

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: _____ TIME: _____
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY 5. COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: _____
 1 - AS SUBMITTED 7. CONTRACTOR NO: _____ 11. CONTRACTOR'S VENDOR CODE: _____
 2 - SETTLED WITHOUT AUDIT 8. INITIAL REPORT FOR THIS PROVIDER CCN 12. IF LINE 5, COLUMN 1 IS 4: ENTER
 3 - SETTLED WITH AUDIT 9. FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.
 4 - REOPENED
 5 - AMENDED

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR 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 07/01/2010 AND ENDING 06/30/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		393,160	248,228		1
2 SUBPROVIDER - IPF		16,904			2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF					5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC					10
11 HEALTH CLINIC - FQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		410,064	248,228		200

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

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

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 01/31/2012 10:02

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 8700 WEST NORTH AVENUE
 2 CITY: MELROSE PARK

STATE: IL

P.O.BOX:
 ZIP CODE: 60160

COUNTY: COOK

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

0	COMPONENT NAME	1	CCN NUMBER	2	CBSA NUMBER	3	PROV TYPE	4	DATE CERTIFIED	5	PAYMENT SYSTEM (P, T, O, OR N)			8
											6	7	XIX	
3	HOSPITAL	GOTTLIEB MEMORIAL HOSPITAL	14-0008	16974	1				07/01/1966		N	P	O	3
4	SUBPROVIDER - IPF	GOTTLIEB MEMORIAL PSYCHIATRIC	14-S008	16974	4				01/01/2007		N	P	N	4
5	SUBPROVIDER - IRF													5
6	SUBPROVIDER - (OTHER)													6
7	SWING BEDS - SNF													7
8	SWING BEDS - NF													8
9	HOSPITAL-BASED SNF	GOTTLIEB SKILLED NURSING CARE	14-5526	16974					06/10/1985		N	P	N	9
10	HOSPITAL-BASED NF													10
11	HOSPITAL-BASED OLTC													11
12	HOSPITAL-BASED HHA	GOTTLIEB HOME CARE	14-7255	16974					02/28/1984		N	P	N	12
13	SEPARATELY CERTIFIED ASC													13
14	HOSPITAL-BASED HOSPICE	GOTTLIEB HOSPICE	14-1561	16974					01/01/2000					14
15	HOSPITAL-BASED HEALTH CLINIC - RHC													15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC													16
17	HOSPITAL-BASED (CMHC)													17
18	RENAL DIALYSIS													18
19	OTHER													19
20	COST REPORTING PERIOD (MM/DD/YYYY) FROM: 07/01/2010 TO: 06/30/2011													20
21	TYPE OF CONTROL													21

INPATIENT PPS INFORMATION

22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2)(PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.													1	2
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.													1	N 23

		IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE DAYS	OUT-OF-STATE MEDICAID PAID DAYS	OUT-OF-STATE MEDICAID ELIGIBLE DAYS	MEDICAID HMO DAYS	OTHER MEDICAID DAYS	
		1	2	3	4	5	6	
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPFS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	3,935	1,048					24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				1			26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				1			27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:	ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:	ENDING:		38

		V	XVIII	XIX	
		1	2	3	
45	PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR §412.348(g)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

	1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N	57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 21248? IF YES, COMPLETE WORKSHEET D-5.	N		58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N		60

	Y/N	IME AVERAGE	DIRECT GME AVERAGE	
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	N		61

ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)			62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)			62.01

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N		63
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SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/(COL.1+COL.2))	
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			64

ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4). (SEE INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/(COL.3+COL.4))
1	2	3	4	5

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/(COL.1+COL.2))	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)). (SEE INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1 / (COL.3 + COL.4))
1	2	3	4	5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			N 71
INPATIENT REHABILITATION FACILITY PPS				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			V XIX 1 2 N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 N 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	N N N N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.		85,000,000	85,000,000 119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N		N 120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	N		140
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IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141	NAME:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET:	P.O. BOX:		142
143	CITY:	STATE:	ZIP CODE:	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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

155	HOSPITAL	N	N	155
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC		N	161

MULTICAMPUS

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

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(m)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.			169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

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

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COST

- | | | |
|----|---|----|
| 22 | HAVE ASSETS BEEN RELIEFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS. | 22 |
| 23 | HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | 23 |
| 24 | WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | 24 |
| 25 | HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | 25 |
| 26 | WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | 26 |
| 27 | HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | 27 |

INTEREST EXPENSE

- | | | |
|----|---|----|
| 28 | WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | 28 |
| 29 | DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS. | 29 |
| 30 | HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS. | 30 |
| 31 | HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS. | 31 |

PURCHASED SERVICES

- | | | |
|----|---|----|
| 32 | HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS. | 32 |
| 33 | IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS. | 33 |

PROVIDER-BASED PHYSICIANS

- | | | |
|----|--|----|
| 34 | ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS. | 34 |
| 35 | IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | 35 |

HOME OFFICE COSTS

- | | Y/N | DATE | |
|----|--|------|----|
| | 1 | 2 | |
| 36 | WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT? | | 36 |
| 37 | IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. | | 37 |
| 38 | IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE. | | 38 |
| 39 | IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS. | | 39 |
| 40 | IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. | | 40 |

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	53,085,298	423,322	53,508,620	1,680,376.00	31.84
2	NON-PHYSICIAN ANESTHETIST PART A						1
3	NON-PHYSICIAN ANESTHETIST PART B						2
4	PHYSICIAN-PART A						3
4.01	PHYSICIANS-PART A - DIRECT TEACHING						4
5	PHYSICIAN-PART B		102,550		102,550	1,979.00	51.82
6	NON-PHYSICIAN-PART B						5
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					6
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)						7
8	HOME OFFICE PERSONNEL						8
9	SNF	44	1,868,630	11,968	1,880,598	74,213.00	25.34
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		2,961,509	58,204	3,019,713	96,033.00	31.44
	OTHER WAGES & RELATED COSTS						10
11	CONTRACT LABOR (SEE INSTRUCTIONS)		542,251		542,251	11,887.00	45.62
12	MANAGEMENT AND ADMINISTRATIVE SERVICES						11
13	CONTRACT LABOR: PHYSICIAN-PART A		1,248,747		1,248,747	13,516.00	92.39
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS						12
15	HOME OFFICE: PHYSICIAN-PART A						13
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						14
	WAGE-RELATED COSTS						15
17	WAGE-RELATED COSTS (CORE)		16,098,146		16,098,146		16
18	WAGE-RELATED COSTS (OTHER)						17
19	EXCLUDED AREAS		877,640		877,640		18
20	NON-PHYSICIAN ANESTHETIST PART A						19
21	NON-PHYSICIAN ANESTHETIST PART B						20
22	PHYSICIAN PART A						21
23	PHYSICIAN PART B		29,805		29,805		22
24	WAGE-RELATED COSTS (RHC/FQHC)						23
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						24
	OVERHEAD COSTS - DIRECT SALARIES						25
26	EMPLOYEE BENEFITS		938,833	372,903	1,311,736	45,150.00	29.05
27	ADMINISTRATIVE & GENERAL		7,585,440	-325,579	7,259,861	316,931.00	22.91
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)						26
29	MAINTENANCE & REPAIRS		792,710		792,710	44,407.00	17.85
30	OPERATION OF PLANT		916,430	113	916,543	44,506.00	20.59
31	LAUNDRY & LINEN SERVICE		104,687		104,687	7,936.00	13.19
32	HOUSEKEEPING		1,083,716		1,083,716	100,455.00	10.79
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						31
34	DIETARY		827,514	-303,416	524,098	31,266.00	16.76
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						32
36	CAFETERIA		109,166	303,692	412,858	43,949.00	9.39
37	MAINTENANCE OF PERSONNEL						33
38	NURSING ADMINISTRATION		1,468,821		1,468,821	29,169.00	50.36
39	CENTRAL SERVICES AND SUPPLY		525,609	89,449	615,058	33,180.00	18.54
40	PHARMACY		1,977,238		1,977,238	52,222.00	37.86
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		1,416,345	223	1,416,568	49,754.00	28.47
42	SOCIAL SERVICE		330,977		330,977	11,210.00	29.53
43	OTHER GENERAL SERVICE						41

