVEMENTS	1,883,944				17
18	ACCUMULATED AMORTIZATION	-1,598,229				18
19	FIXED EQUIPMENT	1,286,550				19
20	ACCUMULATED DEPRECIATION	-14,714,734				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	72,108,264				23
24	ACCUMULATED DEPRECIATION	-41,521,314				24
25	MINOR EQUIPMENT DEPRECIABLE	59,626				25
26	ACCUMULATED DEPRECIATION	-67,576				26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE	68,508				29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	44,017,152				30
OTHER ASSETS						
31	INVESTMENTS	7,075,693				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	90,275				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	7,165,968				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	95,512,492				36
LIABILITIES AND FUND BALANCES						
		1	2	3	4	
CURRENT LIABILITIES						
37	ACCOUNTS PAYABLE	13,129,993				37
38	SALARIES, WAGES & FEES PAYABLE	3,695,591				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	194,509				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS	3,470,929				43
44	OTHER CURRENT LIABILITIES	10,049,092				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	30,540,114				45
LONG TERM LIABILITIES						
46	MORTGAGE PAYABLE	148,088				46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	388,523				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	536,611				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	31,076,725				51
CAPITAL ACCOUNTS						
52	GENERAL FUND BALANCE	64,435,767				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	64,435,767				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	95,512,492				60



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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		68,594,483			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		4,677,758			2
3	TOTAL (sum of line 1 and line 2)		73,272,241			3
4	ADDITIONS (credit adjustments)					4
5	EQUITY TRANSFER					5
6	CONTRIBUTIONS	17,822				6
7	CONTRIBUTIONS-RESTRICTED	956,840				7
8	INVESTMENT INCOME REALIZED					8
9	OTHER					9
10	TOTAL ADDITIONS (sum of lines 4-9)		974,662			10
11	SUBTOTAL (line 3 plus line 10)		74,246,903			11
12	DEDUCTIONS (debit adjustments)					12
13	EQUITY TRANSFER	9,635,328				13
14	NET ASSETS RELEASED	175,808				14
15	OTHER					15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		9,811,136			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		64,435,767			19

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



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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	55,551,452		55,551,452	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF	7,207,808		7,207,808	3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	62,759,260		62,759,260	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	62,759,260		62,759,260	17
18	ANCILLARY SERVICES	226,239,630	249,180,980	475,420,610	18
19	OUTPATIENT SERVICES		11,428,199	11,428,199	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	288,998,890	260,609,179	549,608,069	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		133,714,157	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38	ROUNDING			38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		133,714,157	43



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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	549,608,069	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	416,992,060	2
3	NET PATIENT REVENUES (line 1 minus line 2)	132,616,009	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	133,714,157	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-1,098,148	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	1,750	6
7	INCOME FROM INVESTMENTS	1,033,643	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	406,967	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	11,107	18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (RENTAL INCOME)	187,719	24
24.01	OTHER (NET ASSETS RELEASED)	154,587	24.01
24.02	OTHER (GIFT SHOP)	146,007	24.02
24.03	OTHER (MEDICAID MU REVENUE)	500,563	24.03
24.04	OTHER (MEDICARE MU REVENUE)	2,119,866	24.04
24.05	OTHER (UNREALIZED GAINS)	564,546	24.05
24.06	OTHER (OTHER NON OPERATING)	218,157	24.06
24.07	OTHER (OTHER OPERATING)	430,995	24.07
25	TOTAL OTHER INCOME (sum of lines 6-24)	5,775,907	25
26	TOTAL (line 5 plus line 25)	4,677,759	26
27.03	OTHER EXPENSES (ROUNDING)	1	27.03
28	TOTAL OTHER EXPENSES (sum of line 27 and subscripts)	1	28
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	4,677,758	29



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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0113

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	1,838,775	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	61,058	2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	67.71	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)	10.69	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)	4.56	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)	83,848	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.0668	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.1615	8
9	SUM OF LINES 7 AND 8	0.2283	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0473	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	86,974	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	2,070,655	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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



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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	NONPATIENT TELEPHONE						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCH.RCVING.STORING						5.03
5.04	ADMITTING						5.04
5.05	CASHIERING.A/R						5.05
5.06	OTHER ADMIN & GEN						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
31	INTENSIVE CARE UNIT						31
41	SUBPROVIDER - IRF						41
43	NURSERY						43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
50.01	ENDOSCOPY						50.01
51	RECOVERY ROOM						51
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
54.01	ULTRASOUND						54.01
54.02	MAMMOGRAPHY						54.02
55	RADIOLOGY-THERAPEUTIC						55
55.01	ONCOLOGY						55.01
56	RADIOISOTOPE						56
57	CT SCAN						57
58	MRI						58
59	CARDIAC CATHETERIZATION						59
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.						63
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69.01	CARDIOLOGY						69.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192	PHYSICIANS' PRIVATE OFFICES						192
192.01	COVENANT OUTPATIENT PHARMACY						192.01
192.02	REAL ESTATE						192.02



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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
192.03	FOUNDATION							192.03
192.04	OUTREACH PROGRAMS							192.04
192.05	UNASSIGNED							192.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202