

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

WORKSHEET S  
PARTS I & II

INTERMEDIARY [ ] AUDITED DATE RECEIVED \_\_\_\_\_ [ ] INITIAL [ ] RE-OPENING  
USE ONLY: [ ] DESK REVIEWED INTERMEDIARY NO. \_\_\_\_\_ [ ] FINAL [ ] MCR CODE

PART I - CERTIFICATION

CHECK \_\_\_\_\_ ELECTRONICALLY FILED COST REPORT DATE: \_\_\_\_\_  
APPLICABLE BOX \_\_\_\_\_ MANUALLY SUBMITTED COST REPORT TIME: \_\_\_\_\_

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 WHERE 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 GOTTLIEB MEMORIAL HOSPITAL (14-0008) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2009 AND ENDING 06/30/2010, AND THAT 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 II - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		TITLE XIX	
		PART A	PART B		
1	HOSPITAL	1		4	1
2	SUBPROVIDER I	2			2
3	SWING BED - SNF	609412	238349		3
4	SWING BED - NF				4
5	SKILLED NURSING FACILITY	22803			5
6	NURSING FACILITY				6
7	HOME HEALTH AGENCY				7
8	OUTPATIENT REHABILITATION PROVIDER				8
9	HEALTH CLINIC				9
100	TOTAL	632215	238349		100

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 OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 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: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 8700 WEST NORTH AVENUE P.O.BOX: 1  
 1.01 CITY: MELROSE PARK STATE: IL ZIP CODE: 60160 COUNTY: COOK 1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	PROVIDER NUMBER 2	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N)				
				V 4	XVIII 5	XIX 6		
2	HOSPITAL	GOTTLIEB MEMORIAL HOSPITAL	14-0008	07/01/1966	N	P	O	2
3	SUBPROVIDER I	GOTTLIEB MEMORIAL PSYCHIATRIC UNIT	14-S008	01/01/2007	N	P	N	3
4	SWING BEDS - SNF							4
5	SWING BEDS - NF							5
6	HOSPITAL-BASED SNF	GOTTLIEB SKILLED NURSING CARE	14-5526	06/10/1985	N	P	N	6
7	HOSPITAL-BASED NF							7
8	HOSPITAL-BASED OLTC							8
9	HOSPITAL-BASED HHA	GOTTLIEB HOME CARE	14-7255	02/28/1984	N	P	N	9
11	SEPARATELY CERTIFIED ASC							11
12	HOSPITAL-BASED HOSPICE	GOTTLIEB HOSPICE	14-1561	01/01/2000				12
14	HOSP-BASED RHC							14
15	OUTPATIENT REHABILITATION PROVID							15
16	RENAL DIALYSIS							16

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 07/01/2009 TO: 06/30/2010 17  
 18 TYPE OF CONTROL 1 2 18

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1 19  
 20 SUBPROVIDER I 4 20

OTHER INFORMATION

21 INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. 21

21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 'Y' OR 'N' FOR NO. YES 21.01

21.02 HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE. 21.02

21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy)(SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 1 N N 16974 21.03

21.04 FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL. 1 21.04

21.05 FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL. 1 21.05

21.06 DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105 OR MIPPA 147? (SEE INSTRUCTIONS). ENTER 'Y' FOR YES AND 'N' FOR NO. NO 21.06

21.07 DOES THIS HOSPITAL QUALIFY AS AN SCH WITH 100 OR FEWER BEDS UNDER MIPPA 147? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO (SEE INSTRUCTIONS). IS THIS AN SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA SECTION 3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO (SEE INSTRUCTIONS). NO NO 21.07

21.08 WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS? ENTER IN COLUMN 1, 1 IF IT IS BASED ON DATE OF ADMISSION, 2 IF IT IS BASED ON CENSUS DAYS, OR 3 IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE LAST COST REPORTING PERIOD? ENTER IN COLUMN 2, 'Y' FOR YES AND 'N' FOR NO. NO 21.08

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? NO 22

23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW NO 23

23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. 23.01

23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. 23.02

23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. 23.03

23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. 23.04

23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. 23.05

23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. 23.06

23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. 23.07

24 IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3. 24

24.01 IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3. 24.01

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 (CONTINUED)

OTHER INFORMATION

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	YES						25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	YES						25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	YES						25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	NO						25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO						25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	NO	NO					25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	NO	NO					25.06
26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.							26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:							26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.							26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:							26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	NO						27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.	NO						28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st	100	1.0275	1.0471				28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.	1		16974				28.02
<p>A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)</p>								
28.03	STAFFING	0.00	NO					28.03
28.04	RECRUITMENT	0.00	NO					28.04
28.05	RETENTION OF EMPLOYEES	0.00	NO					28.05
28.06	TRAINING	0.00	NO					28.06
28.07	OTHER (SPECIFY)		NO					28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	NO						29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	NO						30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.							30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?							30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)							30.03
30.04	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. 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.							30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO						31
31.01	IS THIS A RURAL HOSPITAL SUBPROVIDER QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO						31.01

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 (CONTINUED)

MISCELLANEOUS COST REPORTING INFORMATION

32 IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. NO 32  
 33 IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2. NO 33  
 34 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA? NO 34  
 35 HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? NO 35

PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL

36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? NO 36  
 36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320? NO 36.01  
 37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? NO 37  
 37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE? NO 37.01

TITLE XIX INPATIENT HOSPITAL SERVICES

38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? YES 38  
 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? NO 38.01  
 38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? NO 38.02  
 38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? NO 38.03  
 38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? NO 38.04  
 40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COL. 2 THE HOME OFFICE CHAIN NUMBER. (SEE INST.) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE ON LINES 40.01-40.03. NO 40  
 40.01 NAME: FI/CONTRACTOR'S NAME: 40.01  
 40.02 STREET: P.O. BOX: 40.02  
 40.03 CITY: STATE: ZIP CODE: 40.03  
 41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? YES 41  
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? NO 42  
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? NO 42.01  
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? NO 42.02  
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS? NO 43  
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY? YES 44  
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? NO 45  
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.  
 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS? 45.01  
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? 45.02  
 45.03 WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? 45.03  
 46 IF YOU ARE PARTICIPATING IN THE NCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE. 46

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COST OR CHARGES, ENTER A 'Y' FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION; ENTER 'N' IF NOT EXEMPT (SEE 42 CFR 413.13).

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC	
	1	2	3	4	5	
47 HOSPITAL	N	N	N	N	N	47
48 SUBPROVIDER I	N	N	N	N	N	48
49 SKILLED NURSING FACILITY	N	N				49
50 HOME HEALTH AGENCY	N	N				50
52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?						52
52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.						52.01
53 IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.						53
53.01 MDH PERIOD: BEGINNING: ENDING:						53.01
54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: PAID LOSSES: AND/OR SELF INSURANCE: 5369315						54
54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.						54.01
55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.						55

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 (CONTINUED)

		DATE	Y/N	LIMIT	Y/N	FEE\$	
		0	1	2	3	4	
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.	/ /	NO	0.00	NO		56
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?		NO				57
58	ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.		NO				58
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS)						58.01
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		NO				59
60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		YES				60
60.01	IF LINE 60 COLUMN 1 IS Y, DOES 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. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)		NO				60.01
MULTICAMPUS							
61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.		NO				61
	COUNTY:	STATE:	ZIP CODE	CBSA	FTE/ CAMPUS		
	1	2	3	4	5		
SETTLEMENT DATA							
63	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y', ENTER THE 'PAID THROUGH' DATE OF THE PS&R IN COLUMN 2 (mm/dd/yyyy)		YES	10/08/2010			63





HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
 PART I  
 (CONTINUED)

COMPONENT	-----DISCHARGES-----				TOTAL ALL PATIENTS
	TITLE	TITLE	TITLE		
	V 12	XVIII 13	XIX 14	15	
1 HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		3391	921	7410	1
2 HMO XIX					2
3 HOSPITAL ADULTS & PEDS - SWING BED SNF					3
4 HOSPITAL ADULTS & PEDS - SWING BED NF					4
5 TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS					5
6 INTENSIVE CARE UNIT					6
7 CORONARY CARE UNIT					7
8 BURN INTENSIVE CARE UNIT					8
9 SURGICAL INTENSIVE CARE UNIT					9
10 OTHER SPECIAL CARE (SPECIFY)					10
11 NURSERY					11
12 TOTAL HOSPITAL		3391	921	7410	12
13 RPCH VISITS					13
14 SUBPROVIDER I		214		231	14
15 SKILLED NURSING FACILITY					15
16 NURSING FACILITY					16
17 OTHER LONG TERM CARE					17
18 HOME HEALTH AGENCY					18
20 ASC (DISTINCT PART)					20
21 HOSPICE (DISTINCT PART)					21
23 O/P REHAB PROVIDER					23
24 RHC I					24
25 TOTAL					25
26 OBSERVATION BED DAYS					26
27 AMBULANCE TRIPS					27
28 EMPLOYEE DISCOUNT DAYS					28

HOSPITAL WAGE INDEX INFORMATION

PART II - WAGE DATA	AMOUNT REPORTED	RECLASS.	ADJUSTED	PAID HOURS	AVERAGE	DATA SOURCE	WORKSHEET S-3 PART II
		OF SALARIES	SALARIES	RELATED	HOURLY WAGE		
		FROM WKST. A-6	(COL.1 + COL.2)	TO SALARY IN COL.3	(COL.3 / COL.4)		
	1	2	3	4	5	6	
1 SALARIES							
2 TOTAL SALARIES	52629741	427978	53057719	1861404.30	28.50		1
3 NON-PHYSICIAN ANESTHETIST PART A							2
4 NON-PHYSICIAN ANESTHETIST PART B							3
5 PHYSICIAN - PART A	116730		116730	896.00	130.28 WS A82		4
6 4.01 TEACHING PHYSICIAN SALARIES							4.01
7 5 PHYSICIAN - PART B	101292		101292	1919.50	52.77 WS A82		5
8 5.01 NON-PHYSICIAN - PART B							5.01
9 6 INTERNS & RESIDENTS (IN APPR PGM)							6
10 6.01 CONTRACT SERVICES, I&R					GL IRIS		6.01
11 7 HOME OFFICE PERSONNEL							7
12 8 SNF	1879802	11726	1891528	75646.21	25.00 CR AND LABOR DI		8
13 8.01 EXCLUDED AREA SALARIES	2972061	87742	3059803	105348.54	29.04 CR AND FTE REPO		8.01
14 OTHER WAGES & RELATED COSTS							
15 9 CONTRACT LABOR	778231		778231	12508.92	62.21 ANALYSIS		9
16 9.01 PHARMACY SERVICES UNDER CONTRACT							9.01
17 9.02 LABORATORY SERVICES UNDER CONTRACT							9.02
18 9.03 MANAGEMENT AND ADMINISTRATIVE SERVICES'							9.03
19 10 CONTRACT LABOR: PHYSICIAN PART A	1343875		1343875	13584.10	98.93 STANDBY		10
20 10.01 TEACHING PHYSICIAN UNDER CONTRACT							10.01
21 11 HOME OFFICE SALARIES & WAGE REL COSTS							11
22 12 HOME OFFICE: PHYSICIAN PART A							12
23 12.01 TEACHING PHYSICIAN SALARIES							12.01
24 WAGE-RELATED COSTS							
25 13 WAGE RELATED COSTS (CORE)	14667049		14667049		CMS 339		13
26 14 WAGE RELATED COSTS (OTHER)					CMS 339		14
27 15 EXCLUDED AREAS	1514311		1514311		CMS 339		15
28 16 NON-PHYSICIAN ANESTHETIST PART A					CMS 339		16
29 17 NON-PHYSICIAN ANESTHETIST PART B					CMS 339		17
30 18 PHYSICIAN PART A	35746		35746		CMS 339		18
31 18.01 PART A TEACHING PHYSICIANS					CMS 339		18.01
32 19 PHYSICIAN PART B	30871		30871		CMS 339		19
33 19.01 WAGE RELATED COSTS (RHC/FQHC)							19.01
34 20 INTERNS & RESIDENTS (IN APPR PGM)					CMS 339		20
35 OVERHEAD COSTS - DIRECT SALARIES							
36 21 EMPLOYEE BENEFITS	931349	347598	1278947	40058.70	31.93		21
37 22 ADMINISTRATIVE & GENERAL	7310077	-307452	7002625	269769.51	25.96		22
38 22.01 ADMINISTRATIVE & GENERAL UNDER CONTACT	27100		27100	116.50	232.62		22.01
39 23 MAINTENANCE & REPAIRS	765281		765281	28176.60	27.16		23
40 24 OPERATION OF PLANT	914193	140	914333	43263.40	21.13		24
41 25 LAUNDRY & LINEN SERVICE	102153		102153	7472.80	13.67		25
42 26 HOUSEKEEPING	1078361		1078361	99362.40	10.85		26
43 26.01 HOUSEKEEPING UNDER CONTRACT							26.01
44 27 DIETARY	776587	-161976	614611	42347.30	14.51		27
45 27.01 DIETARY UNDER CONTRACT							27.01
46 28 CAFETERIA	113323	161986	275309	30118.50	9.14		28
47 29 MAINTENANCE OF PERSONNEL							29
48 30 NURSING ADMINISTRATION	1376242		1376242	28667.50	48.01		30
49 31 CENTRAL SERVICES AND SUPPLY	523302	79024	602326	35346.42	17.04		31
50 32 PHARMACY	1915500		1915500	49089.40	39.02		32
51 33 MEDICAL RECORDS & MEDICAL RECORDS LIBR	1079043	60	1079103	46631.50	23.14		33
52 34 SOCIAL SERVICE	298126		298126	10708.80	27.84		34
53 35 OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
PART III

PART III - HOSPITAL WAGE INDEX SUMMARY	AMOUNT REPORTED	RECLASS.	ADJUSTED	PAID HOURS	AVERAGE	
		OF SALARIES	SALARIES	RELATED	HOURLY WAGE	
		FROM WKST. A-6	(COL.1 + COL.2)	TO SALARY IN COL.3	(COL.3 / COL.4)	
	1	2	3	4	5	
1 NET SALARIES	52555549	427978	52983527	1859601.30	28.49	1
2 EXCLUDED AREA SALARIES	4851863	99468	4951331	180994.75	27.36	2
3 SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	47703686	328510	48032196	1678606.55	28.61	3
4 SUBTOTAL OTHER WAGES & REL COSTS	2122106		2122106	26093.02	81.33	4
5 SUBTOTAL WAGE-RELATED COSTS	14702795		14702795		30.61%	5
6 TOTAL (SUM OF LINES 3 THRU 5)	64528587	328510	64857097	1704699.57	38.05	6
7 NET SALARIES						7
8 EXCLUDED AREA SALARIES						8
9 SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)						9
10 SUBTOTAL OTHER WAGES & REL COSTS						10
11 SUBTOTAL WAGE-RELATED COSTS						11
12 TOTAL (SUM OF LINES 9 THRU 11)						12
13 TOTAL OVERHEAD COSTS	17210637	119380	17330017	731129.33	23.70	13

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7255

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY: COOK

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS		2991		423	3414	1
2 UNDUPLICATED CENSUS COUNT		577.00		138.00	715.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: 40.00	STAFF 1	CONTRACT 2	TOTAL 3	
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)				3
4 DIRECTORS AND ASSISTANT DIRECTOR(S)				4
5 OTHER ADMINISTRATIVE PERSONNEL	7.04		7.04	5
6 DIRECT NURSING SERVICE	9.71		9.71	6
7 NURSING SUPERVISOR				7
8 PHYSICAL THERAPY SERVICE	3.67		3.67	8
9 PHYSICAL THERAPY SUPERVISOR				9
10 OCCUPATIONAL THERAPY SERVICE	.19		.19	10
11 OCCUPATIONAL THERAPY SUPERVISOR				11
12 SPEECH PATHOLOGY SERVICE	.03		.03	12
13 SPEECH PATHOLOGY SUPERVISOR				13
14 MEDICAL SOCIAL SERVICE	.72		.72	14
15 MEDICAL SOCIAL SERVICE SUPERVISOR				15
16 HOME HEALTH AIDE	1.64		1.64	16
17 HOME HEALTH AIDE SUPERVISOR				17
18 OTHER (SPECIFY)				18

HOME HEALTH AGENCY MSA CODES

19 HOW MANY MSAs IN COLUMN 1 OR CBSAs IN COLUMN 1.01 DID YOU PROVIDE SERVICES TO DURING THIS COST REPORTING PERIOD	1	1	1.01	1	19
20 LIST THOSE MSA CODE(S) IN COLUMN 1 AND CBSA CODE(S) IN COLUMN 1.01 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE)	1600		16974		20

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7255

WORKSHEET S-4  
 (CONTINUED)

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 2000

	FULL EPISODES				SCIC WITHIN A PEP 5	SCIC ONLY EPISODES 6	TOTAL 7	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4				
	21	SKILLED NURSING VISITS	6569					
22	SKILLED NURSING VISIT CHARGES	1278564		45855	14823		1339242	22
23	PHYSICAL THERAPY VISITS	4448		20	75		4543	23
24	PHYSICAL THERAPY VISIT CHARGES	819341		3676	13913		836930	24
25	OCCUPATIONAL THERAPY VISITS	402					402	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	74831					74831	26
27	SPEECH PATHOLOGY VISITS	35					35	27
28	SPEECH PATHOLOGY VISIT CHARGES	6493					6493	28
29	MEDICAL SOCIAL SERVICE VISITS	458		8	6		472	29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	101564		1788	1341		104693	30
31	HOME HEALTH AIDE VISITS	1871		7	15		1893	31
32	HOME HEALTH AIDE VISIT CHARGES	285754		1050	2310		289114	32
33	TOTAL VISITS	13783		271	172		14226	33
34	OTHER CHARGES	37574		3837	69		41480	34
35	TOTAL CHARGES	2604121		56206	32456		2692783	35
36	TOTAL NUMBER OF EPISODES	792		100	12		904	36
37	TOTAL NUMBER OF OUTLIER EPISODES				1		1	37
38	TOTAL MEDICAL SUPPLY CHARGES	37574		3837	69		41480	38

PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

GROUP (1)	M3PI REVENUE CODE	SERVICES PRIOR TO OCTOBER 1st		SERVICES ON OR AFTER OCTOBER 1st		SERVICES THROUGH 4/1/2001 - 9/30/2001		SWING BED SNF DAYS	TOTAL
		RATE	DAYS	RATE	DAYS	RATE	DAYS		
1	2	3	3.01	4	4.01	4.02	4.03	4.06	5
1	RUC		18						1
2	RUB		1						2
3	RUA								3
3.01	RUX		22						3.01
3.02	RUL		3						3.02
4	RVC		595						4
5	RVB		949						5
6	RVA								6
6.01	RVX		1273						6.01
6.02	RVL		1508						6.02
7	RHC		491						7
8	RHB		67						8
9	RHA								9
9.01	RHX								9.01
9.02	RHL								9.02
10	RMC		60						10
11	RMB		48						11
12	RMA								12
12.01	RMX		1627						12.01
12.02	RML		985						12.02
13	RLB								13
14	RLA								14
15	SE3		7						15
16	SE2		33						16
17	SE1		7						17
18	SSC								18
19	SSB								19
20	SSA								20
21	CC2		6						21
22	CC1								22
23	CB2								23
24	CB1		2						24
25	CA2								25
26	CA1								26
27	IB2								27
28	IB1								28
29	IA2								29
30	IA1								30
31	BB2								31
32	BB1								32
33	BA2								33
34	BA1								34
35	PE2								35
36	PE1								36
37	PD2								37
38	PD1		2						38
39	PC2								39
40	PC1								40
41	PB2								41
42	PB1								42
43	PA2								43
44	PA1								44
45	AAA								45
45.01	ES3								45.01
45.02	ES2								45.02
45.03	ES1								45.03
45.04	HE2								45.04
45.05	HE1								45.05
45.06	HD2								45.06
45.07	HD1								45.07
45.08	HC2								45.08
45.09	HC1								45.09
45.10	HB2								45.10
45.11	HB1								45.11
45.12	LE2								45.12
45.13	LE1								45.13
45.14	LD2								45.14
45.15	LD1								45.15
45.16	LC2								45.16
45.17	LC1								45.17
45.18	LB2								45.18
45.19	LB1								45.19
45.20	CE2								45.20
45.21	CE1								45.21
45.22	CD2								45.22
45.23	CD1								45.23
46	TOTAL		7704						46

PROVIDER NO. 14-0008 GOTTLIEB MEMORIAL HOSPITAL  
 PERIOD FROM 07/01/2009 TO 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2010.09  
 11/30/2010 11:48

HOSPICE IDENTIFICATION DATA

HOSPICE NO.: 14-1561

WORKSHEET S-9  
 PARTS I & II

PART I - ENROLLMENT DAYS

	TITLE XVIII 1	TITLE XIX 2	TITLE XVIII SKILLED NURSING FACILITY 3	TITLE XIX NURSING FACILITY 4	ALL OTHER 5	TOTAL 6	
1 CONTINUOUS HOME CARE							1
2 ROUTINE HOME CARE	2905				210	3115	2
3 INPATIENT RESPITE CARE	5				5	10	3
4 GENERAL INPATIENT CARE	184				524	708	4
5 TOTAL HOSPICE DAYS	3094				739	3833	5

PART II - CENSUS DATA

	TITLE XVIII 1	TITLE XIX 2	TITLE XVIII SKILLED NURSING FACILITY 3	TITLE XIX NURSING FACILITY 4	ALL OTHER 5	TOTAL 6	
6 NUMBER OF PATIENTS RECEIVING HOSPICE CARE	99				24	123	6
7 TOTAL NUMBER OF UNDUPLICATED CONTINUOUS CARE HOURS BILLABLE TO MEDICARE							7
8 AVERAGE LENGTH OF STAY	31.25				30.79	31.16	8
9 UNDUPLICATED CENSUS COUNT	99				24	123	9

HOSPITAL UNCOMPENSATED CARE DATA

WORKSHEET S-10

UNCOMPENSATED CARE INFORMATION

1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	1
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04	2
2.01	IS IT AT THE TIME OF ADMISSION?	2.01
2.02	IS IT AT THE TIME OF FIRST BILLING?	2.02
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?	2.03
2.04	OTHER METHODS OF WRITE-OFFS (SPECIFY)	2.04
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?	3
4	ARE CHARITY DETERMINATION BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?	4
5	ARE CHARITY DETERMINATION BASED UPON INCOME DATA ONLY?	5
6	ARE CHARITY DETERMINATION BASED UPON NET WORTH DATA?	6
7	ARE CHARITY DETERMINATION BASED UPON INCOME AND NET WORTH DATA?	7
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01	8
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	8.01
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	9
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	9.01
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?	9.02
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	9.03
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?	9.04
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE-OFF?	10
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER LINES 11 THRU 11.04	11
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?	11.01
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?	11.02
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?	11.03
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	11.04
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?	12
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?	13
14	IS YOUR HOSPITAL STATE AND LOCAL GOVERNMENT OWNED? IF YES ANSWER LINE 14.01	14
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THE GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING UNCOMPENSATED CARE?	14.01
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?	14.02
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	15
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?	16
17	REVENUE RELATED TO UNCOMPENSATED CARE	17
17.01	GROSS MEDICAID REVENUES	12359871 17.01
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	18
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)	19
20	RESTRICTED GRANTS	20
21	NON-RESTRICTED GRANTS	21
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	12359871 22
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	23
24	COST TO CHARGE RATIO	0.161416 24
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST	25
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	26
27	TOTAL SCHIP COST	27
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	76313488 28
29	TOTAL GROSS MEDICAID COST	12318218 29
30	OTHER UNCOMPENSATED CARE CHARGES (FROM YOUR RECORDS)	22469103 30
31	UNCOMPENSATED CARE COST	3626873 31
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL	12318218 32



RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL	RECLASSI- FICATIONS	RECLASS. TRIAL BALANCE	ADJUST- MENTS	NET EXP FOR ALLOCATION	
		1	2	3	4	5	6	7	
93	9300 HOSPICE	237910	79329	317239	23400	340639		340639	93
95	SUBTOTALS	52475234	74308899	126784133	-97361	126686772	-3641512	123045260	95
NONREIMBURSABLE COST CENTERS									
96	9600 GIFT, FLOWER, COFFEE SHOP & CAN	30131	35417	65548		65548		65548	96
98	9800 PHYSICIANS' PRIVATE OFFICES				10619	10619		10619	98
98.01	9801 NON-EMPLOYEE CHILD CARE CENTER				86742	86742		86742	98.01
99	9900 NONPAID WORKERS	124376	14793	139169		139169		139169	99
101	TOTAL	52629741	74359109	126988850		126988850	-3641512	123347338	101