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	52,982,748	423,322	53,406,070	1,678,397.0	31.82	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	4,830,139	70,172	4,900,311	170,246.00	28.78	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	48,152,609	353,150	48,505,759	1,508,151.0	32.16	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	1,790,998		1,790,998	25,403.00	70.50	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	16,098,146		16,098,146		33.19%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	66,041,753	353,150	66,394,903	1,533,554.0	43.29	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	18,077,486	137,385	18,214,871	810,135.00	22.48	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS		1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3 QUALIFIED AND NON-QUALIFIED PENSION PLAN COST	6,287,980	3
4 PRIOR YEAR PENSION SERVICE COST		4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5 401K/TSA PLAN ADMINISTRATION FEES		5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	5,259,781	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN	242,832	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	-6,428	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	163,438	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	1,041,881	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)		16
TAXES		
17 FICA-EMPLOYERS PORTION ONLY	3,816,224	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE	128,147	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION		21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT	71,737	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	17,005,592	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

PROVIDER CCN: 14-0008 GOTTSLIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
01/31/2012 10:02

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

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	2,182				2,182	1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION)					894.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: .00	----- NUMBER OF EMPLOYEES ----- (FULL TIME EQUIVALENT)			TOTAL 3	
	STAFF 1	CONTRACT 2			
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)					3
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)					4
5 OTHER ADMINISTRATIVE PERSONNEL		7.40		7.40	5
6 DIRECT NURSING SERVICE		11.97		11.97	6
7 NURSING SUPERVISOR		3.90		3.90	7
8 PHYSICAL THERAPY SERVICE		0.29		0.29	8
9 PHYSICAL THERAPY SUPERVISOR		0.01		0.01	9
10 OCCUPATIONAL THERAPY SERVICE		0.81		0.81	10
11 OCCUPATIONAL THERAPY SUPERVISOR		1.76		1.76	11
12 SPEECH PATHOLOGY SERVICE					12
13 SPEECH PATHOLOGY SUPERVISOR					13
14 MEDICAL SOCIAL SERVICE					14
15 MEDICAL SOCIAL SERVICE SUPERVISOR					15
16 HOME HEALTH AIDE					16
17 HOME HEALTH AIDE SUPERVISOR					17
18 OTHER (SPECIFY)					18

HOME HEALTH AGENCY CBSA CODES

19 ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.	1	19
20 LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE).	16974	20

PPS ACTIVITY

	FULL EPISODES				TOTAL (COLS. 1-4) 5	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4		
21 SKILLED NURSING VISITS	7,017	61	229	44	7,351	21
22 SKILLED NURSING VISIT CHARGES	1,437,791	12,551	46,967	9,053	1,506,362	22
23 PHYSICAL THERAPY VISITS	4,567	5	18	41	4,631	23
24 PHYSICAL THERAPY VISIT CHARGES	887,141	975	3,491	7,995	899,602	24
25 OCCUPATIONAL THERAPY VISITS	546			11	557	25
26 OCCUPATIONAL THERAPY VISIT CHARGES	106,974			2,175	109,149	26
27 SPEECH PATHOLOGY VISITS	24			3	27	27
28 SPEECH PATHOLOGY VISIT CHARGES	4,528			585	5,113	28
29 MEDICAL SOCIAL SERVICE VISITS	495	3	2	3	503	29
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	115,571	704	470	704	117,449	30
31 HOME HEALTH AIDE VISITS	2,114	21	5	8	2,148	31
32 HOME HEALTH AIDE VISIT CHARGES	340,567	3,397	801	1,294	346,059	32
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	14,763	90	254	110	15,217	33
34 OTHER CHARGES	94,655	983	4,049	28	99,715	34
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	2,987,227	18,610	55,778	21,834	3,083,449	35
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	838		103	8	949	36
37 TOTAL NUMBER OF OUTLIER EPISODES		2			2	37
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	94,655	983	4,049	28	99,715	38

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE				
		1	2				
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1			
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	N		2			
							TOTAL
	GROUP				SNF	SWING BED	(COLS.
	1				DAYS	SNF DAYS	2 + 3)
					2	3	4
3	RUX						3
4	RUL						4
5	RVX				542		542 5
6	RVL				268		268 6
7	RHX				15		15 7
8	RHL				5		5 8
9	RMX				515		515 9
10	RML				204		204 10
11	RLX						11
12	RUC				9		9 12
13	RUB				23		23 13
14	RUA						14
15	RVC				1,626		1,626 15
16	RVB				1,118		1,118 16
17	RVA				178		178 17
18	RHC				1,061		1,061 18
19	RHB				371		371 19
20	RHA				124		124 20
21	RMC				617		617 21
22	RMB				500		500 22
23	RMA				127		127 23
24	RLB						24
25	RLA						25
26	ES3						26
27	ES2						27
28	ES1						28
29	HE2						29
30	HE1				4		4 30
31	HD2						31
32	HD1						32
33	HC2						33
34	HC1				16		16 34
35	HB2				2		2 35
36	HB1						36
37	LE2						37
38	LE1						38
39	LD2						39
40	LD1						40
41	LC2						41
42	LC1				6		6 42
43	LB2						43
44	LB1						44
45	CE2				19		19 45
46	CE1				16		16 46
47	CD2				3		3 47
48	CD1				17		17 48
49	CC2				10		10 49
50	CC1				29		29 50
51	CB2				7		7 51
52	CB1				26		26 52
53	CA2						53
54	CA1						54
55	SE3				7		7 55
56	SE2				23		23 56
57	SE1						57
58	SSC						58
59	SSB						59
60	SSA						60
61	IB2						61
62	IB1						62
63	IA1						63
64	IA2						64
65	BB2						65
66	BB1				1		1 66
67	BA2						67
68	BA1						68

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		GROUP	SNF	SWING BED	TOTAL
		1	DAYS	SNF DAYS	(COLS.
			2	3	2 + 3)
					4
69	PE2				69
70	PE1		2		2 70
71	PD2				71
72	PD1		2		2 72
73	PC2				73
74	PC1		2		2 74
75	PB2				75
76	PB1		31		31 76
77	PA2				77
78	PA1				78
199	AAA		1		1 199
200	TOTAL		7,527		7,527 200

		CBSA	CBSA AT	ON/AFTER
			BEGINNING	OF THE COST
			OF COST	REPORTING
			REPORTING	PERIOD (IF
			PERIOD	APPLICABLE)
			1	2

201 ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (IF APPLICABLE). 00004 201

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

		EXPENSES	PERCENTAGE	EXPENSES?
		1	2	3
202	STAFFING			202
203	RECRUITMENT			203
204	RETENTION OF EMPLOYEES			204
205	TRAINING			205
206	OTHER (SPECIFY)			206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)	6,445,454		207

HOSPICE IDENTIFICATION DATA

HOSPICE NO.: 14-1561

WORKSHEET S-9
 PARTS I & II

PART I - ENROLLMENT DAYS

----- UNDUPLICATED DAYS -----						
	TITLE XVIII 1	TITLE XIX 2	TITLE XVIII SKILLED NURSING FACILITY 3	TITLE XIX NURSING FACILITY 4	ALL OTHER 5	TOTAL (SUM OF COLS. 1, 2 & 5) 6
1	CONTINUOUS HOME CARE					1
2	ROUTINE HOME CARE	4,170				4,170
3	INPATIENT RESPITE CARE	5				5
4	GENERAL INPATIENT CARE	187				187
5	TOTAL HOSPICE DAYS	4,362				4,362

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 (SUM OF COLS. 1, 2 & 5) 6
6	NUMBER OF PATIENTS RECEIVING HOSPICE CARE	116				116
7	TOTAL NUMBER OF UNDUPLICATED CONTINUOUS CARE HOURS BILLABLE TO MEDICARE					
8	AVERAGE LENGTH OF STAY (LINE 5/LINE 6)	37.60				37.60
9	UNDUPLICATED CENSUS COUNT	116				116

NOTE: PARTS I & II, COLUMNS 1 AND 2 ALSO INCLUDE THE DAYS REPORTED IN COLUMN 3 AND 4.

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)				0.167138	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				11,057,045	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?					4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				75,632,522	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				12,641,068	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)				1,584,023	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS				15,759	18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				1,584,023	19
			UNINSURED PATIENTS	INSURED PATIENTS	TOTAL	
			1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY		23,341,315		23,341,315	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)		3,901,221		3,901,221	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE		2,859,311		2,859,311	22
23	COST OF CHARITY CARE		1,041,910		1,041,910	23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					N 24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)				7,733,059	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				630,878	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				7,102,181	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				1,187,044	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				2,228,954	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				3,812,977	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS
		1	2	3	4
GENERAL SERVICE COST CENTERS					
1	00100		3,446,864	3,446,864	1
2	00200		3,418,432	3,418,432	2
3	00300				3
4	00400	938,833	18,008,794	18,947,627	-52,984
5	00500	7,585,440	9,057,599	16,643,039	-2,670,409
6	00600	792,710	458,541	1,251,251	
7	00700	916,430	3,059,106	3,975,536	
8	00800	104,687	450,778	555,465	
9	00900	1,083,716	1,030,684	2,114,400	
10	01000	827,514	1,094,467	1,921,981	-696,428
11	01100	109,166	159,766	268,932	696,428
12	01200				
13	01300	1,468,821	93,037	1,561,858	
14	01400	525,609	954,429	1,480,038	-132,566
15	01500	1,977,238	3,449,966	5,427,204	-3,198,562
16	01600	1,416,345	81,054	1,497,399	
17	01700	330,977	2,924	333,901	
19	01900				
20	02000				
21	02100				
22	02200				
23	02300				
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	9,969,297	1,077,149	11,046,446	222,109
31	03100	3,885,862	528,150	4,414,012	-358,706
40	04000	785,520	49,601	835,121	42,000
43	04300				363,161
44	04400	1,868,630	116,889	1,985,519	-41,215
ANCILLARY SERVICE COST CENTERS					
50	05000	2,497,294	8,258,767	10,756,061	-6,803,392
51	05100	355,329	61,425	416,754	
52	05200	1,282,546	216,385	1,498,931	-115,953
53	05300	6,921	254,824	261,745	717,000
54	05400	1,381,850	435,318	1,817,168	16,756
56	05600		556,641	556,641	8,405
56.01	03630	433,339	32,283	465,622	13,250
57	05700		501,210	1,081,381	
59	05900	614,696	2,112,311	2,727,007	-1,632,113
60	06000	2,224,771	3,440,904	5,665,675	10,260
62.30	06250				
65	06500	996,978	229,218	1,226,196	416
66	06600	1,916,893	104,404	2,021,297	
69	06900	371,389	58,636	430,025	49,215
70	07000	85,822	9,121	94,943	1,326
71	07100				7,312,715
72	07200				2,870,712
73	07300				3,198,562
73.01	07301	334,382	1,610,622	1,945,004	
76	03950				
76.01	03951	164,371	6,801	171,172	
76.05	03954				408,140
76.97	07697				
76.98	07698				
76.99	07699				
OUTPATIENT SERVICE COST CENTERS					
90	09000				
90.01	09001				
90.02	09002	259,234	579,930	839,164	2,736
91	09100	2,816,528	1,035,749	3,852,277	-316,329
92	09200				
OTHER REIMBURSABLE COST CENTERS					
99.10	09910				
99.20	09920				
99.30	09930				
99.40	09940				
101	10100	1,771,592	174,380	1,945,972	
SPECIAL PURPOSE COST CENTERS					
116	11600	251,799	93,416	345,215	21,600
118		52,932,700	66,310,575	119,243,275	-63,866
NONREIMBURSABLE COST CENTERS					
190	19000	29,570	33,476	63,046	
192	19200				10,882
192.01	19201				52,984
193	19300	123,028	121,240	244,268	
200		53,085,298	66,465,291	119,550,589	

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	3,446,864	-30,617	3,416,247	1
2	00200	CAP REL COSTS-MVBLE EQUIP	3,418,432	-12,334	3,406,098	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	18,894,643	-493,412	18,401,231	4
5	00500	ADMINISTRATIVE & GENERAL	13,972,630	-2,052,847	11,919,783	5
6	00600	MAINTENANCE & REPAIRS	1,251,251		1,251,251	6
7	00700	OPERATION OF PLANT	3,975,536	-1,585	3,973,951	7
8	00800	LAUNDRY & LINEN SERVICE	555,465		555,465	8
9	00900	HOUSEKEEPING	2,114,400		2,114,400	9
10	01000	DIETARY	1,225,553		1,225,553	10
11	01100	CAFETERIA	965,360	-368,859	596,501	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	1,561,858	-1,031	1,560,827	13
14	01400	CENTRAL SERVICES & SUPPLY	1,347,472		1,347,472	14
15	01500	PHARMACY	2,228,642		2,228,642	15
16	01600	MEDICAL RECORDS & LIBRARY	1,497,399	-1,222	1,496,177	16
17	01700	SOCIAL SERVICE	333,901		333,901	17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS				23
30	03000	ADULTS & PEDIATRICS	11,268,555	-1,033,043	10,235,512	30
31	03100	INTENSIVE CARE UNIT	4,055,306		4,055,306	31
40	04000	SUBPROVIDER - IPF	877,121	-19,774	857,347	40
43	04300	NURSERY	363,161		363,161	43
44	04400	SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	1,944,304		1,944,304	44
50	05000	OPERATING ROOM	3,952,669	-97,489	3,855,180	50
51	05100	RECOVERY ROOM	416,754		416,754	51
52	05200	DELIVERY ROOM & LABOR ROOM	1,382,978	-4,307	1,378,671	52
53	05300	ANESTHESIOLOGY	978,745	-344,750	633,995	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,833,924	-750	1,833,174	54
56	05600	RADIOISOTOPE	565,046		565,046	56
56.01	03630	ULTRASOUND	478,872		478,872	56.01
57	05700	COMPUTED TOMOGRAPHY (CT) SCAN	1,081,381		1,081,381	57
59	05900	CARDIAC CATHETERIZATION	1,094,894	-754	1,094,140	59
60	06000	LABORATORY	5,675,935	-15,475	5,660,460	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	1,226,612		1,226,612	65
66	06600	PHYSICAL THERAPY	2,021,297	-42,472	1,978,825	66
69	06900	ELECTROCARDIOLOGY	479,240	-12,491	466,749	69
70	07000	ELECTROENCEPHALOGRAPHY	96,269		96,269	70
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	7,312,715		7,312,715	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	2,870,712		2,870,712	72
73	07300	DRUGS CHARGED TO PATIENTS	3,198,562		3,198,562	73
73.01	07301	OUTPATIENT PHARMACY	1,945,004	-58,566	1,886,438	73.01
76	03950	LITHOTRIPSY				76
76.01	03951	CARDIAC REHABILITATION	171,172		171,172	76.01
76.05	03954	INPATIENT RENAL DIALYSIS	408,140		408,140	76.05
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS				76.99
90	09000	CLINIC				90
90.01	09001	OUTPATIENT INFUSION PROCEDURES				90.01
90.02	09002	WOUND CARE	841,900	-165,319	676,581	90.02
91	09100	EMERGENCY	3,535,948	-39,478	3,496,470	91
92	09200	OBSERVATION BEDS OTHER REIMBURSABLE COST CENTERS				92
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
101	10100	HOME HEALTH AGENCY	1,945,972		1,945,972	101
SPECIAL PURPOSE COST CENTERS						
116	11600	HOSPICE	366,815		366,815	116
118		SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	119,179,409	-4,796,575	114,382,834	118
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	63,046		63,046	190
192	19200	PHYSICIANS' PRIVATE OFFICES	10,882		10,882	192
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	52,984		52,984	192.01
193	19300	NONPAID WORKERS	244,268		244,268	193
200		TOTAL (SUM OF LINES 118-199)	119,550,589	-4,796,575	114,754,014	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER
1	2	3	4	5	
1 DRUGS SOLD TO PTS	A	DRUGS CHARGED TO PATIENTS	73		3,198,562 1
500 TOTAL RECLASSIFICATIONS					3,198,562 500
CODE LETTER - A					
1 PURCHASED SERVICES	B	INPATIENT RENAL DIALYSIS	76.05		408,140 1
2					2
500 TOTAL RECLASSIFICATIONS					408,140 500
CODE LETTER - B					
1 SHARED DIETARY COST	C	CAFETERIA	11	303,554	392,874 1
500 TOTAL RECLASSIFICATIONS				303,554	392,874 500
CODE LETTER - C					
1 NONEMP CHILD CARE	D	NON-EMPLOYEE CHILD CARE CENTE	192.01	48,106	4,878 1
500 TOTAL RECLASSIFICATIONS				48,106	4,878 500
CODE LETTER - D					
1 HOUSE STAF PHYS.	F	HOSPICE	116		21,600 1
2		ANESTHESIOLOGY	53		717,000 2
3		OPERATING ROOM	50		409,750 3
4		ADULTS & PEDIATRICS	30		1,040,750 4
5		EMERGENCY	91		47,997 5
6		SUBPROVIDER - IPF	40		42,000 6
7		ELECTROCARDIOLOGY	69		32,000 7
500 TOTAL RECLASSIFICATIONS					2,311,097 500
CODE LETTER - F					
1 PT TRANSPORT	H	CENTRAL SERVICES & SUPPLY	14	89,389	9,143 1
2		ADULTS & PEDIATRICS	30	107,130	10,957 2
3		INTENSIVE CARE UNIT	31	14,525	1,486 3
4		SKILLED NURSING FACILITY	44	11,896	1,217 4
5		DELIVERY ROOM & LABOR ROOM	52	13,495	1,380 5
6		RADIOLOGY-DIAGNOSTIC	54	15,201	1,555 6
7		RADIOISOTOPE	56	7,625	780 7
8		ULTRASOUND	56.01	12,021	1,229 8
9		LABORATORY	60	9,308	952 9
10		RESPIRATORY THERAPY	65	377	39 10
11		ELECTROCARDIOLOGY	69	15,618	1,597 11
12		ELECTROENCEPHALOGRAPHY	70	1,203	123 12
13		CARDIAC CATHETERIZATION	59	1,986	203 13
14		WOUND CARE	90.02	2,482	254 14
15		EMERGENCY	91	13,843	1,416 15
16		PHYSICIANS' PRIVATE OFFICES	192	9,872	1,010 16
500 TOTAL RECLASSIFICATIONS				325,971	33,341 500
CODE LETTER - H					
1 FLOOR STOCK SUPPLIES	I	MEDICAL SUPPLIES CHRGED TO PA	71		7,312,715 1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
500 TOTAL RECLASSIFICATIONS					7,312,715 500
CODE LETTER - I					