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----				
		COST CENTER 2	LINE # 3	SALARY 4	OTHER 5	
1 DRUGS SOLD TO PTS	A	DRUGS CHARGED TO PATIENTS	56		3759259	1
2						2
3 PURCHASED SERVICES	B	INPATIENT RENAL DIALYSIS	59.05		385632	3
4	B					4
5						5
6 SHARED DIETARY COST	C	CAFETERIA	12	161986	233450	6
7						7
8 NONEMP CHILD CARE	D	NON-EMPLOYEE CHILD CARE CENTE	98.01	79089	7653	8
9						9
10 HOUSE STAF PHYS.	F	HOSPICE	93		23400	10
11	F	ANESTHESIOLOGY	40		717000	11
12	F	OPERATING ROOM	37		372250	12
13	F	ADULTS & PEDIATRICS	25		370132	13
14	F	EMERGENCY	61		26251	14
15	F	SUBPROVIDER I	31		40134	15
16	F	ELECTROCARDIOLOGY	53		14583	16
17						17
18						18
19 PT TRANSPORT	H	CENTRAL SERVICES & SUPPLY	15	79024	18225	19
20	H	ADULTS & PEDIATRICS	25	103921	23966	20
21	H	INTENSIVE CARE UNIT	26	14090	3250	21
22	H	SKILLED NURSING FACILITY	34	11540	2661	22
23	H	DELIVERY ROOM & LABOR ROOM	39	13090	3019	23
24	H	RADIOLOGY-DIAGNOSTIC	41	13712	3162	24
25	H	RADIOISOTOPE	43	6591	1520	25
26	H	ULTRASOUND	43.01	11293	2604	26
27	H	LABORATORY	44	11286	2603	27
28	H	RESPIRATORY THERAPY	49	360	83	28
29	H	ELECTROCARDIOLOGY	53	13660	3150	29
30	H	ELECTROENCEPHALOGRAPHY	54	1045	241	30
31	H	CARDIAC CATHERIZATION LAB	59.03	2342	540	31
32	H	INPATIENT RENAL DIALYSIS	59.05	7	2	32
33	H	RADIOLOGY-DIAGNOSTIC	41	80	18	33
34	H	WOUND CARE	60.02	6449	1487	34
35	H	EMERGENCY	61	10383	2395	35
36 SUBTOTAL				539948	6018670	36

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF. 10
			LINE #	SALARY	OTHER	
1	1	6	7	8	9	
1 DRUGS SOLD TO PTS	A	PHARMACY	16		3759259	1
2						2
3 PURCHASED SERVICES	B	INTENSIVE CARE UNIT	26		150978	3
4	B	ADULTS & PEDIATRICS	25		234654	4
5						5
6 SHARED DIETARY COST	C	DIETARY	11	161986	233450	6
7						7
8 NONEMP CHILD CARE	D	EMPLOYEE BENEFITS	5	79089	7653	8
9						9
10 HOUSE STAF PHYS.	F	ADMINISTRATIVE & GENERAL	6		1563750	10
11	F					11
12	F					12
13	F					13
14	F					14
15	F					15
16	F					16
17						17
18						18
19 PT TRANSPORT	H	ADMINISTRATIVE & GENERAL	6	307502	70916	19
20	H					20
21	H					21
22	H					22
23	H					23
24	H					24
25	H					25
26	H					26
27	H					27
28	H					28
29	H					29
30	H					30
31	H					31
32	H					32
33	H					33
34	H					34
35	H					35
36 SUBTOTAL				548577	6020660	36

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----				
		COST CENTER	LINE #	SALARY		OTHER
	1	2	3	4	5	
1	H	PHYSICIANS' PRIVATE OFFICES	98	8629	1990	1
2						2
3 FLOOR STOCK SUPPLIES	I	MEDICAL SUPPLIES CHARGED TO P	55		6959114	3
4	I					4
5	I					5
6	I					6
7	I					7
8	I					8
9	I					9
10	I					10
11						11
12 BONUS	K	EMPLOYEE BENEFITS	5	426687		12
13	K	ADMINISTRATIVE & GENERAL	6	50		13
14	K	OPERATION OF PLANT	8	140		14
15	K	DIETARY	11	10		15
16	K	MEDICAL RECORDS & LIBRARY	17	60		16
17	K	ADULTS & PEDIATRICS	25	60		17
18	K	SUBPROVIDER I	31	24		18
19	K	SKILLED NURSING FACILITY	34	186		19
20	K	OPERATING ROOM	37	440		20
21	K	ANESTHESIOLOGY	40	10		21
22	K	LABORATORY	44	150		22
23	K	PHYSICAL THERAPY	50	20		23
24	K	EMERGENCY	61	91		24
25	K	RECOVERY ROOM	38	50		25
26						26
27 IMPLANTS	L	IMPL. DEV. CHARGED TO PATIENT	55.30		3932069	27
28						28
29 NURSERY	M	NURSERY	33	391551	28269	29
30						30
31						31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS				1368106	16940112	36

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- COST CENTER	DECREASE -----			WKST A-7 REF.
			LINE #	SALARY	OTHER	
	1	6	7	8	9	10
1	H					1
2						2
3 FLOOR STOCK SUPPLIES	I	CENTRAL SERVICES & SUPPLY	15		282712	3
4	I	ADULTS & PEDIATRICS	25		276776	4
5	I	INTENSIVE CARE UNIT	26		184242	5
6	I	SKILLED NURSING FACILITY	34		50794	6
7	I	OPERATING ROOM	37		3552993	7
8	I	DELIVERY ROOM & LABOR ROOM	39		138729	8
9	I	CARDIAC CATHERIZATION LAB	59.03		2127936	9
10	I	EMERGENCY	61		344932	10
11						11
12 BONUS	K	EMPLOYEE BENEFITS	5		426687	9 12
13	K	ADMINISTRATIVE & GENERAL	6		50	13
14	K	OPERATION OF PLANT	8		140	14
15	K	DIETARY	11		10	15
16	K	MEDICAL RECORDS & LIBRARY	17		60	16
17	K	ADULTS & PEDIATRICS	25		60	17
18	K	SUBPROVIDER I	31		24	18
19	K	SKILLED NURSING FACILITY	34		186	19
20	K	OPERATING ROOM	37		440	20
21	K	ANESTHESIOLOGY	40		10	21
22	K	LABORATORY	44		150	22
23	K	PHYSICAL THERAPY	50		20	23
24	K	OUTPATIENT PHARMACY	56.01		91	24
25	K	RECOVERY ROOM	38		50	25
26						26
27 IMPLANTS	L	OPERATING ROOM	37		3932069	27
28						28
29 NURSERY	M	ADULTS & PEDIATRICS	25	391551	28269	29
30						30
31						31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS				940128	17368090	36

ANALYSIS OF CHANGES DURING COST REPORTING  
 PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL  
 AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED  
 TO PARTICIPATE IN HEALTH CARE PROGRAMS

WORKSHEET A-7  
 PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND								1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES								3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT								6
7 SUBTOTAL								7
8 RECONCILING ITEMS								8
9 TOTAL								9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	4293071	601828		601828		4894899		1
2 LAND IMPROVEMENTS	4881753					4881753		2
3 BUILDINGS AND FIXTURES	22451603	141462		141462		22593065		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	88467529	2304425		2304425		90771954		5
6 MOVABLE EQUIPMENT	47856261	2497678		2497678		50353939		6
7 SUBTOTAL	167950217	5545393		5545393		173495610		7
8 RECONCILING ITEMS								8
9 TOTAL	167950217	5545393		5545393		173495610		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
 PARTS III & IV

DESCRIPTION	----- COMPUTATION OF RATIOS -----				----- ALLOCATION OF OTHER CAPITAL -----			
	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	1	2	3	4	5	6	7	8
1 OLD CAP REL COSTS-BLDG & FIXT				.000000				1
2 OLD CAP REL COSTS-MVBLE EQUIP				.000000				2
3 NEW CAP REL COSTS-BLDG & FIXT				.000000				3
4 NEW CAP REL COSTS-MVBLE EQUIP				.000000				4
5 TOTAL				.000000				5

DESCRIPTION	----- SUMMARY OF OLD AND NEW CAPITAL -----						
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	3543051						3543051 3
4 NEW CAP REL COSTS-MVBLE EQUIP	3246072						3246072 4
5 TOTAL	6789123						6789123 5

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

DESCRIPTION	----- SUMMARY OF OLD AND NEW CAPITAL -----						
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	3574168						3574168 3
4 NEW CAP REL COSTS-MVBLE EQUIP	3251856						3251856 4
5 TOTAL	6826024						6826024 5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-NEW BLDGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	3
4 INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	4
5 INVESTMENT INCOME-OTHER					5
6 TRADE, QUANTITY, AND TIME DISCOUNTS					6
7 REFUNDS AND REBATES OF EXPENSES					7
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS					8
9 TELEPHONE SERVICES (PAY STATIONS EXCL)	A	-91991	ADMINISTRATIVE & GENERAL	6	9
10 TELEVISION AND RADIO SERVICE	A	-1668	OPERATION OF PLANT	8	10
11 PARKING LOT					11
12 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST				
	A-8-2	-966130			12
13 SALE OF SCRAP, WASTE, ETC.					13
14 RELATED ORGANIZATION TRANSACTIONS	WKST				
	A-8-1				14
15 LAUNDRY AND LINEN SERVICE					15
16 CAFETERIA - EMPLOYEES AND GUESTS	B	-356103	CAFETERIA	12	16
17 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					17
18 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					18
19 SALE OF DRUGS TO OTHER THAN PATIENTS					19
20 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-157	MEDICAL RECORDS & LIBRARY	17	20
21 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					21
22 VENDING MACHINES	B	-9909	CAFETERIA	12	22
23 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES					23
24 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					24
25 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		RESPIRATORY THERAPY	49	25
26 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		PHYSICAL THERAPY	50	26
27 ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST		HOME HEALTH AGENCY	71	27
	A-8-3		UTILIZATION REVIEW-SNF	89	28
28 UTIL REVIEW-PHYSICIANS' COMPENSATION			OLD CAP REL COSTS-BLDG & FIXT	1	29
29 DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-MVBLE EQUIP	2	30
30 DEPRECIATION--OLD MOVABLE EQUIPMENT			NEW CAP REL COSTS-BLDG & FIXT	3	31
31 DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-MVBLE EQUIP	4	32
32 DEPRECIATION--NEW MOVABLE EQUIPMENT			NONPHYSICIAN ANESTHETISTS	20	33
33 NON-PHYSICIAN ANESTHETIST					34
34 PHYSICIANS' ASSISTANT					
35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST				35
36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4				
	WKST				
	WKST A-8-4				36
37 DIRECTOR PHYSICIAN DEVELOPMENT	A	-51374	ADMINISTRATIVE & GENERAL	6	37
37.01 RELATED FRINGE BENEFITS	A	-15219	EMPLOYEE BENEFITS	5	37.01
38 PT PHONE CAPITAL RELATED COST	A	-5784	NEW CAP REL COSTS-MVBLE EQUIP	4	9 38
39 NURSING REVENUE	B	-673	NURSING ADMINISTRATION	14	39
39.01 NEGATIVE SALVAGE VALUE	A	-2771	NEW CAP REL COSTS-BLDG & FIXT	3	9 39.01
39.04 VOLUNTEER SALARIES (632.186)	A	-299820	ADMINISTRATIVE & GENERAL	6	39.04
39.07 MISC INCOME A&G	B	-16510	ADMINISTRATIVE & GENERAL	6	39.07
39.10 OUTSIDE SERVICES PT	B	-15985	PHYSICAL THERAPY	50	39.10
39.15 WEST TOWNS (958.729)	A	-601236	ADMINISTRATIVE & GENERAL	6	39.15
39.19 EMPLOYEE DAY CARE REVENUE	B	-404452	EMPLOYEE BENEFITS	5	39.19
39.20 PHYSICIAN EMPLOYEE BENEFITS	A	-52399	EMPLOYEE BENEFITS	5	39.20
39.22 INTEREST	B	-49001	ADMINISTRATIVE & GENERAL	6	39.22
39.23 DAY CARE DEPR ADDJ	A	-28346	NEW CAP REL COSTS-BLDG & FIXT	3	9 39.23
40 NON ALLOWABLE TAXES	A	97107	ADMINISTRATIVE & GENERAL	6	40
41 RADIOLOGY	B	-159	RADIOLOGY-DIAGNOSTIC	41	41
42 AHA LOBBYING FEES	A	-8704	ADMINISTRATIVE & GENERAL	6	42
43 IHHS LOBBYING COST	A	-27955	ADMINISTRATIVE & GENERAL	6	43
44 OB/GYN OTHER REV	B	-2681	ADULTS & PEDIATRICS	25	44
45 ADVERTISING	A	-604895	ADMINISTRATIVE & GENERAL	6	45
46					46
46.01 MED STAFF CONTRIBUTION ADD BACK	A	22000	ADMINISTRATIVE & GENERAL	6	46.01
47					47
48					48
48.02 INTERDEPT RENT CONFERENCE	A	-57318	ADMINISTRATIVE & GENERAL	6	48.02
48.03 INTERDEPT RENT AUDIOLOGY	A	-27144	PHYSICAL THERAPY	50	48.03
48.05 INTERDEPT RENT OP PHARMACY	A	-57546	OUTPATIENT PHARMACY	56.01	48.05
48.06 EMPLOYEE HEALTH CENTER	B	-4689	EMPLOYEE BENEFITS	5	48.06
49					49
50 TOTAL		-3641512			50

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 THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL 5)	NET ADJ-USTMENTS	WKST A-7 REF
1	2	3	4	5	6	7
1						
2						
3						
4						
5	TOTALS					

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

THE SECRETARY, BY VIRTUE OF 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.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----		TYPE OF BUSINESS
		PERCENT OF OWNERSHIP	PERCENT OF OWNERSHIP	
1	2	3	4	5
1				
2				
3				
4				
5				

- (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:

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	PERCENT OF UNAD- JUSTED RCE LIMIT
1	2		3	4	5	6	7	8	9
1	39	DELIVERY ROOM & LABOR RO	5663	5663					
2	59.03	CARDIAC CATHERIZATION LA	1220	1220					
3	60.02	WOUND CARE	173795	173795					
4	25	ADULTS & PEDIATRICS	309500	309500					
5	37	OPERATING ROOM	94409	94409					
6	61	EMERGENCY	26251	26251					
7	6	ADMINISTRATIVE & GENERAL	116730		116730	177200	896	76332	3817
8	44	LABORATORY	12617	12617					
9	25	ADULTS & PEDIATRICS	35882	35882					
10	41	RADIOLOGY-DIAGNOSTIC	548	548					
11	37	OPERATING ROOM	372250		372250	208000	6029	602900	30145
12	40	ANESTHESIOLOGY	717000		717000	200300	5736	552366	27618
13	53	ELECTROCARDIOLOGY	14583		14583	177200	104	8860	443
14	31	SUBPROVIDER I	40135		40135	154100	287	21263	1063
15	25	ADULTS & PEDIATRICS	24750		24750	196400	177	16713	836
16	6	ADMINISTRATIVE & GENERAL	22307		22307	177200	159	13546	677
17	6	ADMINISTRATIVE & GENERAL	152850		152850	177200	1092	93030	4652
101		TOTAL	2120490	659885	1460605		14480	1385010	69251

PROVIDER NO. 14-0008 GOTTLIEB MEMORIAL HOSPITAL  
 PERIOD FROM 07/01/2009 TO 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (9/96)

VERSION: 2010.09  
 11/30/2010 11:48

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT
LINE NO.	11	12	13	14	15	16	17	18
1	39 DELIVERY ROOM & LABOR RO	AGGREGATE						5663
2	59.03 CARDIAC CATHERIZATION LA	AGGREGATE						1220
3	60.02 WOUND CARE	AGGREGATE						173795
4	25 ADULTS & PEDIATRICS	OB COVERAGE						309500
5	37 OPERATING ROOM	AGGREGATE						94409
6	61 EMERGENCY	ER						26251
7	6 ADMINISTRATIVE & GENERAL	MED ADMIN				76332	40398	40398
8	44 LABORATORY	AGGREGATE						12617
9	25 ADULTS & PEDIATRICS	MOONLIGHTERS						35882
10	41 RADIOLOGY-DIAGNOSTIC	AGGREGATE						548
11	37 OPERATING ROOM	TRAUMA CALL				602900		
12	40 ANESTHESIOLOGY	TRAUMA CALL				552366	164634	164634
13	53 ELECTROCARDIOLOGY	CHAIR				8860	5723	5723
14	31 SUBPROVIDER I	DIRECTOR				21263	18872	18872
15	25 ADULTS & PEDIATRICS	DIRECTOR				16713	8037	8037
16	6 ADMINISTRATIVE & GENERAL	DIRECTOR				13546	8761	8761
17	6 ADMINISTRATIVE & GENERAL	QA				93030	59820	59820
101	TOTAL					1385010	306245	966130



COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION		NET EXP FOR COST ALLOCATION 0	NEW CAP- REL COSTS BLDG&FIXT 3	NEW CAP- REL COSTS MOV EQUIP 4	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINI- STRATIVE & GENERAL 6	MAINTEN- ANCE AND REPAIRS 7	OPERATION OF PLANT 8	
93	HOSPICE	340639			81395	422034	94872	551		93
95	SUBTOTALS	123045260	3510270	3245530	17631946	122929066	22544964	1964662	6083141	95
NONREIMBURSABLE COST CENTERS										
96	GIFT, FLOWER, COFFEE SHOP & CAN	65548	12952	129	10309	88938	19993	724	29642	96
98	PHYSICIANS' PRIVATE OFFICES	10619	19829		2952	33400	7508		45383	98
98.01	NON-EMPLOYEE CHILD CARE CENTER	86742			27058	113800	25582			98.01
99	NONPAID WORKERS	139169		413	42552	182134	40943			99
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	123347338	3543051	3246072	17714817	123347338	22638990	1965386	6158166	103



COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION		LAUNDRY AND LINEN SERVICE 9	HOUSE- KEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINI- STRATION 14	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	
93	HOSPICE		6835		4654	23364	1215	26142		93
95	SUBTOTALS	802515	3245007	2554201	836273	2588931	2543163	3655559	2444076	95
NONREIMBURSABLE COST CENTERS										
96	GIFT, FLOWER, COFFEE SHOP & CAN				1950					96
98	PHYSICIANS' PRIVATE OFFICES									98
98.01	NON-EMPLOYEE CHILD CARE CENTER		12938		3739					98.01
99	NONPAID WORKERS									99
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	802515	3257945	2554201	841962	2588931	2543163	3655559	2444076	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	18	25	26	27	
GENERAL SERVICE COST CENTERS					
1 OLD CAP REL COSTS-BLDG & FIXT					1
2 OLD CAP REL COSTS-MVBLE EQUIP					2
3 NEW CAP REL COSTS-BLDG & FIXT					3
4 NEW CAP REL COSTS-MVBLE EQUIP					4
5 EMPLOYEE BENEFITS					5
6 ADMINISTRATIVE & GENERAL					6
7 MAINTENANCE & REPAIRS					7
8 OPERATION OF PLANT					8
9 LAUNDRY & LINEN SERVICE					9
10 HOUSEKEEPING					10
11 DIETARY					11
12 CAFETERIA					12
13 MAINTENANCE OF PERSONNEL					13
14 NURSING ADMINISTRATION					14
15 CENTRAL SERVICES & SUPPLY					15
16 PHARMACY					16
17 MEDICAL RECORDS & LIBRARY					17
18 SOCIAL SERVICE	579946				18
20 NONPHYSICIAN ANESTHETISTS					20
21 NURSING SCHOOL					21
22 I&R SERVICES-SALARY & FRINGES A					22
23 I&R SERVICES-OTHER PRGM COSTS A					23
24 PARAMED ED PRGM-(SPECIFY)					24
INPATIENT ROUTINE SERV COST CENTERS					
25 ADULTS & PEDIATRICS	368294	24700399		24700399	25
26 INTENSIVE CARE UNIT	38028	8874161		8874161	26
31 SUBPROVIDER I	22044	1990472		1990472	31
33 NURSERY		827189		827189	33
34 SKILLED NURSING FACILITY	119213	5158441		5158441	34
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM		8780845		8780845	37
38 RECOVERY ROOM		897902		897902	38
39 DELIVERY ROOM & LABOR ROOM		2778966		2778966	39
40 ANESTHESIOLOGY		1220203		1220203	40
41 RADIOLOGY-DIAGNOSTIC		4510843		4510843	41
43 RADIOISOTOPE		1068721		1068721	43
43.01 ULTRASOUND		997462		997462	43.01
43.02 MRI-CT SCANS		2432069		2432069	43.02
44 LABORATORY		9190830		9190830	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO					46.30
49 RESPIRATORY THERAPY		2212721		2212721	49
50 PHYSICAL THERAPY		4122158		4122158	50
53 ELECTROCARDIOLOGY		1001666		1001666	53
54 ELECTROENCEPHALOGRAPHY		205880		205880	54
55 MEDICAL SUPPLIES CHARGED TO PAT		9649943		9649943	55
55.30 IMPL. DEV. CHARGED TO PATIENT		5896655		5896655	55.30
56 DRUGS CHARGED TO PATIENTS		8204470		8204470	56
56.01 OUTPATIENT PHARMACY		2563067		2563067	56.01
59 LITHOTRIPSY					59
59.01 CARDIAC REHABILITATION		493116		493116	59.01
59.03 CARDIAC CATHERIZATION LAB		2227380		2227380	59.03
59.05 INPATIENT RENAL DIALYSIS		472335		472335	59.05
59.97 CARDIAC REHABILITATION					59.97
59.98 HYPERBARIC OXYGEN THERAPY					59.98
59.99 LITHOTRIPSY					59.99
OUTPATIENT SERVICE COST CENTERS					
60 CLINIC		9766		9766	60
60.01 OUTPATIENT INFUSION PROCEDURES					60.01
60.02 WOUND CARE		1280746		1280746	60.02
61 EMERGENCY	32367	6857772		6857772	61
62 OBSERVATION BEDS (NON-DISTINCT)					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
65 AMBULANCE SERVICES					65
69.10 CMHC					69.10
69.20 OUTPATIENT PHYSICAL THERAPY					69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY					69.30
69.40 OUTPATIENT SPEECH PATHOLOGY					69.40
71 HOME HEALTH AGENCY		3534819		3534819	71
SPECIAL PURPOSE COST CENTERS					
85.01 PANCREAS ACQUISITION					85.01
85.02 INTESTINAL ACQUISITION					85.02
85.03 ISLET CELL ACQUISITION					85.03

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION		SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		18	25	26	27	
93	HOSPICE		579667		579667	93
95	SUBTOTALS	579946	122740664		122740664	95
	NONREIMBURSABLE COST CENTERS					
96	GIFT, FLOWER, COFFEE SHOP & CAN		141247		141247	96
98	PHYSICIANS' PRIVATE OFFICES		86291		86291	98
98.01	NON-EMPLOYEE CHILD CARE CENTER		156059		156059	98.01
99	NONPAID WORKERS		223077		223077	99
101	CROSS FOOT ADJUSTMENTS					101
102	NEGATIVE COST CENTER					102
103	TOTAL	579946	123347338		123347338	103



ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION		DIR ASSGND CAP-REL COSTS 0	NEW CAP- REL COSTS BLDG&FIXT 3	NEW CAP- REL COSTS MOV EQUIP 4	CAP REL COST TO BE ALLOC 4A	EMPLOYEE BENEFITS 5	ADMINI- STRATIVE & GENERAL 6	MAINTEN- ANCE AND REPAIRS 7	OPERATION OF PLANT 8	
93	HOSPICE	20248			20248	215	4655	39		93
95	SUBTOTALS	966721	3510270	3245530	7722521	46556	1106260	140137	753984	95
NONREIMBURSABLE COST CENTERS										
96	GIFT, FLOWER, COFFEE SHOP & CAN		12952	129	13081	27	981	52	3674	96
98	PHYSICIANS' PRIVATE OFFICES		19829		19829	8	368		5625	98
98.01	NON-EMPLOYEE CHILD CARE CENTER					71	1255			98.01
99	NONPAID WORKERS			413	413	112	2009			99
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	966721	3543051	3246072	7755844	46774	1110873	140189	763283	103



ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION		LAUNDRY AND LINEN SERVICE 9	HOUSE- KEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINI- STRATION 14	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	
93	HOSPICE		225		639	864	268	772		93
95	SUBTOTALS	29018	106658	172783	114745	95731	560779	107981	76871	95
NONREIMBURSABLE COST CENTERS										
96	GIFT, FLOWER, COFFEE SHOP & CAN				268					96
98	PHYSICIANS' PRIVATE OFFICES									98
98.01	NON-EMPLOYEE CHILD CARE CENTER		425		513					98.01
99	NONPAID WORKERS									99
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	29018	107083	172783	115526	95731	560779	107981	76871	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	18	25	26	27	
GENERAL SERVICE COST CENTERS					
1 OLD CAP REL COSTS-BLDG & FIXT					1
2 OLD CAP REL COSTS-MVBLE EQUIP					2
3 NEW CAP REL COSTS-BLDG & FIXT					3
4 NEW CAP REL COSTS-MVBLE EQUIP					4
5 EMPLOYEE BENEFITS					5
6 ADMINISTRATIVE & GENERAL					6
7 MAINTENANCE & REPAIRS					7
8 OPERATION OF PLANT					8
9 LAUNDRY & LINEN SERVICE					9
10 HOUSEKEEPING					10
11 DIETARY					11
12 CAFETERIA					12
13 MAINTENANCE OF PERSONNEL					13
14 NURSING ADMINISTRATION					14
15 CENTRAL SERVICES & SUPPLY					15
16 PHARMACY					16
17 MEDICAL RECORDS & LIBRARY					17
18 SOCIAL SERVICE	32664				18
20 NONPHYSICIAN ANESTHETISTS					20
21 NURSING SCHOOL					21
22 I&R SERVICES-SALARY & FRINGES A					22
23 I&R SERVICES-OTHER PRGM COSTS A					23
24 PARAMED ED PRGM-(SPECIFY)					24
INPATIENT ROUTINE SERV COST CENTERS					
25 ADULTS & PEDIATRICS	20743	1469094		1469094	25
26 INTENSIVE CARE UNIT	2142	367374		367374	26
31 SUBPROVIDER I	1242	112309		112309	31
33 NURSERY		35043		35043	33
34 SKILLED NURSING FACILITY	6714	319438		319438	34
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM		1029745		1029745	37
38 RECOVERY ROOM		49683		49683	38
39 DELIVERY ROOM & LABOR ROOM		180083		180083	39
40 ANESTHESIOLOGY		60031		60031	40
41 RADIOLOGY-DIAGNOSTIC		722330		722330	41
43 RADIOISOTOPE		46267		46267	43
43.01 ULTRASOUND		107931		107931	43.01
43.02 MRI-CT SCANS		314733		314733	43.02
44 LABORATORY		515915		515915	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO					46.30
49 RESPIRATORY THERAPY		110137		110137	49
50 PHYSICAL THERAPY		238499		238499	50
53 ELECTROCARDIOLOGY		104873		104873	53
54 ELECTROENCEPHALOGRAPHY		19652		19652	54
55 MEDICAL SUPPLIES CHARGED TO PAT		304459		304459	55
55.30 IMPL. DEV. CHARGED TO PATIENT		281668		281668	55.30
56 DRUGS CHARGED TO PATIENTS		148629		148629	56
56.01 OUTPATIENT PHARMACY		64180		64180	56.01
59 LITHOTRIPSY					59
59.01 CARDIAC REHABILITATION		75295		75295	59.01
59.03 CARDIAC CATHERIZATION LAB		391947		391947	59.03
59.05 INPATIENT RENAL DIALYSIS		4254		4254	59.05
59.97 CARDIAC REHABILITATION					59.97
59.98 HYPERBARIC OXYGEN THERAPY					59.98
59.99 LITHOTRIPSY					59.99
OUTPATIENT SERVICE COST CENTERS					
60 CLINIC		2179		2179	60
60.01 OUTPATIENT INFUSION PROCEDURES					60.01
60.02 WOUND CARE		56392		56392	60.02
61 EMERGENCY	1823	481049		481049	61
62 OBSERVATION BEDS (NON-DISTINCT)					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
65 AMBULANCE SERVICES					65
69.10 CMHC					69.10
69.20 OUTPATIENT PHYSICAL THERAPY					69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY					69.30
69.40 OUTPATIENT SPEECH PATHOLOGY					69.40
71 HOME HEALTH AGENCY		66019		66019	71
SPECIAL PURPOSE COST CENTERS					
85.01 PANCREAS ACQUISITION					85.01
85.02 INTESTINAL ACQUISITION					85.02
85.03 ISLET CELL ACQUISITION					85.03

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION		SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		18	25	26	27	
93	HOSPICE		27925		27925	93
95	SUBTOTALS	32664	7707133		7707133	95
	NONREIMBURSABLE COST CENTERS					
96	GIFT, FLOWER, COFFEE SHOP & CAN		18083		18083	96
98	PHYSICIANS' PRIVATE OFFICES		25830		25830	98
98.01	NON-EMPLOYEE CHILD CARE CENTER		2264		2264	98.01
99	NONPAID WORKERS		2534		2534	99
101	CROSS FOOT ADJUSTMENTS					101
102	NEGATIVE COST CENTER					102
103	TOTAL	32664	7755844		7755844	103



COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP- REL COSTS BLDG&FIXT SQUARE FEET 3	NEW CAP- REL COSTS MOV EQUIP (DOLLAR VALUE) 4	EMPLOYEE BENEFITS GROSS SALARIES 5	RECON- CILIATION 6A	ADMINI- STRATIVE & GENERAL ACCUM COST 6	MAINTEN- ANCE AND REPAIRS MAINT REQS 7	
85.02 INTESTINAL ACQUISITION							85.02
85.03 ISLET CELL ACQUISITION							85.03
93 HOSPICE			237910		422034	576	93
95 SUBTOTALS	279700	3238856	51536547	-22638990	100290076	2054754	95
NONREIMBURSABLE COST CENTERS							
96 GIFT, FLOWER, COFFEE SHOP & C	1032	129	30131		88938	757	96
98 PHYSICIANS' PRIVATE OFFICES	1580		8629		33400		98
98.01 NON-EMPLOYEE CHILD CARE CENTE			79089		113800		98.01
99 NONPAID WORKERS		412	124376		182134		99
101 CROSS FOOT ADJUSTMENTS							101
102 NEGATIVE COST CENTER							102
103 COST TO BE ALLOC PER B PT I	3543051	3246072	17714817		22638990	1965386	103
104 UNIT COST MULT-WS B PT I		1.002061				.956154	104
104 UNIT COST MULT-WS B PT I	12.550125		.342125		.224798		104
105 COST TO BE ALLOC PER B PT II							105
106 UNIT COST MULT-WS B PT II							106
106 UNIT COST MULT-WS B PT II							106
107 COST TO BE ALLOC PER B PT III			46774		1110873	140189	107
108 UNIT COST MULT-WS B PT III						.068202	108
108 UNIT COST MULT-WS B PT III			.000903		.011031		108



COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	NURSING ADMINI- STRATION (DIRECT NRSG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	
	8	9	10	11	12	14	15	
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
93 HOSPICE			56		346	346	4420	93
95 SUBTOTALS	211785	644600	26587	151422	62172	38339	9253424	95
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & C	1032				145			96
98 PHYSICIANS' PRIVATE OFFICES	1580							98
98.01 NON-EMPLOYEE CHILD CARE CENTE			106		278			98.01
99 NONPAID WORKERS								99
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 COST TO BE ALLOC PER B PT I	6158166	802515	3257945	2554201	841962	2588931	2543163	103
104 UNIT COST MULT-WS B PT I	28.723191		122.052411		13.450947		.274835	
104 UNIT COST MULT-WS B PT I		1.244981		16.868097		67.527348		104
105 COST TO BE ALLOC PER B PT II								104
106 UNIT COST MULT-WS B PT II								105
106 UNIT COST MULT-WS B PT II								106
107 COST TO BE ALLOC PER B PT III	763283	29018	107083	172783	115526	95731	560779	106
108 UNIT COST MULT-WS B PT III	3.560138		4.011651		1.845611		.060602	107
108 UNIT COST MULT-WS B PT III		.045017		1.141069		2.496961		108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	
	(COSTED REQUIS) 16	(TIME SPENT) 17	(TIME SPENT) 18	(ASSIGNED TIME) 22	(ASSIGNED TIME) 23	
GENERAL SERVICE COST CENTERS						
1						1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16	3313519					16
17		5762				17
18			8708			18
20						20
21						21
22				1000		22
23					1000	23
24						24
INPATIENT ROUTINE SERV COST CENTERS						
25	6553	920	5530	1	1	25
26	4889	245	571			26
31	421	55	331			31
33		35				33
34	728	296	1790			34
ANCILLARY SERVICE COST CENTERS						
37	8450	923				37
38	153	46				38
39		72				39
40	4735	94				40
41	2850	163				41
43	204976	76				43
43.01	21	43				43.01
43.02	531	149				43.02
44	40	503				44
46.30						46.30
49	21783	186				49
50	121	100				50
53	619	127				53
54		7				54
55		258				55
55.30						55.30
56	2875338	1009				56
56.01						56.01
59						59
59.01		3				59.01
59.03	9229	173				59.03
59.05						59.05
59.97						59.97
59.98						59.98
59.99						59.99
OUTPATIENT SERVICE COST CENTERS						
60		2				60
60.01						60.01
60.02	3250					60.02
61	143898	277	486	999	999	61
62						62
63.50						63.50
63.60						63.60
OTHER REIMBURSABLE COST CENTERS						
65						65
69.10						69.10
69.20						69.20
69.30						69.30
69.40						69.40
71	1238					71
SPECIAL PURPOSE COST CENTERS						
85.01						85.01

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PHARMACY (COSTED REQUIS) 16	MEDICAL RECORDS & LIBRARY (TIME SPENT) 17	SOCIAL SERVICE (TIME SPENT) 18	I/R-SALARY AND FRINGES (ASSIGNED TIME) 22	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME) 23	
85.02 INTESTINAL ACQUISITION						85.02
85.03 ISLET CELL ACQUISITION						85.03
93 HOSPICE	23696					93
95 SUBTOTALS	3313519	5762	8708	1000	1000	95
NONREIMBURSABLE COST CENTERS						
96 GIFT, FLOWER, COFFEE SHOP & C						96
98 PHYSICIANS' PRIVATE OFFICES						98
98.01 NON-EMPLOYEE CHILD CARE CENTE						98.01
99 NONPAID WORKERS						99
101 CROSS FOOT ADJUSTMENTS						101
102 NEGATIVE COST CENTER						102
103 COST TO BE ALLOC PER B PT I	3655559	2444076	579946			103
104 UNIT COST MULT-WS B PT I	1.103226		66.599219			104
104 UNIT COST MULT-WS B PT I		424.171468				104
105 COST TO BE ALLOC PER B PT II						105
106 UNIT COST MULT-WS B PT II						106
106 UNIT COST MULT-WS B PT II						106
107 COST TO BE ALLOC PER B PT III	107981	76871	32664			107
108 UNIT COST MULT-WS B PT III	.032588		3.751034			108
108 UNIT COST MULT-WS B PT III		13.341027				108

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	24700399		24700399	8037	24708436	25
26 INTENSIVE CARE UNIT	8874161		8874161		8874161	26
31 SUBPROVIDER I	1990472		1990472	18872	2009344	31
33 NURSERY	827189		827189		827189	33
34 SKILLED NURSING FACILITY	5158441		5158441		5158441	34
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	8780845		8780845		8780845	37
38 RECOVERY ROOM	897902		897902		897902	38
39 DELIVERY ROOM & LABOR ROOM	2778966		2778966		2778966	39
40 ANESTHESIOLOGY	1220203		1220203	164634	1384837	40
41 RADIOLOGY-DIAGNOSTIC	4510843		4510843		4510843	41
43 RADIOISOTOPE	1068721		1068721		1068721	43
43.01 ULTRASOUND	997462		997462		997462	43.01
43.02 MRI-CT SCANS	2432069		2432069		2432069	43.02
44 LABORATORY	9190830		9190830		9190830	44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	2212721		2212721		2212721	49
50 PHYSICAL THERAPY	4122158		4122158		4122158	50
53 ELECTROCARDIOLOGY	1001666		1001666	5723	1007389	53
54 ELECTROENCEPHALOGRAPHY	205880		205880		205880	54
55 MEDICAL SUPPLIES CHARGED TO	9649943		9649943		9649943	55
55.30 IMPL. DEV. CHARGED TO PATIE	5896655		5896655		5896655	55.30
56 DRUGS CHARGED TO PATIENTS	8204470		8204470		8204470	56
56.01 OUTPATIENT PHARMACY	2563067		2563067		2563067	56.01
59 LITHOTRIPSY						59
59.01 CARDIAC REHABILITATION	493116		493116		493116	59.01
59.03 CARDIAC CATHERIZATION LAB	2227380		2227380		2227380	59.03
59.05 INPATIENT RENAL DIALYSIS	472335		472335		472335	59.05
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	9766		9766		9766	60
60.01 OUTPATIENT INFUSION PROCEDU						60.01
60.02 WOUND CARE	1280746		1280746		1280746	60.02
61 EMERGENCY	6857772		6857772		6857772	61
62 OBSERVATION BEDS (NON-DISTI	1147574		1147574		1147574	62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65 AMBULANCE SERVICES						65
101 SUBTOTAL	119773752		119773752	197266	119971018	101
102 LESS OBSERVATION BEDS	1147574		1147574		1147574	102
103 TOTAL	118626178		118626178	197266	118823444	103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL 8			
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	83906138		83906138			25
26 INTENSIVE CARE UNIT	22246379		22246379			26
31 SUBPROVIDER I	7652492		7652492			31
33 NURSERY	2562598		2562598			33
34 SKILLED NURSING FACILITY	6920791		6920791			34
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	29886179	20837715	50723894	.173111	.173111	.173111 37
38 RECOVERY ROOM	5453401	3910654	9364055	.095888	.095888	.095888 38
39 DELIVERY ROOM & LABOR ROOM	6059160	737506	6796666	.408872	.408872	.408872 39
40 ANESTHESIOLOGY	9420729	6965912	16386641	.074463	.074463	.084510 40
41 RADIOLOGY-DIAGNOSTIC	6734225	13148015	19882240	.226878	.226878	.226878 41
43 RADIOISOTOPE	2542463	3799464	6341927	.168517	.168517	.168517 43
43.01 ULTRASOUND	3504670	7500771	11005441	.090634	.090634	.090634 43.01
43.02 MRI-CT SCANS	16452024	36497653	52949677	.045932	.045932	.045932 43.02
44 LABORATORY	47768894	34089826	81858720	.112277	.112277	.112277 44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	20748867	2647566	23396433	.094575	.094575	.094575 49
50 PHYSICAL THERAPY	14081183	8902672	22983855	.179350	.179350	.179350 50
53 ELECTROCARDIOLOGY	12062875	10939742	23002617	.043546	.043546	.043795 53
54 ELECTROENCEPHALOGRAPHY	371641	1106874	1478515	.139248	.139248	.139248 54
55 MEDICAL SUPPLIES CHARGED TO	43041023	14226350	57267373	.168507	.168507	.168507 55
55.30 IMPL. DEV. CHARGED TO PATIE	17598284	3201298	20799582	.283499	.283499	.283499 55.30
56 DRUGS CHARGED TO PATIENTS	100176368	14426431	114602799	.071590	.071590	.071590 56
56.01 OUTPATIENT PHARMACY	3	2117119	2117122	1.210637	1.210637	1.210637 56.01
59 LITHOTRIPSY						59
59.01 CARDIAC REHABILITATION	105	691323	691428	.713185	.713185	.713185 59.01
59.03 CARDIAC CATHERIZATION LAB	26439710	7036784	33476494	.066536	.066536	.066536 59.03
59.05 INPATIENT RENAL DIALYSIS	3402806	60051	3462857	.136400	.136400	.136400 59.05
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC		165572	165572	.058983	.058983	.058983 60
60.01 OUTPATIENT INFUSION PROCEDU						60.01
60.02 WOUND CARE	37445	5079364	5116809	.250302	.250302	.250302 60.02
61 EMERGENCY	16129590	27233625	43363215	.158147	.158147	.158147 61
62 OBSERVATION BEDS (NON-DISTI	71038	4315900	4386938	.261589	.261589	.261589 62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65 AMBULANCE SERVICES						65
101 SUBTOTAL	505271081	229638187	734909268			101
102 LESS OBSERVATION BEDS						102
103 TOTAL	505271081	229638187	734909268			103

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

CHECK [ ] TITLE V  
 APPLICABLE [XX] TITLE XVIII-PT A  
 BOXES [ ] TITLE XIX

COST CENTER DESCRIPTION	----- OLD CAPITAL -----			----- NEW CAPITAL -----		
	CAPITAL RELATED COST 1	SWING-BED ADJUSTMENT 2	REDUCED CAPITAL RELATED COST 3	CAPITAL RELATED COST 4	SWING-BED ADJUSTMENT 5	REDUCED CAPITAL RELATED COST 6
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS				1469094		1469094
26 INTENSIVE CARE UNIT				367374		367374
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I				112309		112309
33 NURSERY				35043		35043
101 TOTAL				1983820		1983820

COST CENTER DESCRIPTION	----- OLD CAPITAL -----			----- NEW CAPITAL -----		
	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	PER DIEM 9	INPATIENT PROGRAM CAPITAL COST 10	PER DIEM 11	INPATIENT PROGRAM CAPITAL COST 12
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS	33373	17739			44.02	780871
26 INTENSIVE CARE UNIT	5389	3078			68.17	209827
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I	3532	3362			31.80	106912
33 NURSERY	1695				20.67	
101 TOTAL	43989	24179				1097610

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (14-0008) [ ] SUB III [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] SUB I [ ] SUB IV [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] SUB II

COST CENTER DESCRIPTION	OLD	NEW	TOTAL CHARGES	INPATIENT PROGRAM CHARGES	---- OLD CAPITAL ----		---- NEW CAPITAL ----	
	CAPITAL RELATED COST	CAPITAL RELATED COST			RATIO OF COST TO CHARGES	CAPITAL COSTS	RATIO OF COST TO CHARGES	CAPITAL COSTS
	1	2	3	4	5	6	7	8
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM		1029745	50723894	8392748			.020301	170381 37
38 RECOVERY ROOM		49683	9364055	1570648			.005306	8334 38
39 DELIVERY ROOM & LABOR ROOM		180083	6796666	3666			.026496	97 39
40 ANESTHESIOLOGY		60031	16386641	2407237			.003663	8818 40
41 RADIOLOGY-DIAGNOSTIC		722330	19882240	5881326			.036330	213669 41
43 RADIOISOTOPE		46267	6341927	1509355			.007295	11011 43
43.01 ULTRASOUND		107931	11005441	1238454			.009807	12146 43.01
43.02 MRI-CT SCANS		314733	52949677	8853512			.005944	52625 43.02
44 LABORATORY		515915	81858720	25824690			.006303	162773 44
46.30 BLOOD CLOTTING FACTORS ADMIN								46.30
49 RESPIRATORY THERAPY		110137	23396433	6129120			.004707	28850 49
50 PHYSICAL THERAPY		238499	22983855	3663622			.010377	38017 50
53 ELECTROCARDIOLOGY		104873	23002617	7103909			.004559	32387 53
54 ELECTROENCEPHALOGRAPHY		19652	1478515	196558			.013292	2613 54
55 MEDICAL SUPPLIES CHARGED TO P		304459	57267373	31556125			.005316	167752 55
55.30 IMPL. DEV. CHARGED TO PATIENT		281668	20799582	14609908			.013542	197847 55.30
56 DRUGS CHARGED TO PATIENTS		148629	114602799	49268606			.001297	63901 56
56.01 OUTPATIENT PHARMACY		64180	2117122				.030315	56.01
59 LITHOTRIPSY								59
59.01 CARDIAC REHABILITATION		75295	691428				.108898	59.01
59.03 CARDIAC CATHERIZATION LAB		391947	33476494	7626646			.011708	89293 59.03
59.05 INPATIENT RENAL DIALYSIS		4254	3462857				.001228	59.05
59.97 CARDIAC REHABILITATION								59.97
59.98 HYPERBARIC OXYGEN THERAPY								59.98
59.99 LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC		2179	165572				.013160	60
60.01 OUTPATIENT INFUSION PROCEDURE								60.01
60.02 WOUND CARE		56392	5116809	2476			.011021	27 60.02
61 EMERGENCY		481049	43363215	8126517			.011093	90147 61
62 OBSERVATION BEDS (NON-DISTINC		68231	4386938				.015553	62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65 AMBULANCE SERVICES								65
101 TOTAL		5378162	611620870	183965123				1350688 101

PROVIDER NO. 14-0008 GOTTLIEB MEMORIAL HOSPITAL  
 PERIOD FROM 07/01/2009 TO 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2010.09  
 11/30/2010 11:48

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

CHECK [ ] TITLE V  
 APPLICABLE [XX] TITLE XVIII-PT A  
 BOXES [ ] TITLE XIX

COST CENTER	DESCRIPTION	NONPHYSICIAN	MEDICAL	SWING-BED	TOTAL	TOTAL	PER	INPATIENT	INPATIENT
		ANESTHETIST	EDUCATION	ADJUSTMENT	COSTS	PATIENT		PROGRAM	PROGRAM
		COST	COST	AMOUNT		DAYS	DIEM	DAYS	PASS THRU
		1	2	3	4	5	6	7	8
	INPAT ROUTINE SERV COST CTRS								
25	ADULTS & PEDIATRICS					33373		17739	25
26	INTENSIVE CARE UNIT					5389		3078	26
27	CORONARY CARE UNIT								27
28	BURN INTENSIVE CARE UNIT								28
29	SURGICAL INTENSIVE CARE UNIT								29
30	OTHER SPECIAL CARE (SPECIFY)								30
31	SUBPROVIDER I					3532		3362	31
33	NURSERY					1695			33
34	SKILLED NURSING FACILITY					9730		7704	34
35	NURSING FACILITY								35
101	TOTAL					53719		31883	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-0008) [ ] SUB IV [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] SUB I [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] SUB II [ ] NF  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST COST	NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST				
	1	1.01	2	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM							37
38 RECOVERY ROOM							38
39 DELIVERY ROOM & LABOR ROOM							39
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC							41
43 RADIOISOTOPE							43
43.01 ULTRASOUND							43.01
43.02 MRI-CT SCANS							43.02
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
53 ELECTROCARDIOLOGY							53
54 ELECTROENCEPHALOGRAPHY							54
55 MEDICAL SUPPLIES CHARGED TO P							55
55.30 IMPL. DEV. CHARGED TO PATIENT							55.30
56 DRUGS CHARGED TO PATIENTS							56
56.01 OUTPATIENT PHARMACY							56.01
59 LITHOTRIPSY							59
59.01 CARDIAC REHABILITATION							59.01
59.03 CARDIAC CATHERIZATION LAB							59.03
59.05 INPATIENT RENAL DIALYSIS							59.05
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC							60
60.01 OUTPATIENT INFUSION PROCEDURE							60.01
60.02 WOUND CARE							60.02
61 EMERGENCY							61
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES							65
101 TOTAL							101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-0008) [ ] SUB IV [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] SUB I [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] SUB II [ ] NF  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT	TOTAL	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH		COST TO	RATIO OF COST	PROGRAM	PROGRAM	
	COSTS	CHARGES	CHARGES	TO CHARGES	CHARGES	PASS THROUGH	PROGRAM
	3.01	4	5	5.01	6	7	8
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		50723894			8392748		3544595 37
38 RECOVERY ROOM		9364055			1570648		842350 38
39 DELIVERY ROOM & LABOR ROOM		6796666			3666		39
40 ANESTHESIOLOGY		16386641			2407237		1108322 40
41 RADIOLOGY-DIAGNOSTIC		19882240			5881326		4429978 41
43 RADIOISOTOPE		6341927			1509355		1290551 43
43.01 ULTRASOUND		11005441			1238454		782938 43.01
43.02 MRI-CT SCANS		52949677			8853512		9809564 43.02
44 LABORATORY		81858720			25824690		1347412 44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY		23396433			6129120		1570220 49
50 PHYSICAL THERAPY		22983855			3663622		99777 50
53 ELECTROCARDIOLOGY		23002617			7103909		2849914 53
54 ELECTROENCEPHALOGRAPHY		1478515			196558		90442 54
55 MEDICAL SUPPLIES CHARGED TO P		57267373			31556125		8561993 55
55.30 IMPL. DEV. CHARGED TO PATIENT		20799582			14609908		1323816 55.30
56 DRUGS CHARGED TO PATIENTS		114602799			49268606		5302620 56
56.01 OUTPATIENT PHARMACY		2117122					56.01
59 LITHOTRIPSY							59
59.01 CARDIAC REHABILITATION		691428					59.01
59.03 CARDIAC CATHORIZATION LAB		33476494			7626646		3727577 59.03
59.05 INPATIENT RENAL DIALYSIS		3462857					59.05
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC		165572					14328 60
60.01 OUTPATIENT INFUSION PROCEDURE							60.01
60.02 WOUND CARE		5116809			2476		501396 60.02
61 EMERGENCY		43363215			8126517		5785296 61
62 OBSERVATION BEDS (NON-DISTINC		4386938					1458472 62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES							65
101 TOTAL		611620870			183965123		54441561 101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-0008) [ ] SUB IV [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] SUB I [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] SUB II [ ] NF  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
38 RECOVERY ROOM					38
39 DELIVERY ROOM & LABOR ROOM					39
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
43 RADIOISOTOPE					43
43.01 ULTRASOUND					43.01
43.02 MRI-CT SCANS					43.02
44 LABORATORY					44
46.30 BLOOD CLOTTING FACTORS ADMIN					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
53 ELECTROCARDIOLOGY					53
54 ELECTROENCEPHALOGRAPHY					54
55 MEDICAL SUPPLIES CHARGED TO P					55
55.30 IMPL. DEV. CHARGED TO PATIENT					55.30
56 DRUGS CHARGED TO PATIENTS					56
56.01 OUTPATIENT PHARMACY					56.01
59 LITHOTRIPSY					59
59.01 CARDIAC REHABILITATION					59.01
59.03 CARDIAC CATHERIZATION LAB					59.03
59.05 INPATIENT RENAL DIALYSIS					59.05
59.97 CARDIAC REHABILITATION					59.97
59.98 HYPERBARIC OXYGEN THERAPY					59.98
59.99 LITHOTRIPSY					59.99
OUTPATIENT SERVICE COST CENTERS					
60 CLINIC					60
60.01 OUTPATIENT INFUSION PROCEDURE					60.01
60.02 WOUND CARE					60.02
61 EMERGENCY					61
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
65 AMBULANCE SERVICES					65
101 TOTAL					101