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----		SALARY	OTHER
		COST CENTER	LINE #		
	1	2	3	4	5
1 BONUS	K	EMPLOYEE BENEFITS	4	421,009	1
2		ADMINISTRATIVE & GENERAL	5	392	2
3		OPERATION OF PLANT	7	113	3
4		DIETARY	10	138	4
5		CAFETERIA	11	138	5
6		CENTRAL SERVICES & SUPPLY	14	60	6
7		MEDICAL RECORDS & LIBRARY	16	223	7
8		ADULTS & PEDIATRICS	30	227	8
9		SUBPROVIDER - IPF	40	88	9
10		SKILLED NURSING FACILITY	44	72	10
11		OPERATING ROOM	50	413	11
12		RECOVERY ROOM	51	50	12
13		ANESTHESIOLOGY	53	141	13
14		LABORATORY	60	10	14
15		PHYSICAL THERAPY	66	20	15
16		EMERGENCY	91	90	16
17		GIFT, FLOWER, COFFEE SHOP & C	190	138	17
500 TOTAL RECLASSIFICATIONS CODE LETTER - K				423,322	500
1 IMPLANTS	L	IMPL. DEV. CHARGED TO PATIENT	72		2,870,712 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - L					2,870,712 500
1 NURSERY	M	NURSERY	43	338,911	24,250 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - M				338,911	24,250 500
GRAND TOTAL (INCREASES)				1,439,864	16,556,569

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF.
			LINE #	SALARY	OTHER	
	1	6	7	8	9	10
1 DRUGS SOLD TO PTS	A	PHARMACY	15		3,198,562	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A					3,198,562	500
1 PURCHASED SERVICES	B	INTENSIVE CARE UNIT	31		139,141	1
2 ADULTS & PEDIATRICS			30		268,999	2
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					408,140	500
1 SHARED DIETARY COST	C	DIETARY	10	303,554	392,874	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - C				303,554	392,874	500
1 NONEMP CHILD CARE	D	EMPLOYEE BENEFITS	4	48,106	4,878	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - D				48,106	4,878	500
1 HOUSE STAF PHYS.	F	ADMINISTRATIVE & GENERAL	5		2,311,097	1
2						2
3						3
4						4
5						5
6						6
7						7
500 TOTAL RECLASSIFICATIONS CODE LETTER - F					2,311,097	500
1 PT TRANSPORT	H	ADMINISTRATIVE & GENERAL	5	325,971	33,341	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
500 TOTAL RECLASSIFICATIONS CODE LETTER - H				325,971	33,341	500
1 FLOOR STOCK SUPPLIES	I	CENTRAL SERVICES & SUPPLY	14		231,098	1
2 ADULTS & PEDIATRICS			30		304,568	2
3 INTENSIVE CARE UNIT			31		235,576	3
4 SKILLED NURSING FACILITY			44		54,328	4
5 OPERATING ROOM			50		4,342,430	5
6 DELIVERY ROOM & LABOR ROOM			52		130,828	6
7 CARDIAC CATHETERIZATION			59		1,634,302	7
8 EMERGENCY			91		379,585	8
500 TOTAL RECLASSIFICATIONS CODE LETTER - I					7,312,715	500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 BONUS	K	EMPLOYEE BENEFITS	4		421,009	9 1
2		ADMINISTRATIVE & GENERAL	5		392	2
3		OPERATION OF PLANT	7		113	3
4		DIETARY	10		138	4
5		CAFETERIA	11		138	5
6		CENTRAL SERVICES & SUPPLY	14		60	6
7		MEDICAL RECORDS & LIBRARY	16		223	7
8		ADULTS & PEDIATRICS	30		227	8
9		SUBPROVIDER - IPF	40		88	9
10		SKILLED NURSING FACILITY	44		72	10
11		OPERATING ROOM	50		413	11
12		RECOVERY ROOM	51		50	12
13		ANESTHESIOLOGY	53		141	13
14		LABORATORY	60		10	14
15		PHYSICAL THERAPY	66		20	15
16		EMERGENCY	91		90	16
17		GIFT, FLOWER, COFFEE SHOP & C	190		138	17
500 TOTAL RECLASSIFICATIONS CODE LETTER - K					423,322	500
1 IMPLANTS	L	OPERATING ROOM	50		2,870,712	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - L					2,870,712	500
1 NURSERY	M	ADULTS & PEDIATRICS	30	338,911	24,250	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - M				338,911	24,250	500
GRAND TOTAL (DECREASES)				1,016,542	16,979,891	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN 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	4,894,899					4,894,899		1
2 LAND IMPROVEMENTS	5,280,884					5,280,884		2
3 BUILDINGS AND FIXTURES	25,255,687	988,892	71,627	1,060,519		26,316,206		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	92,810,863	1,934,141		1,934,141	78,118	94,666,886		5
6 MOVABLE EQUIPMENT	52,777,398	1,943,253	3,737	1,946,990	2,653,528	52,070,860		6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	181,019,731	4,866,286	75,364	4,941,650	2,731,646	183,229,735		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	181,019,731	4,866,286	75,364	4,941,650	2,731,646	183,229,735		10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14)
1 CAP REL COSTS-BLDG & FIXT	3,446,864						3,446,864 1
2 CAP REL COSTS-MVBLE EQUIP	3,418,432						3,418,432 2
3 TOTAL (SUM OF LINES 1-2)	6,865,296						6,865,296 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL
								(SUM OF COLS. 5-7)
1 CAP REL COSTS-BLDG & FIXT								1
2 CAP REL COSTS-MVBLE EQUIP								2
3 TOTAL (SUM OF LINES 1-2)								3