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D  
 PARTS V & VI

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-0008) [ ] SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] SUB I [ ] NF  
 BOXES [ ] TITLE XIX - O/P [ ] SUB II [ ] S/B-SNF  
 [ ] SUB III [ ] S/B-NF  
 [ ] SUB IV [ ] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C,			PROGRAM CHARGES		
	PART II	PART I	PART II	OUTPATIENT	OUTPATIENT	OTHER
	COL. 8	COL. 9	COL. 9	AMBULATORY	RADIOLOGY	OUTPATIENT
	1	1.01	1.02	SURGICAL	CENTER	DIAGNOSTIC
				2	3	4
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	.173111	.173111	.173111			37
38 RECOVERY ROOM	.095888	.095888	.095888			38
39 DELIVERY ROOM & LABOR ROOM	.408872	.408872	.408872			39
40 ANESTHESIOLOGY	.074463	.074463	.074463			40
41 RADIOLOGY-DIAGNOSTIC	.226878	.226878	.226878			41
43 RADIOISOTOPE	.168517	.168517	.168517			43
43.01 ULTRASOUND	.090634	.090634	.090634			43.01
43.02 MRI-CT SCANS	.045932	.045932	.045932			43.02
44 LABORATORY	.112277	.112277	.112277			44
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
49 RESPIRATORY THERAPY	.094575	.094575	.094575			49
50 PHYSICAL THERAPY	.179350	.179350	.179350			50
53 ELECTROCARDIOLOGY	.043546	.043546	.043546			53
54 ELECTROENCEPHALOGRAPHY	.139248	.139248	.139248			54
55 MEDICAL SUPPLIES CHARGED TO PAT	.168507	.168507	.168507			55
55.30 IMPL. DEV. CHARGED TO PATIENT	.283499	.283499	.283499			55.30
56 DRUGS CHARGED TO PATIENTS	.071590	.071590	.071590			56
56.01 OUTPATIENT PHARMACY	1.210637	1.210637	1.210637			56.01
59 LITHOTRIPSY						59
59.01 CARDIAC REHABILITATION	.713185	.713185	.713185			59.01
59.03 CARDIAC CATHERIZATION LAB	.066536	.066536	.066536			59.03
59.05 INPATIENT RENAL DIALYSIS	.136400	.136400	.136400			59.05
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	.058983	.058983	.058983			60
60.01 OUTPATIENT INFUSION PROCEDURES						60.01
60.02 WOUND CARE	.250302	.250302	.250302			60.02
61 EMERGENCY	.158147	.158147	.158147			61
62 OBSERVATION BEDS (NON-DISTINCT	.261589	.261589	.261589			62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65 AMBULANCE SERVICES						65
65.01 AMBULANCE SERVICES (2ND PERIOD)						65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56.						65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56.						65.03
101 SUBTOTAL						101
102 CRNA CHARGES						102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS						103
104 NET CHARGES						104

PART VI - VACCINE COST APPORTIONMENT

1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES		1	.071590	1
2 PROGRAM VACCINE CHARGES			16175	2
2.01 PROGRAM VACCINE CHARGES				2.01
3 PROGRAM COSTS			1158	3
3.01 PROGRAM COSTS				3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D  
 PARTS V & VI

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-0008) [ ] SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] SUB I [ ] NF  
 BOXES [ ] TITLE XIX - O/P [ ] SUB II [ ] S/B-SNF  
 [ ] SUB III [ ] S/B-NF  
 [ ] SUB IV [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES					PROGRAM COST		
	ALL OTHER (1)	PPS SER- VICES	ALL OTHER	PPS SER- VICES	PPS SER- VICES	OUTPATIENT AMBULATORY	OUTPATIENT RADIOLOGY	OTHER OUTPATIENT
	(SEE INSTRU.) 5	(SEE INSTRU.) 5.01	(SEE INSTRU.) 5.02	(SEE INSTRU.) 5.03	(SEE INSTRU.) 5.04	SURGICAL CENTER 6	CENTER 7	DIAGNOSTIC 8
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM		3544595						37
38 RECOVERY ROOM		842350						38
39 DELIVERY ROOM & LABOR ROOM								39
40 ANESTHESIOLOGY		1108322						40
41 RADIOLOGY-DIAGNOSTIC		4429978						41
43 RADIOISOTOPE		1290551						43
43.01 ULTRASOUND		782938						43.01
43.02 MRI-CT SCANS		9809564						43.02
44 LABORATORY		1347412						44
46.30 BLOOD CLOTTING FACTORS ADMIN C								46.30
49 RESPIRATORY THERAPY		1570220						49
50 PHYSICAL THERAPY		99777						50
53 ELECTROCARDIOLOGY		2849914						53
54 ELECTROENCEPHALOGRAPHY		90442						54
55 MEDICAL SUPPLIES CHARGED TO PA		8561993						55
55.30 IMPL. DEV. CHARGED TO PATIENT		1323816						55.30
56 DRUGS CHARGED TO PATIENTS		5302620						56
56.01 OUTPATIENT PHARMACY								56.01
59 LITHOTRIPSY								59
59.01 CARDIAC REHABILITATION								59.01
59.03 CARDIAC CATHERIZATION LAB		3727577						59.03
59.05 INPATIENT RENAL DIALYSIS								59.05
59.97 CARDIAC REHABILITATION								59.97
59.98 HYPERBARIC OXYGEN THERAPY								59.98
59.99 LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC		14328						60
60.01 OUTPATIENT INFUSION PROCEDURES								60.01
60.02 WOUND CARE		501396						60.02
61 EMERGENCY		5785296						61
62 OBSERVATION BEDS (NON-DISTINCT)		1458472						62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65 AMBULANCE SERVICES								65
65.01 AMBULANCE SERVICES (2ND PERIOD)								65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56)								65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56)								65.03
101 SUBTOTAL		54441561						101
102 CRNA CHARGES								102
103 PBP CLINIC LAB								103
104 NET CHARGES		54441561						104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D  
 PARTS V & VI

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-0008) [ ] SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] SUB I [ ] NF  
 BOXES [ ] TITLE XIX - O/P [ ] SUB II [ ] S/B-SNF  
 [ ] SUB III [ ] S/B-NF  
 [ ] SUB IV [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM COST				HOSPITAL	HOSPITAL	
	ALL OTHER (COLS 1x5) 9	PPS SERVICES (COLUMNS 1.01x5.01) 9.01	ALL OTHER (COLUMNS 1.01x5.02) 9.02	PPS SERVICES (COLUMNS 1.01x5.03) 9.03	PPS SERVICES (COLUMNS 1.01x5.04) 9.04	I/P PART B CHARGES (SEE INSTRU.) 10	I/P PART B COST (COLUMNS 1.02x10) 11
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		613608					37
38 RECOVERY ROOM		80771					38
39 DELIVERY ROOM & LABOR ROOM							39
40 ANESTHESIOLOGY		82529					40
41 RADIOLOGY-DIAGNOSTIC		1005065					41
43 RADIOISOTOPE		217480					43
43.01 ULTRASOUND		70961					43.01
43.02 MRI-CT SCANS		450573					43.02
44 LABORATORY		151283					44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY		148504					49
50 PHYSICAL THERAPY		17895					50
53 ELECTROCARDIOLOGY		124102					53
54 ELECTROENCEPHALOGRAPHY		12594					54
55 MEDICAL SUPPLIES CHARGED TO PAT		1442756					55
55.30 IMPL. DEV. CHARGED TO PATIENT		375301					55.30
56 DRUGS CHARGED TO PATIENTS		379615					56
56.01 OUTPATIENT PHARMACY							56.01
59 LITHOTRIPSY							59
59.01 CARDIAC REHABILITATION							59.01
59.03 CARDIAC CATHERIZATION LAB		248018					59.03
59.05 INPATIENT RENAL DIALYSIS							59.05
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC		845					60
60.01 OUTPATIENT INFUSION PROCEDURES							60.01
60.02 WOUND CARE		125500					60.02
61 EMERGENCY		914927					61
62 OBSERVATION BEDS (NON-DISTINCT)		381520					62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES							65
65.01 AMBULANCE SERVICES (2ND PERIOD)							65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56.							65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56.							65.03
101 SUBTOTAL		6843847					101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES		6843847					104

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB III [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [XX] SUB I (14-S008) [ ] SUB IV [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] SUB II

COST CENTER DESCRIPTION	OLD CAPITAL	NEW CAPITAL	TOTAL CHARGES	INPATIENT PROGRAM CHARGES	---- OLD CAPITAL ----		---- NEW CAPITAL ----	
	RELATED COST	RELATED COST			RATIO OF COST TO CHARGES	CAPITAL COSTS	RATIO OF COST TO CHARGES	CAPITAL COSTS
	1	2	3	4	5	6	7	8
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM		1029745	50723894				.020301	37
38 RECOVERY ROOM		49683	9364055	5327			.005306	28 38
39 DELIVERY ROOM & LABOR ROOM		180083	6796666				.026496	39
40 ANESTHESIOLOGY		60031	16386641				.003663	40
41 RADIOLOGY-DIAGNOSTIC		722330	19882240	47670			.036330	1732 41
43 RADIOISOTOPE		46267	6341927	2247			.007295	16 43
43.01 ULTRASOUND		107931	11005441	6369			.009807	62 43.01
43.02 MRI-CT SCANS		314733	52949677	161881			.005944	962 43.02
44 LABORATORY		515915	81858720	527916			.006303	3327 44
46.30 BLOOD CLOTTING FACTORS ADMIN								46.30
49 RESPIRATORY THERAPY		110137	23396433	29348			.004707	138 49
50 PHYSICAL THERAPY		238499	22983855	47350			.010377	491 50
53 ELECTROCARDIOLOGY		104873	23002617	29183			.004559	133 53
54 ELECTROENCEPHALOGRAPHY		19652	1478515	46976			.013292	624 54
55 MEDICAL SUPPLIES CHARGED TO P		304459	57267373	56771			.005316	302 55
55.30 IMPL. DEV. CHARGED TO PATIENT		281668	20799582				.013542	55.30
56 DRUGS CHARGED TO PATIENTS		148629	114602799	1882580			.001297	2442 56
56.01 OUTPATIENT PHARMACY		64180	2117122				.030315	56.01
59 LITHOTRIPSY								59
59.01 CARDIAC REHABILITATION		75295	691428				.108898	59.01
59.03 CARDIAC CATHERIZATION LAB		391947	33476494				.011708	59.03
59.05 INPATIENT RENAL DIALYSIS		4254	3462857				.001228	59.05
59.97 CARDIAC REHABILITATION								59.97
59.98 HYPERBARIC OXYGEN THERAPY								59.98
59.99 LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC		2179	165572				.013160	60
60.01 OUTPATIENT INFUSION PROCEDURE								60.01
60.02 WOUND CARE		56392	5116809				.011021	60.02
61 EMERGENCY		481049	43363215	21139			.011093	234 61
62 OBSERVATION BEDS (NON-DISTINC		68231	4386938				.015553	62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65 AMBULANCE SERVICES								65
101 TOTAL		5378162	611620870	2864757				10491 101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB IV [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [XX] SUB I (14-S008) [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] SUB II [ ] NF  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST COST	NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST				
	1	1.01	2	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM							37
38 RECOVERY ROOM							38
39 DELIVERY ROOM & LABOR ROOM							39
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC							41
43 RADIOISOTOPE							43
43.01 ULTRASOUND							43.01
43.02 MRI-CT SCANS							43.02
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
53 ELECTROCARDIOLOGY							53
54 ELECTROENCEPHALOGRAPHY							54
55 MEDICAL SUPPLIES CHARGED TO P							55
55.30 IMPL. DEV. CHARGED TO PATIENT							55.30
56 DRUGS CHARGED TO PATIENTS							56
56.01 OUTPATIENT PHARMACY							56.01
59 LITHOTRIPSY							59
59.01 CARDIAC REHABILITATION							59.01
59.03 CARDIAC CATHERIZATION LAB							59.03
59.05 INPATIENT RENAL DIALYSIS							59.05
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC							60
60.01 OUTPATIENT INFUSION PROCEDURE							60.01
60.02 WOUND CARE							60.02
61 EMERGENCY							61
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES							65
101 TOTAL							101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB IV [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [XX] SUB I (14-S008) [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] SUB II [ ] NF  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT	TOTAL	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH		COST TO	RATIO OF COST	PROGRAM	PROGRAM	
	COSTS	CHARGES	CHARGES	TO CHARGES	CHARGES	PASS THROUGH	PROGRAM
	3.01	4	5	5.01	6	7	8
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		50723894					37
38 RECOVERY ROOM		9364055			5327		38
39 DELIVERY ROOM & LABOR ROOM		6796666					39
40 ANESTHESIOLOGY		16386641					40
41 RADIOLOGY-DIAGNOSTIC		19882240			47670		41
43 RADIOISOTOPE		6341927			2247		43
43.01 ULTRASOUND		11005441			6369		43.01
43.02 MRI-CT SCANS		52949677			161881		43.02
44 LABORATORY		81858720			527916		44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY		23396433			29348		49
50 PHYSICAL THERAPY		22983855			47350		50
53 ELECTROCARDIOLOGY		23002617			29183		53
54 ELECTROENCEPHALOGRAPHY		1478515			46976		54
55 MEDICAL SUPPLIES CHARGED TO P		57267373			56771		55
55.30 IMPL. DEV. CHARGED TO PATIENT		20799582					55.30
56 DRUGS CHARGED TO PATIENTS		114602799			1882580		56
56.01 OUTPATIENT PHARMACY		2117122					56.01
59 LITHOTRIPSY							59
59.01 CARDIAC REHABILITATION		691428					59.01
59.03 CARDIAC CATHORIZATION LAB		33476494					59.03
59.05 INPATIENT RENAL DIALYSIS		3462857					59.05
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC		165572					60
60.01 OUTPATIENT INFUSION PROCEDURE							60.01
60.02 WOUND CARE		5116809					60.02
61 EMERGENCY		43363215			21139		61
62 OBSERVATION BEDS (NON-DISTINC		4386938					62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES							65
101 TOTAL		611620870			2864757		101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB IV [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [XX] SUB I (14-S008) [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] SUB II [ ] NF  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
38 RECOVERY ROOM					38
39 DELIVERY ROOM & LABOR ROOM					39
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
43 RADIOISOTOPE					43
43.01 ULTRASOUND					43.01
43.02 MRI-CT SCANS					43.02
44 LABORATORY					44
46.30 BLOOD CLOTTING FACTORS ADMIN					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
53 ELECTROCARDIOLOGY					53
54 ELECTROENCEPHALOGRAPHY					54
55 MEDICAL SUPPLIES CHARGED TO P					55
55.30 IMPL. DEV. CHARGED TO PATIENT					55.30
56 DRUGS CHARGED TO PATIENTS					56
56.01 OUTPATIENT PHARMACY					56.01
59 LITHOTRIPSY					59
59.01 CARDIAC REHABILITATION					59.01
59.03 CARDIAC CATHERIZATION LAB					59.03
59.05 INPATIENT RENAL DIALYSIS					59.05
59.97 CARDIAC REHABILITATION					59.97
59.98 HYPERBARIC OXYGEN THERAPY					59.98
59.99 LITHOTRIPSY					59.99
OUTPATIENT SERVICE COST CENTERS					
60 CLINIC					60
60.01 OUTPATIENT INFUSION PROCEDURE					60.01
60.02 WOUND CARE					60.02
61 EMERGENCY					61
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
65 AMBULANCE SERVICES					65
101 TOTAL					101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB IV [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] SUB I [XX] SNF (14-5526) [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] SUB II [ ] NF  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST COST	NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST				
	1	1.01	2	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM							37
38 RECOVERY ROOM							38
39 DELIVERY ROOM & LABOR ROOM							39
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC							41
43 RADIOISOTOPE							43
43.01 ULTRASOUND							43.01
43.02 MRI-CT SCANS							43.02
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
53 ELECTROCARDIOLOGY							53
54 ELECTROENCEPHALOGRAPHY							54
55 MEDICAL SUPPLIES CHARGED TO P							55
55.30 IMPL. DEV. CHARGED TO PATIENT							55.30
56 DRUGS CHARGED TO PATIENTS							56
56.01 OUTPATIENT PHARMACY							56.01
59 LITHOTRIPSY							59
59.01 CARDIAC REHABILITATION							59.01
59.03 CARDIAC CATHORIZATION LAB							59.03
59.05 INPATIENT RENAL DIALYSIS							59.05
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC							60
60.01 OUTPATIENT INFUSION PROCEDURE							60.01
60.02 WOUND CARE							60.02
61 EMERGENCY							61
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES							65
101 TOTAL							101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB IV [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] SUB I [XX] SNF (14-5526) [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] SUB II [ ] NF  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT	TOTAL	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH		COST TO	RATIO OF COST	PROGRAM	PROGRAM	PROGRAM
	COSTS	CHARGES	CHARGES	TO CHARGES	CHARGES	PASS THROUGH	PROGRAM
	3.01	4	5	5.01	6	7	8
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		50723894					37
38 RECOVERY ROOM		9364055					38
39 DELIVERY ROOM & LABOR ROOM		6796666					39
40 ANESTHESIOLOGY		16386641			31454		40
41 RADIOLOGY-DIAGNOSTIC		19882240			219090		41
43 RADIOISOTOPE		6341927			30600		43
43.01 ULTRASOUND		11005441			37646		43.01
43.02 MRI-CT SCANS		52949677					43.02
44 LABORATORY		81858720			1890654		44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY		23396433			434891		49
50 PHYSICAL THERAPY		22983855			6656112		50
53 ELECTROCARDIOLOGY		23002617			77604		53
54 ELECTROENCEPHALOGRAPHY		1478515			9556		54
55 MEDICAL SUPPLIES CHARGED TO P		57267373			2961169		55
55.30 IMPL. DEV. CHARGED TO PATIENT		20799582					55.30
56 DRUGS CHARGED TO PATIENTS		114602799			5455996		56
56.01 OUTPATIENT PHARMACY		2117122					56.01
59 LITHOTRIPSY							59
59.01 CARDIAC REHABILITATION		691428					59.01
59.03 CARDIAC CATHORIZATION LAB		33476494			16896		59.03
59.05 INPATIENT RENAL DIALYSIS		3462857					59.05
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC		165572					60
60.01 OUTPATIENT INFUSION PROCEDURE							60.01
60.02 WOUND CARE		5116809					60.02
61 EMERGENCY		43363215					61
62 OBSERVATION BEDS (NON-DISTINC		4386938					62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES							65
101 TOTAL		611620870			17821668		101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB IV [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] SUB I [XX] SNF (14-5526) [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] SUB II [ ] NF  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
38 RECOVERY ROOM					38
39 DELIVERY ROOM & LABOR ROOM					39
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
43 RADIOISOTOPE					43
43.01 ULTRASOUND					43.01
43.02 MRI-CT SCANS					43.02
44 LABORATORY					44
46.30 BLOOD CLOTTING FACTORS ADMIN					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
53 ELECTROCARDIOLOGY					53
54 ELECTROENCEPHALOGRAPHY					54
55 MEDICAL SUPPLIES CHARGED TO P					55
55.30 IMPL. DEV. CHARGED TO PATIENT					55.30
56 DRUGS CHARGED TO PATIENTS					56
56.01 OUTPATIENT PHARMACY					56.01
59 LITHOTRIPSY					59
59.01 CARDIAC REHABILITATION					59.01
59.03 CARDIAC CATHERIZATION LAB					59.03
59.05 INPATIENT RENAL DIALYSIS					59.05
59.97 CARDIAC REHABILITATION					59.97
59.98 HYPERBARIC OXYGEN THERAPY					59.98
59.99 LITHOTRIPSY					59.99
OUTPATIENT SERVICE COST CENTERS					
60 CLINIC					60
60.01 OUTPATIENT INFUSION PROCEDURE					60.01
60.02 WOUND CARE					60.02
61 EMERGENCY					61
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
65 AMBULANCE SERVICES					65
101 TOTAL					101

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

CHECK [ ] TITLE V  
 APPLICABLE [ ] TITLE XVIII-PT A  
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
	CAPITAL RELATED COST 1	SWING-BED ADJUSTMENT 2	REDUCED CAPITAL RELATED COST 3	CAPITAL RELATED COST 4	SWING-BED ADJUSTMENT 5	REDUCED CAPITAL RELATED COST 6
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS				1469094		1469094
26 INTENSIVE CARE UNIT				367374		367374
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I				112309		112309
33 NURSERY				35043		35043
101 TOTAL				1983820		1983820

COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	PER DIEM 9	INPATIENT PROGRAM CAPITAL COST 10	PER DIEM 11	INPATIENT PROGRAM CAPITAL COST 12
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS	33373	3673			44.02	161685
26 INTENSIVE CARE UNIT	5389	167			68.17	11384
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I	3532				31.80	
33 NURSERY	1695	722			20.67	14924
101 TOTAL	43989	4562				187993

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (14-0008) [ ] SUB III [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] SUB I [ ] SUB IV [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] SUB II [XX] OTHER

COST CENTER DESCRIPTION	OLD	NEW	TOTAL CHARGES	INPATIENT PROGRAM CHARGES	---- OLD CAPITAL ----		---- NEW CAPITAL ----	
	CAPITAL RELATED COST	CAPITAL RELATED COST			RATIO OF COST TO CHARGES	CAPITAL COSTS	RATIO OF COST TO CHARGES	CAPITAL COSTS
	1	2	3	4	5	6	7	8
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM		1029745	50723894				.020301	37
38 RECOVERY ROOM		49683	9364055				.005306	38
39 DELIVERY ROOM & LABOR ROOM		180083	6796666				.026496	39
40 ANESTHESIOLOGY		60031	16386641				.003663	40
41 RADIOLOGY-DIAGNOSTIC		722330	19882240				.036330	41
43 RADIOISOTOPE		46267	6341927				.007295	43
43.01 ULTRASOUND		107931	11005441				.009807	43.01
43.02 MRI-CT SCANS		314733	52949677				.005944	43.02
44 LABORATORY		515915	81858720				.006303	44
46.30 BLOOD CLOTTING FACTORS ADMIN								46.30
49 RESPIRATORY THERAPY		110137	23396433				.004707	49
50 PHYSICAL THERAPY		238499	22983855				.010377	50
53 ELECTROCARDIOLOGY		104873	23002617				.004559	53
54 ELECTROENCEPHALOGRAPHY		19652	1478515				.013292	54
55 MEDICAL SUPPLIES CHARGED TO P		304459	57267373				.005316	55
55.30 IMPL. DEV. CHARGED TO PATIENT		281668	20799582				.013542	55.30
56 DRUGS CHARGED TO PATIENTS		148629	114602799				.001297	56
56.01 OUTPATIENT PHARMACY		64180	2117122				.030315	56.01
59 LITHOTRIPSY								59
59.01 CARDIAC REHABILITATION		75295	691428				.108898	59.01
59.03 CARDIAC CATHETERIZATION LAB		391947	33476494				.011708	59.03
59.05 INPATIENT RENAL DIALYSIS		4254	3462857				.001228	59.05
59.97 CARDIAC REHABILITATION								59.97
59.98 HYPERBARIC OXYGEN THERAPY								59.98
59.99 LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC		2179	165572				.013160	60
60.01 OUTPATIENT INFUSION PROCEDURE								60.01
60.02 WOUND CARE		56392	5116809				.011021	60.02
61 EMERGENCY		481049	43363215				.011093	61
62 OBSERVATION BEDS (NON-DISTINC		68231	4386938				.015553	62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65 AMBULANCE SERVICES								65
101 TOTAL		5378162	611620870					101