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14)
1 CAP REL COSTS-BLDG & FIXT	3,416,247						3,416,247 1
2 CAP REL COSTS-MVBLE EQUIP	3,406,098						3,406,098 2
3 TOTAL	6,822,345						6,822,345 3

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 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)	A	-12,334	ADMINISTRATIVE & GENERAL	5	7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-1,585	OPERATION OF PLANT	7	8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,799,145			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1				12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-360,449	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-1,222	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES	B	-8,410	CAFETERIA	11	20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 DIRECTOR PHYSICIAN DEVELOPMENT					33
34 PT PHONE CAPITAL RELATED COST	A	-12,334	CAP REL COSTS-MVBLE EQUIP	2	9 34
35 NURSING REVENUE	B	-1,031	NURSING ADMINISTRATION	13	35
35.01 NEGATIVE SALVAGE VALUE	A	-2,271	CAP REL COSTS-BLDG & FIXT	1	9 35.01
35.04 VOLUNTEER SALARIES (632.186)	A	-284,937	ADMINISTRATIVE & GENERAL	5	35.04
35.07 MISC INCOME A&G	B	-16,242	ADMINISTRATIVE & GENERAL	5	35.07
35.10 OUTSIDE SERVICES PT	B	-14,848	PHYSICAL THERAPY	66	35.10
35.15 WEST TOWNS (958.729)	A	-584,958	ADMINISTRATIVE & GENERAL	5	35.15
35.19 EMPLOYEE DAY CARE REVENUE	B	-463,830	EMPLOYEE BENEFITS	4	35.19
35.20 PHYSICIAN EMPLOYEE BENEFITS	A	-26,297	EMPLOYEE BENEFITS	4	35.20
35.22 INTEREST	B	-389,779	ADMINISTRATIVE & GENERAL	5	35.22
35.23 DAY CARE DEPR ADDJ	A	-28,346	CAP REL COSTS-BLDG & FIXT	1	9 35.23
36 NON ALLOWABLE TAXES	A	-92,050	ADMINISTRATIVE & GENERAL	5	36
37 RADIOLOGY					37
38 AHA LOBBYING FEES	A	-8,935	ADMINISTRATIVE & GENERAL	5	38
39 IHHS LOBBYING COST					39
40 OB/GYN OTHER REV	B	-3,515	ADULTS & PEDIATRICS	30	40
41 ADVERTISING	A	-551,250	ADMINISTRATIVE & GENERAL	5	41
42					42
42.01 MED STAFF CONTRIBUTION ADD BACK	A	15,000	ADMINISTRATIVE & GENERAL	5	42.01
43					43
44					44
44.02 INTERDEPT RENT CONFERENCE	A	-58,332	ADMINISTRATIVE & GENERAL	5	44.02
44.03 INTERDEPT RENT AUDIOLOGY	A	-27,624	PHYSICAL THERAPY	66	44.03
44.05 INTERDEPT RENT OP PHARMACY	A	-58,566	OUTPATIENT PHARMACY	73.01	44.05
44.06 EMPLOYEE HEALTH CENTER	B	-3,285	EMPLOYEE BENEFITS	4	44.06
45					45
46					46
47					47

PROVIDER CCN: 14-0008 GOTTIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
01/31/2012 10:02

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
				COST CENTER 3	LINE NO. 4	
48						48
49						49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-4,796,575			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 (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1						1
2						2
3						3
4						4
5	TOTALS (SUM OF LINES 1-4)					5
	TRANSFER COL. 6, LINE 5 TO					
	WKST A-8, COL. 2, LINE 12.					

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 -----				
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
6						6
7						7
8						8
9						9
10						10

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
 - B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
 - C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
 - D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
 - E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
 - F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
 - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

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	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
LINE NO.	1	2	3	4	5	6	7	8	9
1	52	DELIVERY ROOM & LABOR RO	AGGREGATE						
			4,307	4,307					1
2	59	CARDIAC CATHETERIZATION	AGGREGATE						
			754	754					2
3	90.02	WOUND CARE	AGGREGATE						
			165,319	165,319					3
4	30	ADULTS & PEDIATRICS	OB COVERAGE						
			331,000	331,000					4
5	50	OPERATING ROOM	AGGREGATE						
			97,489	97,489					5
6	91	EMERGENCY	ER						
			33,997	33,997					6
7	5	ADMINISTRATIVE & GENERAL	MED ADMIN						
									7
8	60	LABORATORY	AGGREGATE						
			15,475	15,475					8
9	30	ADULTS & PEDIATRICS	MOONLIGHTERS						
			675,000	675,000					9
10	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE						
			750	750					10
11	50	OPERATING ROOM	TRAUMA CALL						
			372,250		372,250	208,000	8,525	852,500	42,625
12	53	ANESTHESIOLOGY	TRAUMA CALL						
			717,000		372,250	200,300	5,700	548,899	27,445
13	69	ELECTROCARDIOLOGY	CHAIR						
			32,000		32,000	177,200	229	19,509	975
14	40	SUBPROVIDER - IPF	DIRECTOR						
			42,000		42,000	154,100	300	22,226	1,111
15	30	ADULTS & PEDIATRICS	DIRECTOR						
			34,750		34,750	196,400	248	23,417	1,171
16	5	ADMINISTRATIVE & GENERAL	DIRECTOR						
			23,551		23,551	177,200	168	14,312	716
17	5	ADMINISTRATIVE & GENERAL	QA						
			149,400		149,400	177,200	1,067	90,900	4,545
18	30	ADULTS & PEDIATRICS	CHAIR						
			37,500		37,500	196,400	268	25,305	1,265
19	5	ADMINISTRATIVE & GENERAL	CHAIR						
			3,250		3,250	177,200	23	1,959	98
20	91	EMERGENCY	CHAIR						
			14,000		14,000	177,200	100	8,519	426
200		TOTAL	2,749,792	1,324,091	1,080,951		16,628	1,607,546	80,377

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 52	DELIVERY ROOM & LABOR RO	AGGREGATE						4,307	1
2 59	CARDIAC CATHETERIZATION	AGGREGATE						754	2
3 90.02	WOUND CARE	AGGREGATE						165,319	3
4 30	ADULTS & PEDIATRICS	OB COVERAGE						331,000	4
5 50	OPERATING ROOM	AGGREGATE						97,489	5
6 91	EMERGENCY	ER						33,997	6
7 5	ADMINISTRATIVE & GENERAL	MED ADMIN							7
8 60	LABORATORY	AGGREGATE						15,475	8
9 30	ADULTS & PEDIATRICS	MOONLIGHTERS						675,000	9
10 54	RADIOLOGY-DIAGNOSTIC	AGGREGATE						750	10
11 50	OPERATING ROOM	TRAUMA CALL				852,500			11
12 53	ANESTHESIOLOGY	TRAUMA CALL				548,899		344,750	12
13 69	ELECTROCARDIOLOGY	CHAIR				19,509	12,491	12,491	13
14 40	SUBPROVIDER - IPF	DIRECTOR				22,226	19,774	19,774	14
15 30	ADULTS & PEDIATRICS	DIRECTOR				23,417	11,333	11,333	15
16 5	ADMINISTRATIVE & GENERAL	DIRECTOR				14,312	9,239	9,239	16
17 5	ADMINISTRATIVE & GENERAL	QA				90,900	58,500	58,500	17
18 30	ADULTS & PEDIATRICS	CHAIR				25,305	12,195	12,195	18
19 5	ADMINISTRATIVE & GENERAL	CHAIR				1,959	1,291	1,291	19
20 91	EMERGENCY	CHAIR				8,519	5,481	5,481	20
200	TOTAL					1,607,546	130,304	1,799,145	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	NEW CAP- REL COSTS BLDG&FIXT 1	NEW CAP- REL COSTS MOV EQUIP 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	3,416,247	3,416,247				1
2 CAP REL COSTS-MVBLE EQUIP	3,406,098		3,406,098			2
4 EMPLOYEE BENEFITS	18,401,231	24,154	22,795	18,448,180		4
5 ADMINISTRATIVE & GENERAL	11,919,783	341,550	725,866	2,494,951	15,482,150	5
6 MAINTENANCE & REPAIRS	1,251,251	17,244	107,477	272,660	1,648,632	6
7 OPERATION OF PLANT	3,973,951	413,986	270,193	325,766	4,983,896	7
8 LAUNDRY & LINEN SERVICE	555,465	16,554		36,396	608,415	8
9 HOUSEKEEPING	2,114,400	15,405	14,281	384,207	2,528,293	9
10 DIETARY	1,225,553	88,688	28,715	218,979	1,561,935	10
11 CAFETERIA	596,501	78,209	3,544	98,089	776,343	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,560,827	44,411	10,753	490,339	2,106,330	13
14 CENTRAL SERVICES & SUPPLY	1,347,472	96,868	52,707	214,602	1,711,649	14
15 PHARMACY	2,228,642	37,174	4,582	682,470	2,952,868	15
16 MEDICAL RECORDS & LIBRARY	1,496,177	33,834	5,300	384,471	1,919,782	16
17 SOCIAL SERVICE	333,901	19,737	422	106,219	460,279	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	10,235,512	620,101	40,170	3,499,847	14,395,630	30
31 INTENSIVE CARE UNIT	4,055,306	133,111	41,760	1,529,808	5,759,985	31
40 SUBPROVIDER - IPF	857,347	45,596	3,471	291,832	1,198,246	40
43 NURSERY	363,161	15,659	4,037	139,505	522,362	43
44 SKILLED NURSING FACILITY	1,944,304	145,429	3,082	673,929	2,766,744	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,855,180	307,715	416,817	917,516	5,497,228	50
51 RECOVERY ROOM	416,754	18,357	353	138,695	574,159	51
52 DELIVERY ROOM & LABOR ROOM	1,378,671	68,685	40,472	460,621	1,948,449	52
53 ANESTHESIOLOGY	633,995	5,651	16,413	12,991	669,050	53
54 RADIOLOGY-DIAGNOSTIC	1,833,174	120,405	515,409	511,028	2,980,016	54
56 RADIOISOTOPE	565,046	23,016		2,348	590,410	56
56.01 ULTRASOUND	478,872	23,161	67,970	157,829	727,832	56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	1,081,381	43,164	220,689	205,566	1,550,800	57
59 CARDIAC CATHETERIZATION	1,094,140	24,964	322,337	220,559	1,662,000	59
60 LABORATORY	5,660,460	118,807	221,771	799,107	6,800,145	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,226,612	13,226	43,886	354,886	1,638,610	65
66 PHYSICAL THERAPY	1,978,825	132,094	12,853	688,332	2,812,104	66
69 ELECTROCARDIOLOGY	466,749	24,904	59,599	136,131	687,383	69
70 ELECTROENCEPHALOGRAPHY	96,269	12,621	416	30,454	139,760	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	7,312,715				7,312,715	71
72 IMPL. DEV. CHARGED TO PATIENT	2,870,712				2,870,712	72
73 DRUGS CHARGED TO PATIENTS	3,198,562				3,198,562	73
73.01 OUTPATIENT PHARMACY	1,886,438	24,033	1,612	117,988	2,030,071	73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	171,172	43,672	12,420	56,887	284,151	76.01
76.05 INPATIENT RENAL DIALYSIS	408,140			2	408,142	76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		1,113	520		1,633	90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE	676,581	24,904	12,590	106,581	820,656	90.02
91 EMERGENCY	3,496,470	166,437	81,648	888,251	4,632,806	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	1,945,972		18,599	627,273	2,591,844	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	366,815			84,764	451,579	116
118 SUBTOTALS (SUM OF LINES 1-117)	114,382,834	3,384,639	3,405,529	18,361,879	114,264,356	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	63,046	12,488	136	10,735	86,405	190
192 PHYSICIANS' PRIVATE OFFICES	10,882	19,120		3,074	33,076	192
192.01 NON-EMPLOYEE CHILD CARE CENTER	52,984			28,178	81,162	192.01

PROVIDER CCN: 14-0008 GOTTSLIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
01/31/2012 10:02