PROVIDER NO. 14-0008 GOTTLIEB MEMORIAL HOSPITAL  
 PERIOD FROM 07/01/2009 TO 06/30/2010

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

CHECK [ ] TITLE V  
 APPLICABLE [ ] TITLE XVIII-PT A  
 BOXES [XX] TITLE XIX

	COST CENTER DESCRIPTION	NONPHYSICIAN	MEDICAL	SWING-BED	TOTAL	TOTAL	PER	INPATIENT	INPATIENT
		ANESTHETIST	EDUCATION	ADJUSTMENT	COSTS	PATIENT	DIEM	PROGRAM	PROGRAM
		COST	COST	AMOUNT		DAYS		DAYS	PASS THRU
		1	2	3	4	5	6	7	8
	INPAT ROUTINE SERV COST CTRS								
25	ADULTS & PEDIATRICS					33373		3673	25
26	INTENSIVE CARE UNIT					5389		167	26
27	CORONARY CARE UNIT								27
28	BURN INTENSIVE CARE UNIT								28
29	SURGICAL INTENSIVE CARE UNIT								29
30	OTHER SPECIAL CARE (SPECIFY)								30
31	SUBPROVIDER I					3532			31
33	NURSERY					1695		722	33
34	SKILLED NURSING FACILITY					9730		137	34
35	NURSING FACILITY								35
101	TOTAL					53719		4699	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-0008) [ ] SUB IV [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] SUB I [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] SUB II [ ] NF [ ] OTHER  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST COST	NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST				
	1	1.01	2	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM							37
38 RECOVERY ROOM							38
39 DELIVERY ROOM & LABOR ROOM							39
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC							41
43 RADIOISOTOPE							43
43.01 ULTRASOUND							43.01
43.02 MRI-CT SCANS							43.02
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
53 ELECTROCARDIOLOGY							53
54 ELECTROENCEPHALOGRAPHY							54
55 MEDICAL SUPPLIES CHARGED TO P							55
55.30 IMPL. DEV. CHARGED TO PATIENT							55.30
56 DRUGS CHARGED TO PATIENTS							56
56.01 OUTPATIENT PHARMACY							56.01
59 LITHOTRIPSY							59
59.01 CARDIAC REHABILITATION							59.01
59.03 CARDIAC CATHERIZATION LAB							59.03
59.05 INPATIENT RENAL DIALYSIS							59.05
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC							60
60.01 OUTPATIENT INFUSION PROCEDURE							60.01
60.02 WOUND CARE							60.02
61 EMERGENCY							61
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES							65
101 TOTAL							101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-0008) [ ] SUB IV [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] SUB I [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] SUB II [ ] NF [ ] OTHER  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT	TOTAL	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH		COST TO	RATIO OF COST	PROGRAM	PROGRAM	
	COSTS	CHARGES	CHARGES	TO CHARGES	CHARGES	PASS THROUGH	PROGRAM
	3.01	4	5	5.01	6	7	8
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		50723894					37
38 RECOVERY ROOM		9364055					38
39 DELIVERY ROOM & LABOR ROOM		6796666					39
40 ANESTHESIOLOGY		16386641					40
41 RADIOLOGY-DIAGNOSTIC		19882240					41
43 RADIOISOTOPE		6341927					43
43.01 ULTRASOUND		11005441					43.01
43.02 MRI-CT SCANS		52949677					43.02
44 LABORATORY		81858720					44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY		23396433					49
50 PHYSICAL THERAPY		22983855					50
53 ELECTROCARDIOLOGY		23002617					53
54 ELECTROENCEPHALOGRAPHY		1478515					54
55 MEDICAL SUPPLIES CHARGED TO P		57267373					55
55.30 IMPL. DEV. CHARGED TO PATIENT		20799582					55.30
56 DRUGS CHARGED TO PATIENTS		114602799					56
56.01 OUTPATIENT PHARMACY		2117122					56.01
59 LITHOTRIPSY							59
59.01 CARDIAC REHABILITATION		691428					59.01
59.03 CARDIAC CATHORIZATION LAB		33476494					59.03
59.05 INPATIENT RENAL DIALYSIS		3462857					59.05
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC		165572					60
60.01 OUTPATIENT INFUSION PROCEDURE							60.01
60.02 WOUND CARE		5116809					60.02
61 EMERGENCY		43363215					61
62 OBSERVATION BEDS (NON-DISTINC		4386938					62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES							65
101 TOTAL		611620870					101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-0008) [ ] SUB IV [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] SUB I [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] SUB II [ ] NF [ ] OTHER  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
38 RECOVERY ROOM					38
39 DELIVERY ROOM & LABOR ROOM					39
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
43 RADIOISOTOPE					43
43.01 ULTRASOUND					43.01
43.02 MRI-CT SCANS					43.02
44 LABORATORY					44
46.30 BLOOD CLOTTING FACTORS ADMIN					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
53 ELECTROCARDIOLOGY					53
54 ELECTROENCEPHALOGRAPHY					54
55 MEDICAL SUPPLIES CHARGED TO P					55
55.30 IMPL. DEV. CHARGED TO PATIENT					55.30
56 DRUGS CHARGED TO PATIENTS					56
56.01 OUTPATIENT PHARMACY					56.01
59 LITHOTRIPSY					59
59.01 CARDIAC REHABILITATION					59.01
59.03 CARDIAC CATHERIZATION LAB					59.03
59.05 INPATIENT RENAL DIALYSIS					59.05
59.97 CARDIAC REHABILITATION					59.97
59.98 HYPERBARIC OXYGEN THERAPY					59.98
59.99 LITHOTRIPSY					59.99
OUTPATIENT SERVICE COST CENTERS					
60 CLINIC					60
60.01 OUTPATIENT INFUSION PROCEDURE					60.01
60.02 WOUND CARE					60.02
61 EMERGENCY					61
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
65 AMBULANCE SERVICES					65
101 TOTAL					101

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	SNF	
	(PPS) (14-0008)	(PPS) (14-S008)	1	1	1	(PPS) (14-5526)	
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	33373	3532				9730	1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	33373	3532				9730	2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	33373	3532				9730	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							6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	17739	3362				7704	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							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							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							13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15 TOTAL NURSERY DAYS							15
16 TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (14-0008)	SUB I (PPS) (14-S008)	SUB II	SUB III	SUB IV	SNF (PPS) (14-5526)	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
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	24708436	2009344				5158441	21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST							26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	24708436	2009344				5158441	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	83436668	2406144				80831824	28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	83436668	2406144				80831824	30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.296134	.835089				.063817	31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	2500.12	681.24				8307.48	33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	24708436	2009344				5158441	37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS) (14-0008)	SUB I (PPS) (14-S008)	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	740.37	568.90				38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	13133423	1912642				39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	13133423	1912642				41
	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT	8874161	5389	1646.72	3078	5068604	43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (PPS) (14-0008)	SUB I (PPS) (14-S008)	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	23170470	245761				48
49 TOTAL PROGRAM INPATIENT COSTS	41372497	2158403				49
	PASS THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	990698	106912				50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	1350688	10491				51
52 TOTAL PROGRAM EXCLUDABLE COST	2341386	117403				52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	39031111	2041000				53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS)	SUB I (PPS)	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION						
	1	1	1	1	1	
54						54
54						PROGRAM DISCHARGES
55						TARGET AMOUNT PER DISCHARGE
56						TARGET AMOUNT
57						DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58						BONUS PAYMENT
58.01						LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET
58.02						LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET
58.03						IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT
58.04						RELIEF PAYMENT
59						ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01						ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)
59.02						PROGRAM DISCHARGES PRIOR TO JULY 1
59.03						PROGRAM DISCHARGES AFTER JULY 1
59.04						PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05						REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1
59.06						REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
59.07						REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)
59.08						REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)
PROGRAM INPATIENT ROUTINE SWING BED COST						
60						MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
61						MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
62						TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS
63						TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
64						TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
65						TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

PROVIDER NO. 14-0008 GOTTlieb MEMORIAL HOSPITAL  
PERIOD FROM 07/01/2009 TO 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM  
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11/30/2010 11:48

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
PARTS III & IV

[ ] TITLE V-INPT

[XX] TITLE XVIII-PART A

[ ] TITLE XIX-INPT

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

	SNF (PPS) (14-5526)	
66 SNF/NF/ICF/MR ROUTINE SERVICE COST	5158441	66
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	530.16	67
68 PROGRAM ROUTINE SERVICE COST	4084353	68
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		69
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	4084353	70
71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS	319438	71
72 PER DIEM CAPITAL RELATED COSTS	32.83	72
73 PROGRAM CAPITAL RELATED COSTS	252922	73
74 INPATIENT ROUTINE SERVICE COST	3831431	74
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		75
76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT	3831431	76
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		77
78 INPATIENT ROUTINE SERVICE COST LIMITATION		78
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS	4084353	79
80 PROGRAM INPATIENT ANCILLARY SERVICES	2403206	80
81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION		81
82 TOTAL PROGRAM INPATIENT OPERATING COSTS	6487559	82

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PARTS III & IV

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

HOSPITAL SUB I SUB II SUB III SUB IV  
 (PPS) (PPS)  
 (14-0008) (14-S008)  
 1 1 1 1 1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	1550	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	740.37	84
85 OBSERVATION BED COST	1147574	85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST - HOSPITAL

	COST 1	ROUTINE COST (FROM LINE 27) 2	COLUMN 1 DIVIDED BY COLUMN 2 3	TOTAL OBSERVATION BED COST (FROM LINE 85) 4	OBSERVATION BED PASS-THROUGH COST COL 3 TIMES COL 4 5	
86 OLD CAPITAL-RELATED COST		24708436		1147574		86
87 NEW CAPITAL-RELATED COST	1469094	24708436	.059457	1147574	68231	87
88 NON PHYSICIAN ANESTHETIST		24708436		1147574		88
89 MEDICAL EDUCATION		24708436		1147574		89

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-0008)	SUB I	SUB II	SUB III	SUB IV	NF	
INPATIENT DAYS	1	1	1	1	1	1	
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	33373						1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	33373						2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	33373						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							6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3673						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							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							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							13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15 TOTAL NURSERY DAYS	1695						15
16 TITLE V OR XIX NURSERY DAYS	722						16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I (CONT)

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-0008)	SUB I	SUB II	SUB III	SUB IV	NF	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
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	24700399						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST							26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	24700399						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	83436668						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	83436668						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.296038						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	2500.12						33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	24700399						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		HOSPITAL (OTHER) (14-0008)	SUB I	SUB II	SUB III	SUB IV		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		1	1	1	1	1		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	740.13						38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	2718497						39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM							40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	2718497						41
		TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST		
		1	2	3	4	5		
42	NURSERY (TITLES V AND XIX ONLY)	827189	1695	488.02	722	352350		42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS							
43	INTENSIVE CARE UNIT	8874161	5389	1646.72	167	275002		43
44	CORONARY CARE UNIT							44
45	BURN INTENSIVE CARE UNIT							45
46	SURGICAL INTENSIVE CARE UNIT							46
47	OTHER SPECIAL CARE (SPECIFY)							47
		HOSPITAL (OTHER) (14-0008)	SUB I	SUB II	SUB III	SUB IV		
		1	1	1	1	1		
48	PROGRAM INPATIENT ANCILLARY SERVICE COST							48
49	TOTAL PROGRAM INPATIENT COSTS	3345849						49
		PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	187993						50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES							51
52	TOTAL PROGRAM EXCLUDABLE COST	187993						52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS							53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II (CONT)

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-0008)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION						
54	1	1	1	1	1	54
54						PROGRAM DISCHARGES
55						TARGET AMOUNT PER DISCHARGE
56						TARGET AMOUNT
57						DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58						BONUS PAYMENT
58.01						LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET
58.02						LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET
58.03						IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT
58.04						RELIEF PAYMENT
59						ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01						ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)
59.02						PROGRAM DISCHARGES PRIOR TO JULY 1
59.03						PROGRAM DISCHARGES AFTER JULY 1
59.04						PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05						REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1
59.06						REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
59.07						REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)
59.08						REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)
PROGRAM INPATIENT ROUTINE SWING BED COST						
60						MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
61						MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
62						TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS
63						TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
64						TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
65						TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

PROVIDER NO. 14-0008 GOTTlieb MEMORIAL HOSPITAL  
PERIOD FROM 07/01/2009 TO 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2010.09  
11/30/2010 11:48

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
PARTS III & IV

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

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

	1	
66 SNF/NF/ICF/MR ROUTINE SERVICE COST		66
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM		67
68 PROGRAM ROUTINE SERVICE COST		68
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		69
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS		70
71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS		71
72 PER DIEM CAPITAL RELATED COSTS		72
73 PROGRAM CAPITAL RELATED COSTS		73
74 INPATIENT ROUTINE SERVICE COST		74
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		75
76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT		76
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		77
78 INPATIENT ROUTINE SERVICE COST LIMITATION		78
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS		79
80 PROGRAM INPATIENT ANCILLARY SERVICES		80
81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION		81
82 TOTAL PROGRAM INPATIENT OPERATING COSTS		82

PROVIDER NO. 14-0008 GOTTlieb MEMORIAL HOSPITAL  
PERIOD FROM 07/01/2009 TO 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2010.09  
11/30/2010 11:48

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
PARTS III & IV

[ ] TITLE V-INPT                      [ ] TITLE XVIII-PART A                      [XX] TITLE XIX-INPT

HOSPITAL (OTHER) (14-0008)	SUB I	SUB II	SUB III	SUB IV
1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	1550	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	740.37	84
85 OBSERVATION BED COST	1147574	85

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[ ] TITLE V [XX] HOSPITAL (14-0008) [ ] SNF [XX] PPS  
 [XX] TITLE XVIII-PT A [ ] SUB I [ ] NF [ ] TEFRA  
 [ ] TITLE XIX [ ] SUB II [ ] S/B-SNF [ ] OTHER  
 [ ] SUB III  
 [ ] SUB IV [ ] ICF/MR

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS		39035470		25
26 INTENSIVE CARE UNIT		12471926		26
31 SUBPROVIDER I				31
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.173111	8392748	1452877	37
38 RECOVERY ROOM	.095888	1570648	150606	38
39 DELIVERY ROOM & LABOR ROOM	.408872	3666	1499	39
40 ANESTHESIOLOGY	.084510	2407237	203436	40
41 RADIOLOGY-DIAGNOSTIC	.226878	5881326	1334343	41
43 RADIOISOTOPE	.168517	1509355	254352	43
43.01 ULTRASOUND	.090634	1238454	112246	43.01
43.02 MRI-CT SCANS	.045932	8853512	406660	43.02
44 LABORATORY	.112277	25824690	2899519	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.094575	6129120	579662	49
50 PHYSICAL THERAPY	.179350	3663622	657071	50
53 ELECTROCARDIOLOGY	.043795	7103909	311116	53
54 ELECTROENCEPHALOGRAPHY	.139248	196558	27370	54
55 MEDICAL SUPPLIES CHARGED TO PAT	.168507	31556125	5317428	55
55.30 IMPL. DEV. CHARGED TO PATIENT	.283499	14609908	4141894	55.30
56 DRUGS CHARGED TO PATIENTS	.071590	49268606	3527140	56
56.01 OUTPATIENT PHARMACY	1.210637			56.01
59 LITHOTRIPSY				59
59.01 CARDIAC REHABILITATION	.713185			59.01
59.03 CARDIAC CATHERIZATION LAB	.066536	7626646	507447	59.03
59.05 INPATIENT RENAL DIALYSIS	.136400			59.05
59.97 CARDIAC REHABILITATION				59.97
59.98 HYPERBARIC OXYGEN THERAPY				59.98
59.99 LITHOTRIPSY				59.99
OUTPATIENT SERVICE COST CENTERS				
60 CLINIC	.058983			60
60.01 OUTPATIENT INFUSION PROCEDURES				60.01
60.02 WOUND CARE	.250302	2476	620	60.02
61 EMERGENCY	.158147	8126517	1285184	61
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	.261589			62
63.50 RHC				63.50
63.60 FQHC				63.60
65 AMBULANCE SERVICES				65
101 TOTAL		183965123	23170470	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		183965123		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> SNF	<input checked="" type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-PT A	<input checked="" type="checkbox"/> SUB I (14-S008)	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input type="checkbox"/> S/B-SNF	<input type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS				25
26 INTENSIVE CARE UNIT				26
31 SUBPROVIDER I		7272662		31
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.173111			37
38 RECOVERY ROOM	.095888	5327	511	38
39 DELIVERY ROOM & LABOR ROOM	.408872			39
40 ANESTHESIOLOGY	.084510			40
41 RADIOLOGY-DIAGNOSTIC	.226878	47670	10815	41
43 RADIOISOTOPE	.168517	2247	379	43
43.01 ULTRASOUND	.090634	6369	577	43.01
43.02 MRI-CT SCANS	.045932	161881	7436	43.02
44 LABORATORY	.112277	527916	59273	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.094575	29348	2776	49
50 PHYSICAL THERAPY	.179350	47350	8492	50
53 ELECTROCARDIOLOGY	.043795	29183	1278	53
54 ELECTROENCEPHALOGRAPHY	.139248	46976	6541	54
55 MEDICAL SUPPLIES CHARGED TO PAT	.168507	56771	9566	55
55.30 IMPL. DEV. CHARGED TO PATIENT	.283499			55.30
56 DRUGS CHARGED TO PATIENTS	.071590	1882580	134774	56
56.01 OUTPATIENT PHARMACY	1.210637			56.01
59 LITHOTRIPSY				59
59.01 CARDIAC REHABILITATION	.713185			59.01
59.03 CARDIAC CATHERIZATION LAB	.066536			59.03
59.05 INPATIENT RENAL DIALYSIS	.136400			59.05
59.97 CARDIAC REHABILITATION				59.97
59.98 HYPERBARIC OXYGEN THERAPY				59.98
59.99 LITHOTRIPSY				59.99
OUTPATIENT SERVICE COST CENTERS				
60 CLINIC	.058983			60
60.01 OUTPATIENT INFUSION PROCEDURES				60.01
60.02 WOUND CARE	.250302			60.02
61 EMERGENCY	.158147	21139	3343	61
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	.261589			62
63.50 RHC				63.50
63.60 FQHC				63.60
65 AMBULANCE SERVICES				65
101 TOTAL		2864757	245761	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		2864757		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input type="checkbox"/> HOSPITAL	<input checked="" type="checkbox"/> SNF (14-5526)	<input checked="" type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input type="checkbox"/> S/B-SNF	<input type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS				25
26 INTENSIVE CARE UNIT				26
31 SUBPROVIDER I				31
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.173111			37
38 RECOVERY ROOM	.095888			38
39 DELIVERY ROOM & LABOR ROOM	.408872			39
40 ANESTHESIOLOGY	.074463	31454	2342	40
41 RADIOLOGY-DIAGNOSTIC	.226878	219090	49707	41
43 RADIOISOTOPE	.168517	30600	5157	43
43.01 ULTRASOUND	.090634	37646	3412	43.01
43.02 MRI-CT SCANS	.045932			43.02
44 LABORATORY	.112277	1890654	212277	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.094575	434891	41130	49
50 PHYSICAL THERAPY	.179350	6656112	1193774	50
53 ELECTROCARDIOLOGY	.043546	77604	3379	53
54 ELECTROENCEPHALOGRAPHY	.139248	9556	1331	54
55 MEDICAL SUPPLIES CHARGED TO PAT	.168507	2961169	498978	55
55.30 IMPL. DEV. CHARGED TO PATIENT	.283499			55.30
56 DRUGS CHARGED TO PATIENTS	.071590	5455996	390595	56
56.01 OUTPATIENT PHARMACY	1.210637			56.01
59 LITHOTRIPSY				59
59.01 CARDIAC REHABILITATION	.713185			59.01
59.03 CARDIAC CATHERIZATION LAB	.066536	16896	1124	59.03
59.05 INPATIENT RENAL DIALYSIS	.136400			59.05
59.97 CARDIAC REHABILITATION				59.97
59.98 HYPERBARIC OXYGEN THERAPY				59.98
59.99 LITHOTRIPSY				59.99
OUTPATIENT SERVICE COST CENTERS				
60 CLINIC	.058983			60
60.01 OUTPATIENT INFUSION PROCEDURES				60.01
60.02 WOUND CARE	.250302			60.02
61 EMERGENCY	.158147			61
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	.261589			62
63.50 RHC				63.50
63.60 FQHC				63.60
65 AMBULANCE SERVICES				65
101 TOTAL		17821668	2403206	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		17821668		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input checked="" type="checkbox"/> HOSPITAL (14-0008)	<input type="checkbox"/> SNF	<input type="checkbox"/> PPS
<input type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input checked="" type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input type="checkbox"/> S/B-SNF	<input checked="" type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS
	1	2	3
INPATIENT ROUTINE SERVICE COST CENTERS			
25 ADULTS & PEDIATRICS			25
26 INTENSIVE CARE UNIT			26
31 SUBPROVIDER I			31
ANCILLARY SERVICE COST CENTERS			
37 OPERATING ROOM	.173111		37
38 RECOVERY ROOM	.095888		38
39 DELIVERY ROOM & LABOR ROOM	.408872		39
40 ANESTHESIOLOGY	.074463		40
41 RADIOLOGY-DIAGNOSTIC	.226878		41
43 RADIOISOTOPE	.168517		43
43.01 ULTRASOUND	.090634		43.01
43.02 MRI-CT SCANS	.045932		43.02
44 LABORATORY	.112277		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO			46.30
49 RESPIRATORY THERAPY	.094575		49
50 PHYSICAL THERAPY	.179350		50
53 ELECTROCARDIOLOGY	.043546		53
54 ELECTROENCEPHALOGRAPHY	.139248		54
55 MEDICAL SUPPLIES CHARGED TO PAT	.168507		55
55.30 IMPL. DEV. CHARGED TO PATIENT	.283499		55.30
56 DRUGS CHARGED TO PATIENTS	.071590		56
56.01 OUTPATIENT PHARMACY	1.210637		56.01
59 LITHOTRIPSY			59
59.01 CARDIAC REHABILITATION	.713185		59.01
59.03 CARDIAC CATHERIZATION LAB	.066536		59.03
59.05 INPATIENT RENAL DIALYSIS	.136400		59.05
59.97 CARDIAC REHABILITATION			59.97
59.98 HYPERBARIC OXYGEN THERAPY			59.98
59.99 LITHOTRIPSY			59.99
OUTPATIENT SERVICE COST CENTERS			
60 CLINIC	.058983		60
60.01 OUTPATIENT INFUSION PROCEDURES			60.01
60.02 WOUND CARE	.250302		60.02
61 EMERGENCY	.158147		61
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	.261589		62
63.50 RHC			63.50
63.60 FQHC			63.60
65 AMBULANCE SERVICES			65
101 TOTAL			101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES			102
103 NET CHARGES			103

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

DRG AMOUNT	HOSPITAL (14-0008)	SUB I	SUB II	SUB III	SUB IV	
1 OTHER THAN OUTLIER PAYMENTS OCCURRING BEFORE OCTOBER 1	6744297					1
1.01 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER OCTOBER 1 AND BEFORE JANUARY 1	6675802					1.01
1.02 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER JAN 1 MANAGED CARE PATIENTS	14069972					1.02
1.03 PAYMENTS PRIOR TO MARCH 1 OR OCTOBER 1	912883					1.03
1.04 PAYMENTS ON OR AFTER OCTOBER 1 AND PRIOR TO JANUARY 1	946863					1.04
1.05 PAYMENTS ON OR AFTER JAN 1 BUT BEFORE APR 1/OCT 1	1910787					1.05
1.06 ADDITIONAL AMOUNT RECEIVED OR TO BE RECEIVED						1.06
1.07 PAYMENTS FOR DISCHARGES ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.07
1.08 SIMULATED PAYMENTS FROM THE PS&R ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.08
2 OUTLIER PAYMENTS PRIOR TO OCTOBER 1, 1997						2
2.01 OUTLIER PAYMENTS ON OR AFTER OCTOBER 1, 1997 INDIRECT MEDICAL EDUCATION ADJUSTMENT	1699333					2.01
3 BED DAYS AVAILABLE DIVIDED BY NO. OF DAYS IN CR PERIOD	215.80					3
3.01 NO OF INTERNS & RESIDENTS FROM WORKSHEET S-3, PART I						3.01
3.02 INDIRECT MEDICAL EDUCATION PERCENTAGE						3.02
3.03 INDIRECT MEDICAL EDUCATION ADJUSTMENT						3.03
3.04 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR THE MOST RECENT CR PERIOD ENDING ON OR BEFORE DEC 31, 1996	2.54					3.04
3.05 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)						3.05
3.06 ADJUSTED FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii) [ FOR CR PERIODS ENDING ] [ ON OR AFTER 7/1/2005 ] [E-3,PT.VI, LN.15][PLUS LN.3.06]						3.06
3.07 SUM OF LINES 3.04-3.06	0.00 0.00	2.54				3.07
3.08 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		1.10				3.08
3.09 FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING PRIOR TO OCTOBER 1						3.09
3.10 FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING ON OR AFTER OCT. 1						3.10
3.11 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.09						3.11
3.12 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.10						3.12
3.13 FTE COUNT FOR RESIDENTS IN DENTAL & PODIATRIC PROGRAMS						3.13
3.14 CURRENT YEAR ALLOWABLE FTE	1.10					3.14
3.15 TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR, IF NONE BUT PRIOR YEAR TEACHING WAS IN EFFECT ENTER 1 HERE..	1.19					3.15
3.16 TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO. IF THERE WAS NO FTE COUNT IN THIS PERIOD BUT PRIOR YR TEACHING WAS IN EFFECT ENTER 1 HERE.. RES. IN INIT YRS	1.00					3.16
3.17 SUM OF LINES 3.14 THROUGH 3.16 DIVIDED BY THE NUMBER OF THOSE LINES IN EXCESS OF ZERO	0.00	1.10				3.17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART A  
 (CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL (14-0008)	SUB I	SUB II	SUB III	SUB IV	
3.18	CURRENT YEAR RESIDENT TO BED RATIO	0.005097				3.18
3.19	PRIOR YEAR RESIDENT TO BED RATIO	0.005478				3.19
3.20	FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1997, ENTER THE LESSER OF LINES 3.18 OR 3.19	0.005097				3.20
3.21	IME PAYMENTS FOR DSCHGS OCCURRING PRIOR TO OCTOBER 1	21302				3.21
3.22	IME PAYMENTS FOR DSCHGS AFTER SEP 30 BUT BEFORE JAN 1	21206				3.22
3.23	IME PAYMENTS FOR DSCHGS OCCURRING ON OR AFTER JANUARY 1 [SUM OF LINES][PLUS E-3,PT.VI [ 3.21-3.23 ] [ LINE 23 ]	44458				3.23
3.24	SUM OF LINES 3.21-3.23 DISPROPORTIONATE SHARE ADJUSTMENT	86966 0	86966			3.24
4	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS	0.0367				4
4.01	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS	0.1346				4.01
4.02	SUM OF 4 AND 4.01	0.1713				4.02
4.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE	0.0388				4.03
4.04	DISPROPORTIONATE SHARE ADJUSTMENT ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES	1066615				4.04
5	TOTAL MEDICARE DISCHARGES ON WKST S-3, PART I EXCLUDING DISCHARGES FOR DRGs 302, 316 AND 317					5
5.01	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING DRGs 302, 316 AND 317					5.01
5.02	DIVIDE LINE 5.01 BY LINE 5					5.02
5.03	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING DRGs 302, 316 AND 317					5.03
5.04	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK					5.04
5.05	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS					5.05
5.06	TOTAL ADDITIONAL PAYMENT					5.06
6	SUBTOTAL	30342985				6
7	HOSPITAL SPECIFIC PAYMENTS					7
7.01	HOSPITAL SPECIFIC PAYMENTS (1996 HSR)					7.01
8	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS	30342985				8
9	PAYMENT FOR INPATIENT PROGRAM CAPITAL	2404619				9
10	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL					10
11	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT	32020				11
11.01	NURSING AND ALLIED HEALTH MANAGED CARE					11.01
11.02	ADD-ON PAYMENT FOR NEW TECHNOLOGIES					11.02
12	NET ORGAN ACQUISITION COST					12
13	COST OF TEACHING PHYSICIANS					13
14	ROUTINE SERVICE OTHER PASS THROUGH COSTS					14
15	ANCILLARY SERVICE OTHER PASS THROUGH COSTS					15
16	TOTAL	32779624				16
17	PRIMARY PAYER PAYMENTS	3565				17
18	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES	32776059				18
19	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	2582624				19
20	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	296138				20
21	REIMBURSABLE BAD DEBTS	455019				21
21.01	REDUCED PROGRAM REIMBURSABLE BAD DEBTS	318513				21.01
21.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	280461				21.02
22	SUBTOTAL	30215810				22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A  
(CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL (14-0008)	SUB I	SUB II	SUB III	SUB IV	
23	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION					23
24	OTHER ADJUSTMENTS					24
24.99	OUTLIER RECONCILIATION ADJUSTMENT	-239				24.99
25	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS					25
26	AMOUNT DUE PROVIDER	30215571				26
27	SEQUESTRATION ADJUSTMENT					27
28	INTERIM PAYMENTS	29606159				28
28.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					28.01
29	BALANCE DUE PROVIDER (PROGRAM)	609412				29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	340350				30
	TO BE COMPLETED BY INTERMEDIARY					
50	OPERATING OUTLIER AMOUNT FROM WKST E, PART A, LINE 2.01					50
51	CAPITAL OUTLIER AMOUNT FROM WKST L, PART I, LINE 3.01					51
52	OPERATING OUTLIER RECONCILIATION AMOUNT (SEE INSTR.)					52
53	CAPITAL OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)					53
54	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY					54
55	TIME VALUE OF MONEY (SEE INSTRUCTIONS)					55
56	CAPITAL TIME VALUE OF MONEY (SEE INSTRUCTIONS)					56

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-0008) 1	HOSPITAL (14-0008) 1.01	HOSPITAL (14-0008) 1.02
1 MEDICAL AND OTHER SERVICES	1158		1
1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000	6843847		1.01
1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS	7195032		1.02
1.03 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO			1.03
1.04 LINE 1.01 TIMES LINE 1.03			1.04
1.05 LINE 1.02 DIVIDED BY LINE 1.04			1.05
1.06 TRANSITIONAL CORRIDOR PAYMENT			1.06
1.07 AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101			1.07
2 INTERNS AND RESIDENTS			2
3 ORGAN ACQUISITIONS			3
4 COST OF TEACHING PHYSICIANS			4
5 TOTAL COST	1158		5
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
6 ANCILLARY SERVICE CHARGES	16175		6
7 INTERNS AND RESIDENTS SERVICE CHARGES			7
8 ORGAN ACQUISITION CHARGES			8
9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS			9
10 TOTAL REASONABLE CHARGES	16175		10
CUSTOMARY CHARGES			
11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			11
12 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)			12
13 RATIO OF LINE 11 TO LINE 12			13
14 TOTAL CUSTOMARY CHARGES	16175		14
15 EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST	15017		15
16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			16
17 LESSER OF COST OR CHARGES	1158		17
17.01 TOTAL PPS PAYMENTS	7195032		17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-0008) 1	HOSPITAL (14-0008) 1.01	HOSPITAL (14-0008) 1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES AND COINSURANCE			18
18.01 DEDUCTIBLES AND COINSURANCE RELATING TO LINE 17.01	1820674		18.01
19 SUBTOTAL	5375516		19
20 SUM OF AMOUNTS FROM WKST E, PARTS C,D & E			20
21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	4603		21
22 ESRD DIRECT MEDICAL EDUCATION COSTS			22
23 SUBTOTAL	5380119		23
24 PRIMARY PAYER PAYMENTS			24
25 SUBTOTAL	5380119		25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS	338298		27
27.01 REDUCED REIMBURSABLE BAD DEBTS	236809		27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	242453		27.02
28 SUBTOTAL	5616928		28
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			29
30 OTHER ADJUSTMENTS			30
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)			30.99
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			31
32 SUBTOTAL	5616928		32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS	5378579		34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM	238349		35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2			36
TO BE COMPLETED BY CONTRACTOR			
50 ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)			50
51 OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCT			51
52 THE RATE USED TO CALCULATE THE TIME VALUE			52
53 TIME VALUE OF MONEY (SEE INSTRUCTIONS)			53
54 TOTAL (SUM OF LINES 51 AND 53)			54

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	SUB I (14-S008) 1	SUB I (14-S008) 1.01	SUB I (14-S008) 1.02	
1				1
1.01				1.01
1.02				1.02
1.03				1.03
1.04				1.04
1.05				1.05
1.06				1.06
1.07				1.07
2				2
3				3
4				4
5				5
COMPUTATION OF LESSER OF COST OR CHARGES				
REASONABLE CHARGES				
6				6
7				7
8				8
9				9
10				10
CUSTOMARY CHARGES				
11				11
12				12
13				13
14				14
15				15
16				16
17				17
17.01				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	SUB I (14-S008) 1	SUB I (14-S008) 1.01	SUB I (14-S008) 1.02	
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18 DEDUCTIBLES AND COINSURANCE				18
18.01 DEDUCTIBLES AND COINSURANCE RELATING TO LINE 17.01				18.01
19 SUBTOTAL				19
20 SUM OF AMOUNTS FROM WKST E, PARTS C,D & E				20
21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS				21
22 ESRD DIRECT MEDICAL EDUCATION COSTS				22
23 SUBTOTAL				23
24 PRIMARY PAYER PAYMENTS				24
25 SUBTOTAL				25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26 COMPOSITE RATE ESRD				26
27 BAD DEBTS				27
27.01 REDUCED REIMBURSABLE BAD DEBTS				27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)				27.02
28 SUBTOTAL				28
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION				29
30 OTHER ADJUSTMENTS				30
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)				30.99
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS				31
32 SUBTOTAL				32
33 SEQUESTRATION ADJUSTMENT				33
34 INTERIM PAYMENTS				34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)				34.01
35 BALANCE DUE PROVIDER/PROGRAM				35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2				36
TO BE COMPLETED BY CONTRACTOR				
50 ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)				50
51 OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCT				51
52 THE RATE USED TO CALCULATE THE TIME VALUE				52
53 TIME VALUE OF MONEY (SEE INSTRUCTIONS)				53
54 TOTAL (SUM OF LINES 51 AND 53)				54

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	SNF (14-5526) 1	SNF (14-5526) 1.01	SNF (14-5526) 1.02	
1				1
1.01				1.01
1.02				1.02
1.03				1.03
1.04				1.04
1.05				1.05
1.06				1.06
1.07				1.07
2				2
3				3
4				4
5				5
COMPUTATION OF LESSER OF COST OR CHARGES				
REASONABLE CHARGES				
6				6
7				7
8				8
9				9
10				10
CUSTOMARY CHARGES				
11				11
12				12
13				13
14				14
15				15
16				16
17				17
17.01				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	SNF (14-5526) 1	SNF (14-5526) 1.01	SNF (14-5526) 1.02	
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18 DEDUCTIBLES AND COINSURANCE				18
18.01 DEDUCTIBLES AND COINSURANCE RELATING TO LINE 17.01				18.01
19 SUBTOTAL				19
20 SUM OF AMOUNTS FROM WKST E, PARTS C,D & E				20
21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS				21
22 ESRD DIRECT MEDICAL EDUCATION COSTS				22
23 SUBTOTAL				23
24 PRIMARY PAYER PAYMENTS				24
25 SUBTOTAL				25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26 COMPOSITE RATE ESRD				26
27 BAD DEBTS				27
27.01 REDUCED REIMBURSABLE BAD DEBTS				27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)				27.02
28 SUBTOTAL				28
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION				29
30 OTHER ADJUSTMENTS				30
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)				30.99
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS				31
32 SUBTOTAL				32
33 SEQUESTRATION ADJUSTMENT				33
34 INTERIM PAYMENTS				34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)				34.01
35 BALANCE DUE PROVIDER/PROGRAM				35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2				36
TO BE COMPLETED BY CONTRACTOR				
50 ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)				50
51 OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCT				51
52 THE RATE USED TO CALCULATE THE TIME VALUE				52
53 TIME VALUE OF MONEY (SEE INSTRUCTIONS)				53
54 TOTAL (SUM OF LINES 51 AND 53)				54

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED  
 HOSPITAL (14-0008)

WORKSHEET E-1

DESCRIPTION	INPATIENT		PART B		
	PART A		PART B		
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		29105673		5376681	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.		52039		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .04 .05 10/22/2002 PROVIDER .51 TO .52 PROGRAM .53 .54	02/05/2010 335687 06/11/2010 112760	02/05/2010	1898	3.01 3.02 3.03 3.04 3.05 3.50 3.51 3.52 3.53 3.54
SUBTOTAL	.99	448447		1898	3.99
4 TOTAL INTERIM PAYMENTS		29606159		5378579	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .50 TO .51 PROGRAM .52			NONE	5.01 5.02 5.03 5.50 5.51 5.52
SUBTOTAL	.99				5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER .01 PROVIDER TO .02 PROGRAM	609412		238349	6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY		30215571		5616928	7

NAME OF INTERMEDIARY: \_\_\_\_\_  
 SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

INTERMEDIARY NUMBER: \_\_\_\_\_  
 DATE (MO/DAY/YR): \_\_\_\_\_

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED  
 SUBPROVIDER I (14-S008)

WORKSHEET E-1

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		2592972		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.		NONE		NONE 2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .04 .05 .50 PROVIDER .51 TO .52 PROGRAM .53 .54			3.01 3.02 NONE 3.03 3.04 3.05 3.50 3.51 NONE 3.52 3.53 3.54
SUBTOTAL	.99			3.99
4 TOTAL INTERIM PAYMENTS		2592972		4
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .50 TO .51 PROGRAM .52			5.01 5.02 NONE 5.03 5.50 NONE 5.51 5.52
SUBTOTAL	.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER .01 PROVIDER TO .02 PROGRAM			6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY		2592972		7
NAME OF INTERMEDIARY: _____		INTERMEDIARY NUMBER: _____		
SIGNATURE OF AUTHORIZED PERSON: _____		DATE (MO/DAY/YR): _____		

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED  
 SKILLED NURSING FACILITY I (14-5526)

WORKSHEET E-1

DESCRIPTION	INPATIENT		PART B	
	PART A		AMOUNT	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3186872		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.		NONE	NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01			3.01
	TO .02			3.02
	PROVIDER .03	NONE	NONE	3.03
	TO .04			3.04
	PROGRAM .05			3.05
	TO .50			3.50
	PROVIDER .51			3.51
	TO .52	NONE	NONE	3.52
	PROGRAM .53			3.53
	TO .54			3.54
SUBTOTAL	.99			3.99
4 TOTAL INTERIM PAYMENTS		3186872		4
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01			5.01
	TO .02	NONE	NONE	5.02
	PROVIDER .03			5.03
	PROVIDER .50			5.50
	TO .51	NONE	NONE	5.51
	PROGRAM .52			5.52
SUBTOTAL	.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01	22803		6.01
	PROVIDER TO .02			6.02
PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY		3209675		7
NAME OF INTERMEDIARY: _____		INTERMEDIARY NUMBER: _____		
SIGNATURE OF AUTHORIZED PERSON: _____		DATE (MO/DAY/YR): _____		

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART I

MEDICARE PART A SERVICES - TEFRA

	HOSPITAL	SUB I (14-S008)	SUB II	SUB III	SUB IV
1					1
1.01					1.01
1.02					1.02
1.03					1.03
1.04					1.04
1.05					1.05
1.06					1.06
1.07					1.07
1.08		2721193			1.08
1.09		495			1.09
1.10					1.10
1.11					1.11
1.12					1.12
1.13					1.13
1.14					1.14
1.15					1.15
1.16		9.676712			1.16
1.17					1.17
1.18					1.18
1.19		2721688			1.19
1.20					1.20
1.21					1.21
1.22					1.22
1.23		2721688			1.23
1.35					1.35
1.36					1.36
1.37					1.37
1.38					1.38
1.39					1.39
1.40					1.40
1.41					1.41
1.42					1.42
2					2
3					3
4		2721688			4
5					5
6		2721688			6
7		76948			7
8		2644740			8
9		51768			9
10		2592972			10
11					11
11.01					11.01
11.02					11.02
12		2592972			12
13					13

PROVIDER NO. 14-0008 GOTTlieb MEMORIAL HOSPITAL  
PERIOD FROM 07/01/2009 TO 06/30/2010

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
PART I

MEDICARE PART A SERVICES - TEFRA

	HOSPITAL	SUB I (14-S008)	SUB II	SUB III	SUB IV	
13.01	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)					13.01
14	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION					14
15	OTHER ADJUSTMENTS					15
16	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS					16
17	TOTAL AMOUNT PAYABLE TO THE PROVIDER	2592972				17
18	SEQUESTRATION ADJUSTMENT					18
19	INTERIM PAYMENTS	2592972				19
19.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					19.01
20	BALANCE DUE PROVIDER/PROGRAM					20
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2					21
TO BE COMPLETED BY INTERMEDIARY						
50	ORIGINAL OUTLIER AMOUNT					50
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)					51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY					52
53	OPERATING TIME VALUE OF MONEY (SEE INSTRUCTIONS)					53

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART III

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

[ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

SNF I  
 (14-5526)  
 (PPS)  
 2

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL/SNF/NF SERVICES	1
2	MEDICAL AND OTHER SERVICES	2
3	INTERNS AND RESIDENTS	3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS ONLY	4
5	COST OF TEACHING PHYSICIANS	5
6	SUBTOTAL	6
7	INPATIENT PRIMARY PAYER PAYMENTS	7
8	OUTPATIENT PRIMARY PAYER PAYMENTS	8
9	SUBTOTAL	9
COMPUTATION OF LESSER OF COST OR CHARGES		
10	ROUTINE SERVICE CHARGES	10
11	ANCILLARY SERVICE CHARGES	11
12	INTERNS AND RESIDENTS SERVICE CHARGES	12
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE	13
14	TEACHING PHYSICIANS	14
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION	15
16	TOTAL REASONABLE CHARGES	16
CUSTOMARY CHARGES		
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	17
18	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)	18
19	RATIO OF LINE 17 TO LINE 18	19
20	TOTAL CUSTOMARY CHARGES	20
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	21
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	22
23	COST OF COVERED SERVICES	23
PROSPECTIVE PAYMENT AMOUNT		
24	OTHER THAN OUTLIER PAYMENTS	24
25	OUTLIER PAYMENTS	25
26	PROGRAM CAPITAL PAYMENTS	26
27	CAPITAL EXCEPTION PAYMENTS	27
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS	28
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS	29
30	SUBTOTAL	30
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)	31
32	AMOUNT FROM LINE 30	32
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	33

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART III

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

	[ ] TITLE V	[XX] TITLE XVIII	[ ] TITLE XIX
		SNF I (14-5526) (PPS) 2	
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
34	EXCESS OF REASONABLE COST		34
35	SUBTOTAL	3419852	35
36	COINSURANCE	232980	36
37	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E, LINE 19		37
38	REIMBURSABLE BAD DEBTS	26322	38
38.01	REDUCED REIMBURSABLE BAD DEBTS		38.01
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	14591	38.02
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING ON OR AFTER 10/01/05 (SEE INSTR.)	22803	38.03
39	UTILIZATION REVIEW		39
40	SUBTOTAL	3209675	40
41	INPATIENT ROUTINE SERVICE COST		41
42	MEDICARE INPATIENT ROUTINE CHARGES		42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		43
44	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)		44
45	RATIO OF LINE 43 TO LINE 44		45
46	TOTAL CUSTOMARY CHARGES		46
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		47
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		48
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION		49
50	OTHER ADJUSTMENTS		50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		51
52	SUBTOTAL	3209675	52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)		53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS		54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER	3209675	55
56	SEQUESTRATION ADJUSTMENT		56
57	INTERIM PAYMENTS	3186872	57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)		57.01
58	BALANCE DUE PROVIDER/PROGRAM	22803	58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		59

CALCULATION OF REIMBURSEMENT SETTLEMENT  
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3  
 PART III

	[ ] TITLE V	[ ] TITLE XVIII	[XX] TITLE XIX			NF I	
		HOSPITAL (14-0008) (OTHER)	SUB I (14-S008)	SUB II	SUB III	SUB IV	(PPS)
	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1	1	
1	INPATIENT HOSPITAL/SNF/NF SERVICES	3345849					1
2	MEDICAL AND OTHER SERVICES						2
3	INTERNS AND RESIDENTS						3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O						4
5	COST OF TEACHING PHYSICIANS						5
6	SUBTOTAL	3345849					6
7	INPATIENT PRIMARY PAYER PAYMENTS						7
8	OUTPATIENT PRIMARY PAYER PAYMENTS						8
9	SUBTOTAL	3345849					9
	COMPUTATION OF LESSER OF COST OR CHARGES						
10	ROUTINE SERVICE CHARGES						10
11	ANCILLARY SERVICE CHARGES						11
12	INTERNS AND RESIDENTS SERVICE CHARGES						12
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE						13
14	TEACHING PHYSICIANS						14
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION						15
16	TOTAL REASONABLE CHARGES						16
	CUSTOMARY CHARGES						
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE						17
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)						18
19	RATIO OF LINE 17 TO LINE 18						19
20	TOTAL CUSTOMARY CHARGES						20
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST						21
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	3345849					22
23	COST OF COVERED SERVICES	3345849					23
	PROSPECTIVE PAYMENT AMOUNT						
24	OTHER THAN OUTLIER PAYMENTS						24
25	OUTLIER PAYMENTS						25
26	PROGRAM CAPITAL PAYMENTS						26
27	CAPITAL EXCEPTION PAYMENTS						27
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS						28
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS						29
30	SUBTOTAL	3345849					30
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED						31
32	LESSER OF LINES 30 OR 31	3345849					32
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)						33

CALCULATION OF REIMBURSEMENT SETTLEMENT  
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3  
 PART III

	[ ] TITLE V	[ ] TITLE XVIII	[XX] TITLE XIX				
		HOSPITAL (14-0008) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I
		1	1	1	1	1	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT						
34	EXCESS OF REASONABLE COST	3345849					34
35	SUBTOTAL						35
36	COINSURANCE						36
37	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E,						37
38	REIMBURSABLE BAD DEBTS						38
38.01	REDUCED REIMBURSABLE BAD DEBTS						38.01
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)						38.02
39	UTILIZATION REVIEW						39
40	SUBTOTAL						40
41	INPATIENT ROUTINE SERVICE COST						41
42	MEDICARE INPATIENT ROUTINE CHARGES						42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE						43
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)						44
45	RATIO OF LINE 43 TO LINE 44						45
46	TOTAL CUSTOMARY CHARGES						46
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST						47
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES						48
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM UTILIZATION						49
50	OTHER ADJUSTMENTS						50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING DEPRECIABLE ASSETS						51
52	SUBTOTAL						52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT						53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS						54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER						55
56	SEQUESTRATION ADJUSTMENT						56
57	INTERIM PAYMENTS						57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						57.01
58	BALANCE DUE PROVIDER/PROGRAM						58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT SECTION 115.2						59

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

WORKSHEET E-3  
 PART IV

[ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT

1	NUMBER OF FTE RESIDENTS FOR OB/GYN & PRIMARY CARE		1
1.01	NUMBER OF FTE RESIDENTS FOR ALL OTHERS		1.01
2	UPDATED PER RESIDENT AMOUNT FOR OB/GYN & PRIMARY CARE		2
2.01	UPDATED PER RESIDENT AMOUNT FOR ALL OTHERS		2.01
3	AGGREGATE APPROVED AMOUNT		3
3.01	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR CR PERIODS ENDING ON OR BEFORE DEC 31, 1996	1.54	3.01
3.02	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.86(g)(6)		3.02
3.03	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR 413.86(g)(4) [E-3,PT.VI,LN.4] [PLUS LINE 3.03]		3.03
3.04	FTE ADJUSTMENT CAP	1.54	3.04
3.05	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR	1.10	3.05
3.06	LESSER OF LINE 3.04 OR LINE 3.05	1.10	3.06
3.07	WEIGHTED FTE COUNT FOR PRIMARY CARE PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO	1.10	3.07
3.08	WEIGHTED FTE COUNT FOR ALL OTHER PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO		3.08
3.09	SUM OF LINES 3.07 AND LINE 3.08	1.10	3.09
3.10	SEE INSTRUCTIONS	1.10	3.10
3.11	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO		3.11
3.12	SEE INSTRUCTIONS		3.12
3.13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR CR YEAR. (SEE INSTRUCTIONS)	1.19	3.13
3.14	TOTAL WEIGHTED RESIDENT FTE COUNT FOR PENULTIMATE CR YEAR. (SEE INSTRUCTIONS)	1.00	3.14
3.15	ROLLING AVERAGE FTE COUNT (SEE INSTRUCTIONS)	0.73	3.15
3.16	SEE INSTRUCTIONS [RESIDENTS IN INITIAL YEARS 0.00]	0.73	3.16
3.17	SEE INSTRUCTIONS	77169.35	3.17
3.18	SEE INSTRUCTIONS	56334	3.18

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

WORKSHEET E-3  
 PART IV  
 (CONT)

[ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

3.19	SEE INSTRUCTIONS			3.19
3.20	SEE INSTRUCTIONS			3.20
3.21	SEE INSTRUCTIONS		0.37	3.21
3.22	SEE INSTRUCTIONS [RESIDENTS IN INITIAL YEARS 0.00]		0.37	3.22
3.23	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001		0.00	3.23
3.24	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001			3.24
3.25	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001		56334	3.25
COMPUTATION OF PROGRAM PATIENT LOAD				
4	PROGRAM PART A INPATIENT DAYS		24179	4
5	TOTAL INPATIENT DAYS		40744	5
6	RATIO OF PROGRAM INPATIENT DAYS TO TOTAL INPATIENT DAYS		.593437	6
		[LINE 6 x ] [E-3,PART 6]		
		[LINE 3.25] [ LINE 11 ]		
6.01	TOTAL GME PAYMENT FOR NON-MANAGED CARE DAYS 33431 0		33431	6.01
6.02	PROGRAM MANAGED CARE DAYS OCCURRING ON OR AFTER JAN 1 OF THIS COST REPORTING PERIOD		2688	6.02
6.03	TOTAL INPATIENT DAYS FROM LINE 5 ABOVE		40744	6.03
6.04	APPROPRIATE PERCENTAGE FOR INCLUSION OF MANAGED CARE DAYS		100.00	6.04
6.05	GRADUATE MEDICAL EDUCATION PAYMENT FOR MANAGED CARE DAYS ON OR AFTER JAN 1 THROUGH THE END OF THE COST REPORTING PERIOD		3192	6.05
6.06	PROGRAM MANAGED CARE DAYS OCCURRING BEFORE JAN 1 OF THIS COST REPORTING YEAR			6.06
6.07	APPROPRIATE PERCENTAGE USING THE CRITERIA IDENTIFIED ON LINE 6.04 ABOVE		100.00	6.07
		[PRIOR TO ] [E-3,PART 6]		
		[ 422 ] [ LINE 12 ]		
6.08	GRAD.MED.ED.PAYMENT FOR MANAGED CARE DAYS 0 0			6.08
	PRIOR TO JAN 1 OF THIS COST REPORTING PERIOD			
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
7	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS			7
8	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES			8
9	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES			9
10	MEDICARE O/P ESRD CHARGES			10
11	MEDICARE O/P ESRD DIRECT MEDICAL EDUCATION COSTS			11

PROVIDER NO. 14-0008 GOTTlieb MEMORIAL HOSPITAL  
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DIRECT GRADUATE MEDICAL EDUCATION (GME)  
& ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-3  
PART IV  
(CONT)

[ ] TITLE V

[XX] TITLE XVIII

[ ] TITLE XIX

APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY  
PART A REASONABLE COST

12	REASONABLE COST	47615253	12
13	ORGAN ACQUISITION COSTS		13
14	COST OF TEACHING PHYSICIANS		14
15	PRIMARY PAYER PAYMENTS	3565	15
16	TOTAL PART A REASONABLE COST	47611688	16
PART B REASONABLE COST			
17	REASONABLE COST	6845005	17
18	PRIMARY PAYER PAYMENTS		18
19	TOTAL PART B REASONABLE COST	6845005	19
20	TOTAL REASONABLE COST	54456693	20
21	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST	.874304	21
22	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST	.125696	22

ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B

23	TOTAL PROGRAM GME PAYMENT		23
23.01	FOR COST REPORTING PERIODS ENDING ON OR AFTER JAN 1, 1998	36623	23.01
24	PART A MEDICARE GME PAYMENT - TITLE XVIII ONLY	32020	24
25	PART B MEDICARE GME PAYMENT - TITLE XVIII ONLY	4603	25