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

COST CENTER DESCRIPTION		NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	NEW CAP- REL COSTS BLDG&FIXT 1	NEW CAP- REL COSTS MOV EQUIP 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
193	NONPAID WORKERS	244,268		433	44,314	289,015	193
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	114,754,014	3,416,247	3,406,098	18,448,180	114,754,014	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINI- STRATIVE & GENERAL 5	MAINTEN- ANCE AND REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY AND LINEN SERVICE 8	HOUSE- KEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	15,482,150					5
6 MAINTENANCE & REPAIRS	257,116	1,905,748				6
7 OPERATION OF PLANT	777,273	335,973	6,097,142			7
8 LAUNDRY & LINEN SERVICE	94,887	391	38,904	742,597		8
9 HOUSEKEEPING	394,305	190,125	36,202		3,148,925	9
10 DIETARY	243,595	45,389	208,426	131	84,701	10
11 CAFETERIA	121,076	1,451	183,798		74,202	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	328,497	2,539	104,370		6,488	13
14 CENTRAL SERVICES & SUPPLY	266,944	90,360	227,651		47,659	14
15 PHARMACY	460,520	2,542	87,363		37,750	15
16 MEDICAL RECORDS & LIBRARY	299,403	2,193	79,514		22,060	16
17 SOCIAL SERVICE	71,784	199	46,383			17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,245,107	37,971	1,457,308	325,228	1,230,407	30
31 INTENSIVE CARE UNIT	898,310	12,021	312,824	55,075	132,124	31
40 SUBPROVIDER - IPF	186,875		107,156	36,096		40
43 NURSERY	81,466		36,799	5,774	28,902	43
44 SKILLED NURSING FACILITY	431,493	1,934	341,775	99,440	264,249	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	857,331	129,578	723,164	191,246	310,020	50
51 RECOVERY ROOM	89,544		43,141		29,964	51
52 DELIVERY ROOM & LABOR ROOM	303,874	7,514	161,417	10,618	60,518	52
53 ANESTHESIOLOGY	104,343	50,703	13,281		4,365	53
54 RADIOLOGY-DIAGNOSTIC	464,754	317,737	282,964	359	78,685	54
56 RADIOISOTOPE	92,079	118	54,090		31,262	56
56.01 ULTRASOUND	113,510	18,553	54,431	84	6,488	56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	241,858	274,087	101,440	196	34,565	57
59 CARDIAC CATHETERIZATION	259,201	72,539	58,669	369		59
60 LABORATORY	1,060,530	208,918	279,210		115,727	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	255,553	4,102	31,083		15,454	65
66 PHYSICAL THERAPY	438,567	2,467	310,435		176,009	66
69 ELECTROCARDIOLOGY	107,202	25,567	58,527		33,503	69
70 ELECTROENCEPHALOGRAPHY	21,797	2,308	29,661		3,421	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,140,469					71
72 IMPL. DEV. CHARGED TO PATIENT	447,708					72
73 DRUGS CHARGED TO PATIENTS	498,838					73
73.01 OUTPATIENT PHARMACY	316,604	125	56,479			73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	44,315	1,700	102,635		43,412	76.01
76.05 INPATIENT RENAL DIALYSIS	63,653					76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	255		2,616			90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE	127,987	1,175		346		90.02
91 EMERGENCY	722,519	60,865	391,144	17,635	112,306	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	404,216	3,945			145,573	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	70,427	579			6,606	116
118 SUBTOTALS (SUM OF LINES 1-117)	15,405,785	1,905,668	6,022,860	742,597	3,136,420	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,475	80	29,349			190
192 PHYSICIANS' PRIVATE OFFICES	5,158		44,933			192
192.01 NON-EMPLOYEE CHILD CARE CENTER	12,658				12,505	192.01
193 NONPAID WORKERS	45,074					193
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	15,482,150	1,905,748	6,097,142	742,597	3,148,925	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINI- STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10	11	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	2,144,177					10
11 CAFETERIA		1,156,870				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		25,468	2,573,692			13
14 CENTRAL SERVICES & SUPPLY		31,401		2,375,664		14
15 PHARMACY		43,617		2,033	3,586,693	15
16 MEDICAL RECORDS & LIBRARY		41,436				16
17 SOCIAL SERVICE		9,518		42		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,351,868	289,223	1,050,515	59,041	7,093	30
31 INTENSIVE CARE UNIT	228,929	87,160	316,584	19,461	5,292	31
40 SUBPROVIDER - IPF	150,042	28,850	104,790	10,429	1,244	40
43 NURSERY		8,502	30,880			43
44 SKILLED NURSING FACILITY	413,338	67,218	244,151			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		69,824	253,617	34,569	9,147	50
51 RECOVERY ROOM		7,855	28,530	13,816	166	51
52 DELIVERY ROOM & LABOR ROOM		30,292	110,026	7,018		52
53 ANESTHESIOLOGY		1,830	6,646	43,320	5,125	53
54 RADIOLOGY-DIAGNOSTIC		43,802		13,694	3,085	54
56 RADIOISOTOPE		517		1,311	221,875	56
56.01 ULTRASOUND		8,908		1,598	23	56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN		13,251		24,631	575	57
59 CARDIAC CATHETERIZATION		11,902			9,990	59
60 LABORATORY		83,593		7,594	43	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		30,828		26,930	23,579	65
66 PHYSICAL THERAPY		54,041		16,304	131	66
69 ELECTROCARDIOLOGY		13,399		5,649	670	69
70 ELECTROENCEPHALOGRAPHY		3,290		1,470		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				950,017		71
72 IMPL. DEV. CHARGED TO PATIENT				1,009,490		72
73 DRUGS CHARGED TO PATIENTS					3,112,386	73
73.01 OUTPATIENT PHARMACY		9,814		30,042		73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION		3,900		588		76.01
76.05 INPATIENT RENAL DIALYSIS						76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE		11,791		24,474	3,518	90.02
91 EMERGENCY		67,995	246,971	59,221	155,761	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		43,432	157,755	11,787	1,340	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE		6,395	23,227	1,135	25,650	116
118 SUBTOTALS (SUM OF LINES 1-117)	2,144,177	1,149,052	2,573,692	2,375,664	3,586,693	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		2,680				190
192 PHYSICIANS' PRIVATE OFFICES						192
192.01 NON-EMPLOYEE CHILD CARE CENTER						192.01
193 NONPAID WORKERS		5,138				193
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,144,177	1,156,870	2,573,692	2,375,664	3,586,693	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	2,364,388					16
17 SOCIAL SERVICE		588,205				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	377,514	373,538	23,200,443		23,200,443	30
31 INTENSIVE CARE UNIT	100,534	38,570	7,966,869		7,966,869	31
40 SUBPROVIDER - IPF	144,030	143,269	2,111,027		2,111,027	40
43 NURSERY	14,362		729,047		729,047	43
44 SKILLED NURSING FACILITY			4,630,342		4,630,342	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	378,745		8,454,469		8,454,469	50
51 RECOVERY ROOM	18,876		806,051		806,051	51
52 DELIVERY ROOM & LABOR ROOM	29,545		2,669,271		2,669,271	52
53 ANESTHESIOLOGY	38,572		937,235		937,235	53
54 RADIOLOGY-DIAGNOSTIC	66,886		4,251,982		4,251,982	54
56 RADIOISOTOPE	31,186		1,022,848		1,022,848	56
56.01 ULTRASOUND	17,645		949,072		949,072	56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	61,141		2,302,544		2,302,544	57
59 CARDIAC CATHETERIZATION	70,989		2,145,659		2,145,659	59
60 LABORATORY	206,402		8,762,162		8,762,162	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	76,324		2,102,463		2,102,463	65
66 PHYSICAL THERAPY	41,034		3,851,092		3,851,092	66
69 ELECTROCARDIOLOGY	52,113		984,013		984,013	69
70 ELECTROENCEPHALOGRAPHY	2,872		204,579		204,579	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	105,868		9,509,069		9,509,069	71
72 IMPL. DEV. CHARGED TO PATIENT			4,327,910		4,327,910	72
73 DRUGS CHARGED TO PATIENTS	414,033		7,223,819		7,223,819	73
73.01 OUTPATIENT PHARMACY			2,443,135		2,443,135	73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	1,231		481,932		481,932	76.01
76.05 INPATIENT RENAL DIALYSIS			471,795		471,795	76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	821		5,325		5,325	90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE			989,947		989,947	90.02
91 EMERGENCY	113,665	32,828	6,613,716		6,613,716	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY			3,359,892		3,359,892	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE			585,598		585,598	116
118 SUBTOTALS (SUM OF LINES 1-117)	2,364,388	588,205	114,093,306		114,093,306	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			131,989		131,989	190
192 PHYSICIANS' PRIVATE OFFICES			83,167		83,167	192
192.01 NON-EMPLOYEE CHILD CARE CENTER			106,325		106,325	192.01
193 NONPAID WORKERS			339,227		339,227	193
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,364,388	588,205	114,754,014		114,754,014	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP- REL COSTS BLDG&FIXT 1	NEW CAP- REL COSTS MOV EQUIP 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		24,154	22,795	46,949	46,949	4