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

WORKSHEET E-3  
PART IV

[ ] TITLE V

[ ] TITLE XVIII

[XX] TITLE XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT		
1	NUMBER OF FTE RESIDENTS FOR OB/GYN & PRIMARY CARE	1
1.01	NUMBER OF FTE RESIDENTS FOR ALL OTHERS	1.01
2	UPDATED PER RESIDENT AMOUNT FOR OB/GYN & PRIMARY CARE	2
2.01	UPDATED PER RESIDENT AMOUNT FOR ALL OTHERS	2.01
3	AGGREGATE APPROVED AMOUNT	3
3.01	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR CR PERIODS ENDING ON OR BEFORE DEC 31, 1996	3.01
3.02	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.86(g)(6)	3.02
3.03	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR 413.86(g)(4) [E-3,PT.VI,LN.4] [PLUS LINE 3.03]	3.03
3.04	FTE ADJUSTMENT CAP	3.04
3.05	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR	3.05
3.06	LESSER OF LINE 3.04 OR LINE 3.05	3.06
3.07	WEIGHTED FTE COUNT FOR PRIMARY CARE PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO	3.07
3.08	WEIGHTED FTE COUNT FOR ALL OTHER PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO	3.08
3.09	SUM OF LINES 3.07 AND LINE 3.08	3.09
3.10	SEE INSTRUCTIONS	3.10
3.11	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO	3.11
3.12	SEE INSTRUCTIONS	3.12
3.13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR CR YEAR. (SEE INSTRUCTIONS)	3.13
3.14	TOTAL WEIGHTED RESIDENT FTE COUNT FOR PENULTIMATE CR YEAR. (SEE INSTRUCTIONS)	3.14
3.15	ROLLING AVERAGE FTE COUNT (SEE INSTRUCTIONS)	3.15
3.16	SEE INSTRUCTIONS [RESIDENTS IN INITIAL YEARS 0.00]	3.16
3.17	SEE INSTRUCTIONS	3.17
3.18	SEE INSTRUCTIONS	3.18

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

WORKSHEET E-3  
 PART IV  
 (CONT)

[ ] TITLE V [ ] TITLE XVIII [XX] TITLE XIX

3.19	SEE INSTRUCTIONS			3.19
3.20	SEE INSTRUCTIONS			3.20
3.21	SEE INSTRUCTIONS			3.21
3.22	SEE INSTRUCTIONS [RESIDENTS IN INITIAL YEARS	0.00]	0.00	3.22
3.23	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001		0.00	3.23
3.24	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001			3.24
3.25	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001			3.25
COMPUTATION OF PROGRAM PATIENT LOAD				
4	PROGRAM PART A INPATIENT DAYS		3840	4
5	TOTAL INPATIENT DAYS		40744	5
6	RATIO OF PROGRAM INPATIENT DAYS TO TOTAL INPATIENT DAYS		.094247	6
		[LINE 6 x ] [E-3,PART 6]		
		[LINE 3.25] [ LINE 11 ]		
6.01	TOTAL GME PAYMENT FOR NON-MANAGED CARE DAYS	0	0	6.01
6.02	PROGRAM MANAGED CARE DAYS OCCURRING ON OR AFTER JAN 1 OF THIS COST REPORTING PERIOD			6.02
6.03	TOTAL INPATIENT DAYS FROM LINE 5 ABOVE		40744	6.03
6.04	APPROPRIATE PERCENTAGE FOR INCLUSION OF MANAGED CARE DAYS		100.00	6.04
6.05	GRADUATE MEDICAL EDUCATION PAYMENT FOR MANAGED CARE DAYS ON OR AFTER JAN 1 THROUGH THE END OF THE COST REPORTING PERIOD			6.05
6.06	PROGRAM MANAGED CARE DAYS OCCURRING BEFORE JAN 1 OF THIS COST REPORTING YEAR			6.06
6.07	APPROPRIATE PERCENTAGE USING THE CRITERIA IDENTIFIED ON LINE 6.04 ABOVE		100.00	6.07
		[PRIOR TO ] [E-3,PART 6]		
		[ 422 ] [ LINE 12 ]		
6.08	GRAD.MED.ED.PAYMENT FOR MANAGED CARE DAYS PRIOR TO JAN 1 OF THIS COST REPORTING PERIOD	0	0	6.08
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
7	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS			7
8	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES			8
9	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES			9
10	MEDICARE O/P ESRD CHARGES			10
11	MEDICARE O/P ESRD DIRECT MEDICAL EDUCATION COSTS			11

PROVIDER NO. 14-0008 GOTTLIEB MEMORIAL HOSPITAL  
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DIRECT GRADUATE MEDICAL EDUCATION (GME)  
& ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-3  
PART IV  
(CONT)

[ ] TITLE V

[ ] TITLE XVIII

[XX] TITLE XIX

APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY

PART A REASONABLE COST

12	REASONABLE COST	12
13	ORGAN ACQUISITION COSTS	13
14	COST OF TEACHING PHYSICIANS	14
15	PRIMARY PAYER PAYMENTS	15
16	TOTAL PART A REASONABLE COST	16

PART B REASONABLE COST

17	REASONABLE COST	17
18	PRIMARY PAYER PAYMENTS	18
19	TOTAL PART B REASONABLE COST	19
20	TOTAL REASONABLE COST	20
21	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST	21
22	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST	22

ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B

23	TOTAL PROGRAM GME PAYMENT	23
23.01	FOR COST REPORTING PERIODS ENDING ON OR AFTER JAN 1, 1998	23.01
24	PART A MEDICARE GME PAYMENT - TITLE XVIII ONLY	24
25	PART B MEDICARE GME PAYMENT - TITLE XVIII ONLY	25

BALANCE SHEET

WORKSHEET G

ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
<b>CURRENT ASSETS</b>				
1 CASH ON HAND AND IN BANKS	34879091			1
2 TEMPORARY INVESTMENTS				2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	15404710			4
5 OTHER RECEIVABLES				5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1439432			6
7 INVENTORY	2657012			7
8 PREPAID EXPENSES	2604728			8
9 OTHER CURRENT ASSETS	7983839			9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS	62089948			11
<b>FIXED ASSETS</b>				
12 LAND	4894899			12
12.01 ACCUMULATED DEPRECIATION				12.01
13 LAND IMPROVEMENTS	5280884			13
13.01 ACCUMULATED DEPRECIATION	-4832438			13.01
14 BUILDINGS	25255687			14
14.01 ACCUMULATED DEPRECIATION	-22311471			14.01
15 LEASEHOLD IMPROVEMENTS				15
15.01 ACCUMULATED AMORTIZATION				15.01
16 FIXED EQUIPMENT	92810863			16
16.01 ACCUMULATED DEPRECIATION	-59788587			16.01
17 AUTOMOBILES AND TRUCKS				17
17.01 ACCUMULATED DEPRECIATION				17.01
18 MAJOR MOVABLE EQUIPMENT	53098253			18
18.01 ACCUMULATED DEPRECIATION	-39701719			18.01
19 MINOR EQUIPMENT DEPRECIABLE				19
19.01 ACCUMULATED DEPRECIATION				19.01
20 MINOR EQUIPMENT-NONDEPRECIABLE				20
21 TOTAL FIXED ASSETS	54706371			21
<b>OTHER ASSETS</b>				
22 INVESTMENTS				22
23 DEPOSITS ON LEASES				23
24 DUE FROM OWNERS/OFFICERS				24
25 OTHER ASSETS	694795			25
26 TOTAL OTHER ASSETS	694795			26
27 TOTAL ASSETS	117491114			27
<b>LIABILITIES AND FUND BALANCES</b>				
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
<b>CURRENT LIABILITIES</b>				
28 ACCOUNTS PAYABLE	4416868			28
29 SALARIES, WAGES & FEES PAYABLE	7311206			29
30 PAYROLL TAXES PAYABLE	1264573			30
31 NOTES & LOANS PAYABLE (SHORT TERM)	18836737			31
32 DEFERRED INCOME				32
33 ACCELERATED PAYMENTS				33
34 DUE TO OTHER FUNDS				34
35 OTHER CURRENT LIABILITIES	1328992			35
36 TOTAL CURRENT LIABILITIES	33158376			36
<b>LONG-TERM LIABILITIES</b>				
37 MORTGAGE PAYABLE				37
38 NOTES PAYABLE	13866			38
39 UNSECURED LOANS				39
40 LOANS FROM OWNERS .01 PRIOR TO 7/1/66				40
.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES	48407082			41
42 TOTAL LONG TERM LIABILITIES	48420948			42
43 TOTAL LIABILITIES	81579324			43
<b>CAPITAL ACCOUNTS</b>				
44 GENERAL FUND BALANCE	35911790			44
45 SPECIFIC PURPOSE FUND BALANCE				45
46 DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				46
47 DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				47
48 GOVERNING BODY CREATED - ENDOWMENT FUND BAL				48
49 PLANT FUND BALANCE - INVESTED IN PLANT				49
50 PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				50
51 TOTAL FUND BALANCES	35911790			51
52 TOTAL LIABILITIES AND FUND BALANCES	117491114			52

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
1 FUND BALANCES AT BEGINNING OF PERIOD	27304457			1
2 NET INCOME (LOSS)	9754747			2
3 TOTAL	37059204			3
4 ADDITIONS (CREDIT ADJUSTMENTS)				4
5				5
6				6
7				7
8				8
9				9
10 TOTAL ADDITIONS				10
11 SUBTOTAL	37059204			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)	1147414			12
13				13
14				14
15				15
16				16
17				17
18 TOTAL DEDUCTIONS	1147414			18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	35911790			19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
GENERAL INPATIENT ROUTINE CARE SERVICES				
1 HOSPITAL	83436668		83436668	1
2 SUBPROVIDER I	7652492		7652492	2
4 SWING BED - SNF				4
5 SWING BED - NF				5
6 SKILLED NURSING FACILITY	6920791		6920791	6
7 NURSING FACILITY				7
8 OTHER LONG TERM CARE				8
9 TOTAL GENERAL INPATIENT CARE SERVICES	98009951		98009951	9
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
10 INTENSIVE CARE UNIT	22246316		22246316	10
11 CORONARY CARE UNIT				11
12 BURN INTENSIVE CARE UNIT				12
13 SURGICAL INTENSIVE CARE UNIT				13
14 OTHER SPECIAL CARE (SPECIFY)				14
15 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE	22246316		22246316	15
16 TOTAL INPATIENT ROUTINE CARE SERVICES	120256267		120256267	16
17 ANCILLARY SERVICES	368814186	188481975	557296161	17
18 OUTPATIENT SERVICES	4661986	48333103	52995089	18
18.50 RHC				18.50
18.60 FQHC				18.60
19 HOME HEALTH AGENCY				19
20 AMBULANCE		3556117	3556117	20
21 CORF				21
22 ASC				22
23 HOSPICE				23
24 HOSPICE		766223	766223	24
24.01	95495		95495	24.01
25 TOTAL PATIENT REVENUES	493827934	241137418	734965352	25

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		126988850	26
27 ADD (SPECIFY)			27
28 BAD DEBTS	6967463		28
29			29
30			30
31			31
32			32
33 TOTAL ADDITIONS		6967463	33
34 DEDUCT (SPECIFY)			34
35			35
36			36
37			37
38			38
39 TOTAL DEDUCTIONS			39
40 TOTAL OPERATING EXPENSES		133956313	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES	734965352	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	601930254	2
3	NET PATIENT REVENUES	133035098	3
4	LESS - TOTAL OPERATING EXPENSES	133956313	4
5	NET INCOME FROM SERVICE TO PATIENTS	-921215	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	4304743	6
7	INCOME FROM INVESTMENTS	49001	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	16573	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	356103	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	60087	20
21	RENTAL OF VENDING MACHINES	9909	21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	DAY CARE	660729	24
24.01	REFERENCE LAB	4361749	24.01
24.02	MISCELLANEOUS	850668	24.02
24.03	GAIN ON DISPOSALS	6400	24.03
25	TOTAL OTHER INCOME	10675962	25
26	TOTAL	9754747	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	9754747	31

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7255

WORKSHEET H

	SALARIES	EMPLOYEE	TRANS-	CONTRACTED/	OTHER	TOTAL HHA
	1	BENEFITS	PORTATION	PURCH SVCS	COSTS	COST
		2	3	4	5	6
GENERAL SERVICE COST CENTER						
1 CAPITAL RELATED-BLDG & FIXTURES						1
2 CAPITAL RELATED-MOVABLE EQUIPMENT						2
3 PLANT OPERATION & MAINTENANCE						3
4 TRANSPORTATION						4
5 ADMINISTRATIVE AND GENERAL	417898		43105		84388	545391
HHA REIMBURSABLE SERVICES						
6 SKILLED NURSING CARE	818296					818296
7 PHYSICAL THERAPY	385413					385413
8 OCCUPATIONAL THERAPY	24337			46480		70817
9 SPEECH PATHOLOGY	2872					2872
10 MEDICAL SOCIAL SERVICES	51994					51994
11 HOME HEALTH AIDE	59769					59769
12 SUPPLIES					40520	40520
13 DRUGS						13
13.20 COST OF ADMINISTERING VACCINES						13.20
14 DME						14
HHA NONREIMBURSABLE SERVICES						
15 HOME DIALYSIS AIDE SERVICES						15
16 RESPIRATORY THERAPY						16
17 PRIVATE DUTY NURSING						17
18 CLINIC						18
19 HEALTH PROMOTION ACTIVITIES						19
20 DAY CARE PROGRAM						20
21 HOME DELIVERED MEALS PROGRAM						21
22 HOMEMAKER SERVICE						22
23 ALL OTHERS						23
23.50 TELEMEDICINE						23.50
24 TOTAL	1760579		43105	46480	124908	1975072

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7255

WORKSHEET H  
 (CONTINUED)

	RECLASSIFI- CATIONS 7	RECLASSIFIED TRIAL BALANCE 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION 10	
GENERAL SERVICE COST CENTER					
1 CAPITAL RELATED-BLDG & FIXTURES					1
2 CAPITAL RELATED-MOVABLE EQUIPMENT					2
3 PLANT OPERATION & MAINTENANCE					3
4 TRANSPORTATION					4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES		545391		545391	5
6 SKILLED NURSING CARE		818296		818296	6
7 PHYSICAL THERAPY		385413		385413	7
8 OCCUPATIONAL THERAPY		70817		70817	8
9 SPEECH PATHOLOGY		2872		2872	9
10 MEDICAL SOCIAL SERVICES		51994		51994	10
11 HOME HEALTH AIDE		59769		59769	11
12 SUPPLIES		40520		40520	12
13 DRUGS					13
13.20 COST OF ADMINISTERING VACCINES					13.20
14 DME					14
HHA NONREIMBURSABLE SERVICES					
15 HOME DIALYSIS AIDE SERVICES					15
16 RESPIRATORY THERAPY					16
17 PRIVATE DUTY NURSING					17
18 CLINIC					18
19 HEALTH PROMOTION ACTIVITIES					19
20 DAY CARE PROGRAM					20
21 HOME DELIVERED MEALS PROGRAM					21
22 HOMEMAKER SERVICE					22
23 ALL OTHERS					23
23.50 TELEMEDICINE					23.50
24 TOTAL		1975072		1975072	24

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 14-7255

WORKSHEET H-4  
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL BLDGS & FIXTURES	CAP REL MOVABLE EQUIPMENT	PLANT OPERATN & TRANSPORT- MAINT	ATION	SUBTOTAL 4A	ADMIN & GENERAL 5	TOTAL 6
	0	1	2	3	4	4A	5	6
GENERAL SERVICE COST CENTER								
1 CAPITAL RELATED-BLDG & FLXT								1
2 CAPITAL RELATED-MOVABLE EQUIP								2
3 PLANT OPERATION & MAINTENANCE								3
4 TRANSPORTATION								4
5 ADMINISTRATIVE AND GENERAL	545391					545391	545391	5
HHA REIMBURSABLE SERVICES								
6 SKILLED NURSING CARE	818296					818296	312162	1130458
7 PHYSICAL THERAPY	385413					385413	147026	532439
8 OCCUPATIONAL THERAPY	70817					70817	27015	97832
9 SPEECH PATHOLOGY	2872					2872	1096	3968
10 MEDICAL SOCIAL SERVICES	51994					51994	19835	71829
11 HOME HEALTH AIDE	59769					59769	22800	82569
12 SUPPLIES	40520					40520	15457	55977
13 DRUGS								13
13.20 COST OF ADMINISTERING VACCINES								13.20
14 DME								14
HHA NONREIMBURSABLE SERVICES								
15 HOME DIALYSIS AIDE SERVICES								15
16 RESPIRATORY THERAPY								16
17 PRIVATE DUTY NURSING								17
18 CLINIC								18
19 HEALTH PROMOTION ACTIVITIES								19
20 DAY CARE PROGRAM								20
21 HOME DELIVERED MEALS PROGRAM								21
22 HOMEMAKER SERVICE								22
23 ALL OTHERS								23
23.50 TELEMEDICINE								23.50
24 TOTAL	1975072					1975072		1975072

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COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7255

WORKSHEET H-4  
 PART II

	CAP REL BLDGS & FIXTURES (SQUARE FEET) 1	CAP REL MOVABLE EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT- ATION (MILEAGE) 4	RECONCIL- IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
GENERAL SERVICE COST CENTER							
1 CAPITAL RELATED-BLDG & FIXT							1
2 CAPITAL RELATED-MOVABLE EQUIP							2
3 PLANT OPERATION & MAINTENANCE							3
4 TRANSPORTATION							4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES					-545391	1429681	5
6 SKILLED NURSING CARE						818296	6
7 PHYSICAL THERAPY						385413	7
8 OCCUPATIONAL THERAPY						70817	8
9 SPEECH PATHOLOGY						2872	9
10 MEDICAL SOCIAL SERVICES						51994	10
11 HOME HEALTH AIDE						59769	11
12 SUPPLIES						40520	12
13 DRUGS							13
13.20 COST OF ADMINISTERING VACCINES							13.20
14 DME							14
HHA NONREIMBURSABLE SERVICES							
15 HOME DIALYSIS AIDE SERVICES							15
16 RESPIRATORY THERAPY							16
17 PRIVATE DUTY NURSING							17
18 CLINIC							18
19 HEALTH PROMOTION ACTIVITIES							19
20 DAY CARE PROGRAM							20
21 HOME DELIVERED MEALS PROGRAM							21
22 HOMEMAKER SERVICE							22
23 ALL OTHERS							23
23.50 TELEMEDICINE							23.50
24 TOTAL					-545391	1429681	24
25 COST TO BE ALLOC (PER W/S H)						545391	25
26 UNIT COST MULTIPLIER						.381477	26







ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7255

WORKSHEET H-5  
 PART I

HHA COST CENTER	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL	ALLOCATED HHA A & G	TOTAL HHA COSTS	
	24	25	26	27	28	29	
1 ADMINISTRATIVE AND GENERAL		539142		539142			1
2 SKILLED NURSING CARE		1727477		1727477	310901	2038378	2
3 PHYSICAL THERAPY		813631		813631	146432	960063	3
4 OCCUPATIONAL THERAPY		130022		130022	23400	153422	4
5 SPEECH PATHOLOGY		6064		6064	1091	7155	5
6 MEDICAL SOCIAL SERVICES		109763		109763	19754	129517	6
7 HOME HEALTH AIDE		126175		126175	22708	148883	7
8 SUPPLIES		82545		82545	14856	97401	8
9 DRUGS							9
9.20 COST OF ADMINISTERING VACC							9.20
10 DME							10
11 HOME DIALYSIS AIDE SERVICE							11
12 RESPIRATORY THERAPY							12
13 PRIVATE DUTY NURSING							13
14 CLINIC							14
15 HEALTH PROMOTION ACTIVITIE							15
16 DAY CARE PROGRAM							16
17 HOME DELIVERED MEALS PROGR							17
18 HOMEMAKER SERVICE							18
19 ALL OTHERS							19
19.50 TELEMEDICINE							19.50
20 TOTALS		3534819		3534819	539142	3534819	20
21 UNIT COST MULTIPLIER					.179973		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS  
 STATISTICAL BASIS

HHA NO.: 14-7255

WORKSHEET H-5  
 PART II

HHA COST CENTER	OLD CAP BLDGS & FIXTURES SQUARE FEET	OLD CAP MOVABLE EQUIPMENT DOLLAR VALUE	NEW CAP- REL COSTS BLDG&FIXT SQUARE FEET	NEW CAP- REL COSTS MOV EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINI- STRATIVE & GENERAL ACCUM COST	MAINTEN- ANCE AND REPAIRS MAINT REQS	
	1	2	3	4	5	6A	6	7	
1 ADMINISTRATIVE AND GENERAL				17689	417898		160698	1472	1
2 SKILLED NURSING CARE					818296		1410419		2
3 PHYSICAL THERAPY					385413		664298		3
4 OCCUPATIONAL THERAPY					24337		106158		4
5 SPEECH PATHOLOGY					2872		4951		5
6 MEDICAL SOCIAL SERVICES					51994		89617		6
7 HOME HEALTH AIDE					59769		103017		7
8 SUPPLIES							55977		8
9 DRUGS									9
9.20 COST OF ADMINISTERING VACC									9.20
10 DME									10
11 HOME DIALYSIS AIDE SERVICE									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIE									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGR									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
19.50 TELEMEDICINE									19.50
20 TOTALS				17689	1760579		2595135	1472	20
21 TOTAL COST TO BE ALLOCATED				17725	602338		583381	1407	21
22 UNIT COST MULTIPLIER					.342125		.224798		22
22 UNIT COST MULTIPLIER				1.002035				.955842	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS  
 STATISTICAL BASIS

HHA NO.: 14-7255

WORKSHEET H-5  
 PART II

HHA COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINI- STRATION (DIRECT NRSG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	
	8	9	10	11	12	13	14	15	
1 ADMINISTRATIVE AND GENERAL			1234		2350		2350		1
2 SKILLED NURSING CARE									2
3 PHYSICAL THERAPY									3
4 OCCUPATIONAL THERAPY									4
5 SPEECH PATHOLOGY									5
6 MEDICAL SOCIAL SERVICES									6
7 HOME HEALTH AIDE									7
8 SUPPLIES								45910	8
9 DRUGS									9
9.20 COST OF ADMINISTERING VACC									9.20
10 DME									10
11 HOME DIALYSIS AIDE SERVICE									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIE									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGR									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
19.50 TELEMEDICINE									19.50
20 TOTALS			1234		2350		2350	45910	20
21 TOTAL COST TO BE ALLOCATED			150613		31610		158689	12618	21
22 UNIT COST MULTIPLIER			122.052674		13.451064		67.527234		22
22 UNIT COST MULTIPLIER								.274842	22



APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7255

WORKSHEET H-6  
 PARTS I & II

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

PART I - APPORTIONMENT OF HHA COST CENTERS: COMPUTATION OF THE LESSER OF AGGREGATE PROGRAM COST OR THE AGGREGATE OF THE PROGRAM LIMITATION

COST PER VISIT COMPUTATION		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL	AVERAGE	
PATIENT SERVICES		WKST H-5, PART I, COL 29, LINE	COSTS	ANCILLARY COSTS	COSTS	VISITS	COST PER VISIT	
		1		2	3	4	5	
1	SKILLED NURSING CARE	2	2038378		2038378	8265	246.63	1
2	PHYSICAL THERAPY	3	960063		960063	6169	155.63	2
3	OCCUPATIONAL THERAPY	4	153422		153422	538	285.17	3
4	SPEECH PATHOLOGY	5	7155		7155	61	117.30	4
5	MEDICAL SOCIAL SERV	6	129517		129517	542	238.96	5
6	HOME HEALTH AIDE SERV	7	148883		148883	2038	73.05	6
7	TOTAL		3437418		3437418	17613		7
LIMITATION COST COMPUTATION			MSA				PROGRAM	
PATIENT SERVICES			NO.				COST	
				2	3	4	LIMITS	
8	SKILLED NURSING CARE	1	1600				5	8
9	PHYSICAL THERAPY		1600					9
10	OCCUPATIONAL THERAPY		1600					10
11	SPEECH PATHOLOGY		1600					11
12	MEDICAL SOCIAL SERV		1600					12
13	HOME HEALTH AIDE SERV		1600					13
14	TOTAL							14
SUPPLIES AND DRUGS COST COMPUTATIONS		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL		
OTHER PATIENT SERVICES		WKST H-5, PART I, COL 29, LINE	COSTS	ANCILLARY COSTS	COSTS	CHARGES	RATIO	
		1		2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	97401		97401	66461	1.465536	15
16	COST OF DRUGS	9						16
16.20	COST OF ADMINISTERING VACCINES	9.20						16.20
PER BENEFICIARY COST LIMITATION:						MSA	AMOUNT	
						NO.		
						1	2	
17	PROGRAM UNDUPLICATED CENSUS FROM WORKSHEET S-4					1600		17
18	PER BENEFICIARY COST LIMITATION					1600		18
19	PER BENEFICIARY COST LIMITATION							19





CALCULATION OF HHA REMIBURSEMENT SETTLEMENT

HHA NO.: 14-7255

WORKSHEET H-7  
 PARTS I & II

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

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

DESCRIPTION	PART A 1	----- PART B -----		
		NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3	
1 REASONABLE COST OF PROGRAM SERVICES				1
2 REASONABLE COST OF SERVICES				2
2 TOTAL CHARGES	1630139	1062642		2
CUSTOMARY CHARGES				
3 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				3
4 AMOUNT 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(B)				4
5 RATIO OF LINE 3 TO LINE 4 (NOT TO EXCEED 1.000000)				5
6 TOTAL CUSTOMARY CHARGES	1630139	1062642		6
7 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST	1630139	1062642		7
8 EXCESS OF TOTAL REASONABLE COST OVER TOTAL CUSTOMARY CHARGES				8
9 PRIMARY PAYOR PAYMENTS				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10.01 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	1575792	1028328	10.01
10.02 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			10.02
10.03 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	26487	29719	10.03
10.04 TOTAL PPS REIMBURSEMENT - PEP EPISODES	27860	4595	10.04
10.05 TOTAL PPS REIMBURSEMENT - SCIC WITHIN A PEP EPISODES			10.05
10.06 TOTAL PPS REIMBURSEMENT - SCIC EPISODES			10.06
10.07 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			10.07
10.08 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			10.08
10.09 TOTAL PPS OUTLIER REIMBURSEMENT - SCIC WITHIN A PEP EPISODES			10.09
10.10 TOTAL PPS OUTLIER REIMBURSEMENT - SCIC EPISODES			10.10
10.11 TOTAL OTHER PAYMENTS			10.11
10.12 DME PAYMENTS			10.12
10.13 OXYGEN PAYMENTS			10.13
10.14 PROSTHETIC AND ORTHOTIC PAYMENTS			10.14
11 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCL COINSURANCE)			11
12 SUBTOTAL	1630139	1062642	12
13 EXCESS REASONABLE COST			13
14 SUBTOTAL	1630139	1062642	14
15 COINSURANCE BILLED TO PROGRAM PATIENTS			15
16 NET COST	1630139	1062642	16
17 REIMBURSABLE BAD DEBTS			17
17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			17.01
18 TOTAL COSTS - CURRENT COST REPORTING PERIOD	1630139	1062642	18
19 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			19
20 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM AGENCIES' TERMINATION OR OR DECREASE IN PROGRAM UTILIZATION			20
21 OTHER ADJUSTMENTS (SPECIFY):			21
22 SUBTOTAL	1630139	1062642	22
23 SEQUESTRATION ADJUSTMENT			23
24 SUBTOTAL	1630139	1062642	24
25 TOTAL INTERIM PAYMENTS	1630139	1062642	25
25.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			25.01
26 BALANCE DUE PROVIDER/PROGRAM			26
27 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			27

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHA'S  
 FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

HHA NO.: 14-7255

WORKSHEET H-8

DESCRIPTION	PART A		PART B		
	MO/DAY/YR 1	AMOUNT 2	MO/DAY/YR 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1630139		1062642	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.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01				3.01
	TO .02				3.02
	PROVIDER .03	NONE		NONE	3.03
	PROVIDER .04				3.04
	.05				3.05
	.50				3.50
	PROVIDER .51				3.51
	TO .52	NONE		NONE	3.52
	PROGRAM .53				3.53
	.54				3.54
SUBTOTAL	.99				3.99
4 TOTAL INTERIM PAYMENTS		1630139		1062642	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01				5.01
	TO .02	NONE		NONE	5.02
	PROVIDER .03				5.03
	PROVIDER .50				5.50
	TO .51	NONE		NONE	5.51
	PROGRAM .52				5.52
SUBTOTAL	.99				5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01				6.01
	PROVIDER TO .02				6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY		1630139		1062642	7
NAME OF INTERMEDIARY: _____	INTERMEDIARY NUMBER: _____				
SIGNATURE OF AUTHORIZED PERSON: _____	DATE (MO/DAY/YR): _____				

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE NO.: 14-1561

WORKSHEET K

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANS- PORTATION 3	CONTRACTED SERVICES 4	OTHER 5	TOTAL 6
GENERAL SERVICE COST CENTER						
1 CAPITAL RELATED COSTS-BLDG AND FIXT.						1
2 CAPITAL RELATED COSTS-MOVABLE EQUIP.						2
3 PLANT OPERATION AND MAINTENANCE						3
4 TRANSPORTATION - STAFF						4
5 VOLUNTEER SERVICE COORDINATION						5
6 ADMINISTRATIVE AND GENERAL	103234			15637	27784	146655
INPATIENT CARE SERVICE						
7 INPATIENT - GENERAL CARE						7
8 INPATIENT - RESPITE CARE						8
VISITING SERVICES						
9 PHYSICIAN SERVICES						9
10 NURSING CARE	72782		3706			76488
10.20 NURSING CARE-CONTINUOUS HOME CARE						10.20
11 PHYSICAL THERAPY						11
12 OCCUPATIONAL THERAPY						12
13 SPEECH/LANGUAGE PATHOLOGY						13
14 MEDICAL SOCIAL SERVICES	18316					18316
15 SPIRITUAL COUNSELING	8031					8031
16 DIETARY COUNSELING						16
17 COUNSELING - OTHER	20884					20884
18 HOME HEALTH AIDE AND HOMEMAKER	14255					14255
18.20 HH AIDE & HOMEMAKER-CONT. HOME CARE						18.20
19 OTHER						19
OTHER HOSPICE SERVICE COSTS						
20 DRUGS, BIOLOGICAL & INFUSION THERAPY					26396	26396
20.30 ANALGESICS						20.30
20.31 SEDATIVES / HYPNOTICS						20.31
20.32 OTHER - SPECIFY						20.32
21 DURABLE MEDICAL EQUIPMENT/OXYGEN						21
22 PATIENT TRANSPORTATION						22
23 IMAGING SERVICES						23
24 LABS AND DIAGNOSTICS						24
25 MEDICAL SUPPLIES					6214	6214
26 OUTPATIENT SERVICES (INCLUDING E/R DEPT.)						26
27 RADIATION THERAPY						27
28 CHEMOTHERAPY						28
29 OTHER						29
HOSPICE NONREIMBURSABLE SERVICE						
30 BEREAVEMENT PROGRAM COSTS						30
31 VOLUNTEER PROGRAM COSTS						31
32 FUNDRAISING						32
33 OTHER PROGRAM COSTS						33
34 TOTAL	237502		3706	15637	60394	317239

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE NO.: 14-1561

WORKSHEET K  
 (CONTINUED)

	RECLASSIFI- CATION 7	SUBTOTAL 8	ADJUSTMENTS 9	TOTAL 10	
GENERAL SERVICE COST CENTER					
1 CAPITAL RELATED COSTS-BLDG AND FIXT.					1
2 CAPITAL RELATED COSTS-MOVABLE EQUIP.					2
3 PLANT OPERATION AND MAINTENANCE					3
4 TRANSPORTATION - STAFF					4
5 VOLUNTEER SERVICE COORDINATION					5
6 ADMINISTRATIVE AND GENERAL		146655		146655	6
INPATIENT CARE SERVICE					
7 INPATIENT - GENERAL CARE					7
8 INPATIENT - RESPITE CARE					8
VISITING SERVICES					
9 PHYSICIAN SERVICES	23400	23400		23400	9
10 NURSING CARE		76488		76488	10
10.20 NURSING CARE-CONTINUOUS HOME CARE					10.20
11 PHYSICAL THERAPY					11
12 OCCUPATIONAL THERAPY					12
13 SPEECH/LANGUAGE PATHOLOGY					13
14 MEDICAL SOCIAL SERVICES		18316		18316	14
15 SPIRITUAL COUNSELING		8031		8031	15
16 DIETARY COUNSELING					16
17 COUNSELING - OTHER		20884		20884	17
18 HOME HEALTH AIDE AND HOMEMAKER		14255		14255	18
18.20 HH AIDE & HOMEMAKER-CONT. HOME CARE					18.20
19 OTHER					19
OTHER HOSPICE SERVICE COSTS					
20 DRUGS, BIOLOGICAL & INFUSION THERAPY		26396		26396	20
20.30 ANALGESICS					20.30
20.31 SEDATIVES / HYPNOTICS					20.31
20.32 OTHER - SPECIFY					20.32
21 DURABLE MEDICAL EQUIPMENT/OXYGEN					21
22 PATIENT TRANSPORTATION					22
23 IMAGING SERVICES					23
24 LABS AND DIAGNOSTICS					24
25 MEDICAL SUPPLIES		6214		6214	25
26 OUTPATIENT SERVICES (INCLUDING E/R DEPT.)					26
27 RADIATION THERAPY					27
28 CHEMOTHERAPY					28
29 OTHER					29
HOSPICE NONREIMBURSABLE SERVICE					
30 BEREAVEMENT PROGRAM COSTS					30
31 VOLUNTEER PROGRAM COSTS					31
32 FUNDRAISING					32
33 OTHER PROGRAM COSTS					33
34 TOTAL	23400	340639		340639	34

HOSPICE COMPENSATION ANALYSIS - SALARIES AND WAGES

HOSPICE NO.: 14-1561

WORKSHEET K-1

	ADMINI- STRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER- VISORS 4	NURSES 5	TOTAL THERAPISTS 6	AIDES 7	ALL OTHER 8	TOTAL 9
1	GENERAL SERVICE COST CENTER								
2	CAP REL COSTS-BLDG AND FIXT.								
3	CAP REL COSTS-MOVABLE EQUIP.								
4	PLANT OPERATION & MAINT.								
5	TRANSPORTATION - STAFF								
6	VOLUNTEER SERVICE COORD.								
7	ADMINISTRATIVE AND GENERAL								
8	INPATIENT CARE SERVICE								
9	INPATIENT - GENERAL CARE								
10	INPATIENT - RESPITE CARE								
11	VISITING SERVICES								
12	PHYSICIAN SERVICES								
13	NURSING CARE								
14	NURSING CARE-CONT.HOME CARE								
15	PHYSICAL THERAPY								
16	OCCUPATIONAL THERAPY								
17	SPEECH/LANGUAGE PATHOLOGY								
18	MEDICAL SOCIAL SERVICES								
19	SPIRITUAL COUNSELING								
20	DIETARY COUNSELING								
21	COUNSELING - OTHER								
22	HH AIDE AND HOMEMAKER								
23	HH AIDE & HMKR-CONT.HME CARE								
24	OTHER								
25	OTHER HOSPICE SERVICE COSTS								
26	DRUGS, BIOL. & INFUS. THER.								
27	ANALGESICS								
28	SEDATIVES / HYPNOTICS								
29	OTHER - SPECIFY								
30	DURABLE MED. EQUIP./OXYGEN								
31	PATIENT TRANSPORTATION								
32	IMAGING SERVICES								
33	LABS AND DIAGNOSTICS								
34	MEDICAL SUPPLIES								
35	OUTPAT.SERV.(INCL.E/R DEPT.)								
36	RADIATION THERAPY								
37	CHEMOTHERAPY								
38	OTHER								
39	HOSPICE NONREIMBURSABLE SERVICE								
40	BEREAVEMENT PROGRAM COSTS								
41	VOLUNTEER PROGRAM COSTS								
42	FUNDRAISING								
43	OTHER PROGRAM COSTS								
44	TOTAL								



HOSPICE COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES HOSPICE NO.: 14-1561 WORKSHEET K-3

	ADMINI- STRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER- VISORS 4	NURSES 5	TOTAL THERAPISTS 6	AIDES 7	ALL OTHER 8	TOTAL 9
1	GENERAL SERVICE COST CENTER								
2	CAP REL COSTS-BLDG AND FIXT.								1
3	CAP REL COSTS-MOVABLE EQUIP.								2
4	PLANT OPERATION & MAINT.								3
5	TRANSPORTATION - STAFF								4
6	VOLUNTEER SERVICE COORD.								5
7	ADMINISTRATIVE AND GENERAL								15637
8	INPATIENT CARE SERVICE								15637
9	INPATIENT - GENERAL CARE								7
10	INPATIENT - RESPITE CARE								8
11	VISITING SERVICES								
12	PHYSICIAN SERVICES								9
13	NURSING CARE								10
14	NURSING CARE-CONT.HOME CARE								10.20
15	PHYSICAL THERAPY								11
16	OCCUPATIONAL THERAPY								12
17	SPEECH/LANGUAGE PATHOLOGY								13
18	MEDICAL SOCIAL SERVICES								14
19	SPIRITUAL COUNSELING								15
20	DIETARY COUNSELING								16
21	COUNSELING - OTHER								17
22	HH AIDE AND HOMEMAKER								18
23	HH AIDE & HMKR-CONT.HME CARE								18.20
24	OTHER								19
25	OTHER HOSPICE SERVICE COSTS								
26	DRUGS, BIOL. & INFUS. THER.								20
27	ANALGESICS								20.30
28	SEDATIVES / HYPNOTICS								20.31
29	OTHER - SPECIFY								20.32
30	DURABLE MED. EQUIP./OXYGEN								21
31	PATIENT TRANSPORTATION								22
32	IMAGING SERVICES								23
33	LABS AND DIAGNOSTICS								24
34	MEDICAL SUPPLIES								25
35	OUTPAT.SERV.(INCL.E/R DEPT.)								26
36	RADIATION THERAPY								27
37	CHEMOTHERAPY								28
38	OTHER								29
39	HOSPICE NONREIMBURSABLE SERVICE								
40	BEREAVEMENT PROGRAM COSTS								30
41	VOLUNTEER PROGRAM COSTS								31
42	FUNDRAISING								32
43	OTHER PROGRAM COSTS								33
44	TOTAL								15637
									15637

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

HOSPICE NO.: 14-1561

WORKSHEET K-4  
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL COST BLDG & FIXTURES	CAP REL MOVABLE EQUIPMENT	PLANT OPERATN & MAINT	TRANSPOR- TATION	VOLUNTEER SERV. CO- ORDINATOR	SUBTOTAL 5A	ADMIN & GENERAL 6	TOTAL 7
	0	1	2	3	4	5			
1									1
2									2
3									3
4									4
5									5
6		146655					146655	146655	6
7									7
8									8
9		23400					23400	17691	41091
10		76488					76488	57825	134313
10.20									10.20
11									11
12									12
13									13
14		18316					18316	13847	32163
15		8031					8031	6072	14103
16									16
17		20884					20884	15789	36673
18		14255					14255	10777	25032
18.20									18.20
19									19
20		26396					26396	19956	46352
20.30									20.30
20.31									20.31
20.32									20.32
21									21
22									22
23									23
24									24
25		6214					6214	4698	10912
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34		340639					340639		340639









ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS HOSPICE NO.: 14-1561

WORKSHEET K-5  
 PART I

HOSPICE COST CENTER	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL	ALLOCATED HOSPICE A & G	TOTAL HOSPICE COSTS	
	24	25	26	27	28	29	
1 ADMINISTRATIVE AND GENERAL		71353		71353			1
2 INPATIENT - GENERAL CARE							2
3 INPATIENT - RESPITE CARE							3
4 PHYSICIAN SERVICES		50879		50879	7142	58021	4
5 NURSING CARE		229248		229248	32179	261427	5
5.20 NURSING CARE-CONTINUOUS HOM							5.20
6 PHYSICAL THERAPY							6
7 OCCUPATIONAL THERAPY							7
8 SPEECH/LANGUAGE PATHOLOGY							8
9 MEDICAL SOCIAL SERV. - DIRE		47081		47081	6609	53690	9
10 SPIRITUAL COUNSELING		20644		20644	2898	23542	10
11 DIETARY COUNSELING							11
12 COUNSELING - OTHER		53683		53683	7536	61219	12
13 HOME HLTH AIDE & HOMEMAKERS		36642		36642	5144	41786	13
13.20 HH AIDE & HMKR-CONT. HOME C							13.20
14 OTHER							14
15 DRUGS,BIOLOGICALS & INFUSIO		56772		56772	7969	64741	15
15.30 ANALGESICS							15.30
15.31 SEDATIVES / HYPNOTICS							15.31
15.32 OTHER - SPECIFY							15.32
16 DURABLE MED. EQUIP./OXYGEN							16
17 PATIENT TRANSPORTATION							17
18 IMAGING SERVICES							18
19 LABS AND DIAGNOSTICS							19
20 MEDICAL SUPPLIES		13365		13365	1876	15241	20
21 OUTPAT. SERV.(INCL.E/R DEPT							21
22 RADIATION THERAPY							22
23 CHEMOTHERAPY							23
24 OTHER							24
25 BEREAVEMENT PROGRAM COSTS							25
26 VOLUNTEER PROGRAM COSTS							26
27 FUNDRAISING							27
28 OTHER PROGRAM COSTS							28
29 TOTALS		579667		579667		579667	29
30 UNIT COST MULTIPLIER					.140372		30

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
 STATISTICAL BASIS

HOSPICE NO.: 14-1561

WORKSHEET K-5  
 PART II

HOSPICE COST CENTER	OLD CAP BLDGS & FIXTURES SQUARE FEET	OLD CAP MOVABLE EQUIPMENT DOLLAR VALUE	NEW CAP- REL COSTS BLDG&FIXT SQUARE FEET	NEW CAP- REL COSTS MOV EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINI- STRATIVE & GENERAL ACCUM COST	MAINTEN- ANCE AND REPAIRS MAINT REQS	
	1	2	3	4	5	6A	6	7	
1 ADMINISTRATIVE AND GENERAL					103234		35381		1
2 INPATIENT - GENERAL CARE									2
3 INPATIENT - RESPITE CARE									3
4 PHYSICIAN SERVICES							41091	576	4
5 NURSING CARE					72782		159256		5
5.20 NURSING CARE-CONTINUOUS HOM									5.20
6 PHYSICAL THERAPY									6
7 OCCUPATIONAL THERAPY									7
8 SPEECH/LANGUAGE PATHOLOGY									8
9 MEDICAL SOCIAL SERV. - DIRE					18316		38440		9
10 SPIRITUAL COUNSELING					8031		16855		10
11 DIETARY COUNSELING									11
12 COUNSELING - OTHER					20884		43830		12
13 HOME HLTH AIDE & HOMEMAKERS					14255		29917		13
13.20 HH AIDE & HMKR-CONT. HOME C									13.20
14 OTHER									14
15 DRUGS,BIOLOGICALS & INFUSIO							46352		15
15.30 ANALGESICS									15.30
15.31 SEDATIVES / HYPNOTICS									15.31
15.32 OTHER - SPECIFY									15.32
16 DURABLE MED. EQUIP./OXYGEN									16
17 PATIENT TRANSPORTATION									17
18 IMAGING SERVICES									18
19 LABS AND DIAGNOSTICS									19
20 MEDICAL SUPPLIES							10912		20
21 OUTPAT. SERV.(INCL.E/R DEPT									21
22 RADIATION THERAPY									22
23 CHEMOTHERAPY									23
24 OTHER									24
25 BEREAVEMENT PROGRAM COSTS									25
26 VOLUNTEER PROGRAM COSTS									26
27 FUNDRAISING									27
28 OTHER PROGRAM COSTS									28
29 TOTAL					237502		422034	576	29
30 TOTAL COST TO BE ALLOCATED					81395		94872	551	30
31 UNIT COST MULTIPLIER					.342713		.224797		31
31 UNIT COST MULTIPLIER								.956597	31





APPORTIONMENT OF HOSPICE SHARED SERVICES

HOSPICE NO.: 14-1561

WORKSHEET K-5  
 PART III

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

	WKST C, PART I, COL. 9, LINE 0	COST TO CHARGE RATIO 1	TOTAL HOSPICE CHARGES 2	HOSPICE SHARED ANCILLARY COSTS 3
ANCILLARY SERVICE COST CENTERS				
1	PHYSICAL THERAPY	50	0.179350	1
2	OCCUPATIONAL THERAPY	51		2
3	SPEECH/LANGUAGE PATHOLOGY	52		3
4	DRUGS, BIOLOGICALS AND INFUSION	56	0.071590	4
4.01	OUTPATIENT PHARMACY	56.01	1.210637	4.01
5	DURABLE MEDICAL EQUIPMENT/OXYGEN	67		5
6	LABS AND DIAGNOSTICS	44	0.112277	6
7	MEDICAL SUPPLIES	55	0.168507	7
7.30	IMPL. DEV. CHARGED TO PATIENT	55.30	0.283499	7.30
8	OUTPATIENT SERVICES (INCL. E/R DEPT)	61	0.158147	8
9	RADIATION THERAPY	41	0.226878	9
10	LITHOTRIPSY	59		10
10.01	CARDIAC REHABILITATION	59.01	0.713185	10.01
10.03	CARDIAC CATHERIZATION LAB	59.03	0.066536	10.03
10.05	INPATIENT RENAL DIALYSIS	59.05	0.136400	10.05
10.97	CARDIAC REHABILITATION	59.97		10.97
10.98	HYPERBARIC OXYGEN THERAPY	59.98		10.98
10.99	LITHOTRIPSY	59.99		10.99
11	TOTALS			11

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CALCULATION OF HOSPICE PER DIEM COST

HOSPICE NO.: 14-1561

WORKSHEET K-6

COMPUTATION OF PER DIEM COST	TITLE XVIII 1	TITLE XIX 2	OTHER 3	TOTAL 4	
1 TOTAL COST				579667	1
2 TOTAL UNDUPLICATED DAYS				3833	2
3 AGGREGATE COST PER DIEM				151.23	3
4 UNDUPLICATED MEDICARE DAYS	3094				4
5 AGGREGATE MEDICARE COST	467906				5
6 UNDUPLICATED MEDICAID DAYS					6
7 AGGREGATE MEDICAID COST					7
8 UNDUPLICATED SNF DAYS					8
9 AGGREGATE SNF COST					9
10 UNDUPLICATED NF DAYS					10
11 AGGREGATE NF COST					11
12 OTHER UNDUPLICATED DAYS			739		12
13 AGGREGATE COST FOR OTHER DAYS			111759		13

CALCULATION OF CAPITAL PAYMENT - TITLE XVIII - FULLY PROSPECTIVE METHOD

WORKSHEET L

	HOSPITAL (14-0008)	HOSPITAL (14-0008)	SUB I	SUB II	SUB III
	1	1.01			
<b>PART I - FULLY PROSPECTIVE METHOD</b>					
1					1
2					2
3	2263093				3
3.01					3.01
4					4
4.01					4.01
4.02					4.02
4.03					4.03
5					5
5.01					5.01
5.02					5.02
5.03					5.03
5.04					5.04
6	2404619				6
<b>PART II - HOLD HARMLESS METHOD</b>					
1					1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
<b>PART III - PAYMENT UNDER REASONABLE COST</b>					
1					1
2					2
3					3
4					4
5					5
<b>PART IV - COMPUTATION OF EXCEPTION PAYMENTS</b>					
1					1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15					15
16					16
17					17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS 0	SUBTOTAL 4A	SUBTOTAL 25	I&R COST & POST STEP- DOWN ADJS 26	TOTAL 27
GENERAL SERVICE COST CENTERS					
1 OLD CAP REL COSTS-BLDG & FIXT					1
2 OLD CAP REL COSTS-MVBLE EQUIP					2
3 NEW CAP REL COSTS-BLDG & FIXT					3
4 NEW CAP REL COSTS-MVBLE EQUIP					4
5 EMPLOYEE BENEFITS					5
6 ADMINISTRATIVE & GENERAL					6
7 MAINTENANCE & REPAIRS					7
8 OPERATION OF PLANT					8
9 LAUNDRY & LINEN SERVICE					9
10 HOUSEKEEPING					10
11 DIETARY					11
12 CAFETERIA					12
13 MAINTENANCE OF PERSONNEL					13
14 NURSING ADMINISTRATION					14
15 CENTRAL SERVICES & SUPPLY					15
16 PHARMACY					16
17 MEDICAL RECORDS & LIBRARY					17
18 SOCIAL SERVICE					18
20 NONPHYSICIAN ANESTHETISTS					20
21 NURSING SCHOOL					21
22 I&R SERVICES-SALARY & FRINGES					22
23 I&R SERVICES-OTHER PRGM COSTS					23
24 PARAMED ED PRGM-(SPECIFY)					24
INPATIENT ROUTINE SERV COST CENTERS					
25 ADULTS & PEDIATRICS					25
26 INTENSIVE CARE UNIT					26
31 SUBPROVIDER I					31
33 NURSERY					33
34 SKILLED NURSING FACILITY					34
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
38 RECOVERY ROOM					38
39 DELIVERY ROOM & LABOR ROOM					39
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
43 RADIOISOTOPE					43
43.01 ULTRASOUND					43.01
43.02 MRI-CT SCANS					43.02
44 LABORATORY					44
46.30 BLOOD CLOTTING FACTORS ADMIN C					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
53 ELECTROCARDIOLOGY					53
54 ELECTROENCEPHALOGRAPHY					54
55 MEDICAL SUPPLIES CHARGED TO PA					55
55.30 IMPL. DEV. CHARGED TO PATIENT					55.30
56 DRUGS CHARGED TO PATIENTS					56
56.01 OUTPATIENT PHARMACY					56.01
59 LITHOTRIPSY					59
59.01 CARDIAC REHABILITATION					59.01
59.03 CARDIAC CATHERIZATION LAB					59.03
59.05 INPATIENT RENAL DIALYSIS					59.05
59.97 CARDIAC REHABILITATION					59.97
59.98 HYPERBARIC OXYGEN THERAPY					59.98
59.99 LITHOTRIPSY					59.99
OUTPATIENT SERVICE COST CENTERS					
60 CLINIC					60
60.01 OUTPATIENT INFUSION PROCEDURES					60.01
60.02 WOUND CARE					60.02
61 EMERGENCY					61
62 OBSERVATION BEDS (NON-DISTINCT					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
65 AMBULANCE SERVICES					65
69.10 CMHC					69.10
69.20 OUTPATIENT PHYSICAL THERAPY					69.20
69.30 OUTPATIENT OCCUPATIONAL THERAP					69.30
69.40 OUTPATIENT SPEECH PATHOLOGY					69.40
71 HOME HEALTH AGENCY					71
SPECIAL PURPOSE COST CENTERS					
85.01 PANCREAS ACQUISITION					85.01
85.02 INTESTINAL ACQUISITION					85.02
85.03 ISLET CELL ACQUISITION					85.03

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ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	0	4A	25	26	27	
93 HOSPICE						93
95 SUBTOTALS						95
NONREIMBURSABLE COST CENTERS						
96 GIFT, FLOWER, COFFEE SHOP & CA						96
98 PHYSICIANS' PRIVATE OFFICES						98
98.01 NON-EMPLOYEE CHILD CARE CENTER						98.01
99 NONPAID WORKERS						99
101 CROSS FOOT ADJUSTMENTS						101
102 NEGATIVE COST CENTER						102
103 TOTAL						103
104 TOTAL STATISTICAL BASIS						104
105 UNIT COST MULTIPLIER						105
105 UNIT COST MULTIPLIER						105