5 ADMINISTRATIVE & GENERAL	54,069	341,550	725,866	1,121,485	6,351	5
6 MAINTENANCE & REPAIRS		17,244	107,477	124,721	694	6
7 OPERATION OF PLANT	589	413,986	270,193	684,768	829	7
8 LAUNDRY & LINEN SERVICE		16,554		16,554	93	8
9 HOUSEKEEPING	30,994	15,405	14,281	60,680	978	9
10 DIETARY	784	88,688	28,715	118,187	557	10
11 CAFETERIA		78,209	3,544	81,753	250	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		44,411	10,753	55,164	1,248	13
14 CENTRAL SERVICES & SUPPLY	277,780	96,868	52,707	427,355	546	14
15 PHARMACY	14,416	37,174	4,582	56,172	1,737	15
16 MEDICAL RECORDS & LIBRARY		33,834	5,300	39,134	979	16
17 SOCIAL SERVICE		19,737	422	20,159	270	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	174,589	620,101	40,170	834,860	8,897	30
31 INTENSIVE CARE UNIT	21,924	133,111	41,760	196,795	3,894	31
40 SUBPROVIDER - IPF		45,596	3,471	49,067	743	40
43 NURSERY		15,659	4,037	19,696	355	43
44 SKILLED NURSING FACILITY	16,649	145,429	3,082	165,160	1,716	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	59,193	307,715	416,817	783,725	2,336	50
51 RECOVERY ROOM	10,350	18,357	353	29,060	353	51
52 DELIVERY ROOM & LABOR ROOM	14,697	68,685	40,472	123,854	1,173	52
53 ANESTHESIOLOGY	11,407	5,651	16,413	33,471	33	53
54 RADIOLOGY-DIAGNOSTIC		120,405	515,409	635,814	1,301	54
56 RADIOISOTOPE		23,016		23,016	6	56
56.01 ULTRASOUND		23,161	67,970	91,131	402	56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN		43,164	220,689	263,853	523	57
59 CARDIAC CATHETERIZATION	18,169	24,964	322,337	365,470	561	59
60 LABORATORY	39,690	118,807	221,771	380,268	2,034	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	15,645	13,226	43,886	72,757	903	65
66 PHYSICAL THERAPY		132,094	12,853	144,947	1,752	66
69 ELECTROCARDIOLOGY		24,904	59,599	84,503	347	69
70 ELECTROENCEPHALOGRAPHY		12,621	416	13,037	78	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 OUTPATIENT PHARMACY		24,033	1,612	25,645	300	73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION		43,672	12,420	56,092	145	76.01
76.05 INPATIENT RENAL DIALYSIS						76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		1,113	520	1,633		90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE		24,904	12,590	37,494	271	90.02
91 EMERGENCY	107,545	166,437	81,648	355,630	2,261	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY			18,599	18,599	1,597	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	32,072			32,072	216	116
118 SUBTOTALS (SUM OF LINES 1-117)	900,562	3,384,639	3,405,529	7,690,730	46,729	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		12,488	136	12,624	27	190
192 PHYSICIANS' PRIVATE OFFICES		19,120		19,120	8	192
192.01 NON-EMPLOYEE CHILD CARE CENTER					72	192.01
193 NONPAID WORKERS			433	433	113	193
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	900,562	3,416,247	3,406,098	7,722,907	46,949	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINI- STRATIVE & GENERAL 5	MAINTEN- ANCE AND REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY AND LINEN SERVICE 8	HOUSE- KEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	1,127,836					5
6 MAINTENANCE & REPAIRS	18,730	144,145				6
7 OPERATION OF PLANT	56,622	25,410	767,629			7
8 LAUNDRY & LINEN SERVICE	6,912	30	4,898	28,487		8
9 HOUSEKEEPING	28,724	14,381	4,558		109,321	9
10 DIETARY	17,745	3,433	26,241	5	2,941	10
11 CAFETERIA	8,820	110	23,140		2,576	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	23,930	192	13,140		225	13
14 CENTRAL SERVICES & SUPPLY	19,446	6,835	28,661		1,655	14
15 PHARMACY	33,548	192	10,999		1,311	15
16 MEDICAL RECORDS & LIBRARY	21,811	166	10,011		766	16
17 SOCIAL SERVICE	5,229	15	5,840			17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	163,558	2,872	183,478	12,476	42,715	30
31 INTENSIVE CARE UNIT	65,439	909	39,384	2,113	4,587	31
40 SUBPROVIDER - IPF	13,613		13,491	1,385		40
43 NURSERY	5,935		4,633	221	1,003	43
44 SKILLED NURSING FACILITY	31,433	146	43,029	3,815	9,174	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	62,454	9,801	91,046	7,336	10,763	50
51 RECOVERY ROOM	6,523		5,431		1,040	51
52 DELIVERY ROOM & LABOR ROOM	22,136	568	20,322	407	2,101	52
53 ANESTHESIOLOGY	7,601	3,835	1,672		152	53
54 RADIOLOGY-DIAGNOSTIC	33,856	24,033	35,625	14	2,732	54
56 RADIOISOTOPE	6,708	9	6,810		1,085	56
56.01 ULTRASOUND	8,269	1,403	6,853	3	225	56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	17,619	20,731	12,771	8	1,200	57
59 CARDIAC CATHETERIZATION	18,882	5,487	7,386	14		59
60 LABORATORY	77,256	15,802	35,152		4,018	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	18,616	310	3,913		537	65
66 PHYSICAL THERAPY	31,948	187	39,084		6,110	66
69 ELECTROCARDIOLOGY	7,809	1,934	7,368		1,163	69
70 ELECTROENCEPHALOGRAPHY	1,588	175	3,734		119	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	83,080					71
72 IMPL. DEV. CHARGED TO PATIENT	32,614					72
73 DRUGS CHARGED TO PATIENTS	36,339					73
73.01 OUTPATIENT PHARMACY	23,064	9	7,111			73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	3,228	129	12,922		1,507	76.01
76.05 INPATIENT RENAL DIALYSIS	4,637					76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	19		329			90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE	9,323	89		13		90.02
91 EMERGENCY	52,633	4,604	49,245	677	3,899	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	29,446	298			5,054	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	5,130	44			229	116
118 SUBTOTALS (SUM OF LINES 1-117)	1,122,273	144,139	758,277	28,487	108,887	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	982	6	3,695			190
192 PHYSICIANS' PRIVATE OFFICES	376		5,657			192
192.01 NON-EMPLOYEE CHILD CARE CENTER	922				434	192.01
193 NONPAID WORKERS	3,283					193
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,127,836	144,145	767,629	28,487	109,321	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINI- STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10	11	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	169,109					10
11 CAFETERIA		116,649				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		2,568	96,467			13
14 CENTRAL SERVICES & SUPPLY		3,166		487,664		14
15 PHARMACY		4,398		417	108,774	15
16 MEDICAL RECORDS & LIBRARY		4,178				16
17 SOCIAL SERVICE		960		9		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	106,620	29,164	39,376	12,120	215	30
31 INTENSIVE CARE UNIT	18,055	8,789	11,866	3,995	160	31
40 SUBPROVIDER - IPF	11,834	2,909	3,928	2,141	38	40
43 NURSERY		857	1,157			43
44 SKILLED NURSING FACILITY	32,600	6,778	9,151			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		7,040	9,506	7,096	277	50
51 RECOVERY ROOM		792	1,069	2,836	5	51
52 DELIVERY ROOM & LABOR ROOM		3,054	4,124	1,441		52
53 ANESTHESIOLOGY		184	249	8,893	155	53
54 RADIOLOGY-DIAGNOSTIC		4,417		2,811	94	54
56 RADIOISOTOPE		52		269	6,729	56
56.01 ULTRASOUND		898		328	1	56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN		1,336		5,056	17	57
59 CARDIAC CATHETERIZATION		1,200			303	59
60 LABORATORY		8,429		1,559	1	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		3,108		5,528	715	65
66 PHYSICAL THERAPY		5,449		3,347	4	66
69 ELECTROCARDIOLOGY		1,351		1,160	20	69
70 ELECTROENCEPHALOGRAPHY		332		302		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				195,014		71
72 IMPL. DEV. CHARGED TO PATIENT				207,220		72
73 DRUGS CHARGED TO PATIENTS					94,390	73
73.01 OUTPATIENT PHARMACY		990		6,167		73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION		393		121		76.01
76.05 INPATIENT RENAL DIALYSIS						76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE		1,189		5,024	107	90.02
91 EMERGENCY		6,856	9,257	12,157	4,724	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		4,379	5,913	2,420	41	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE		645	871	233	778	116
118 SUBTOTALS (SUM OF LINES 1-117)	169,109	115,861	96,467	487,664	108,774	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		270				190
192 PHYSICIANS' PRIVATE OFFICES						192
192.01 NON-EMPLOYEE CHILD CARE CENTER						192.01
193 NONPAID WORKERS		518				193
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	169,109	116,649	96,467	487,664	108,774	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	77,045					16
17 SOCIAL SERVICE		32,482				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	12,302	20,627	1,469,280		1,469,280	30
31 INTENSIVE CARE UNIT	3,276	2,130	361,392		361,392	31
40 SUBPROVIDER - IPF	4,693	7,912	111,754		111,754	40
43 NURSERY	468		34,325		34,325	43
44 SKILLED NURSING FACILITY			303,002		303,002	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	12,342		1,003,722		1,003,722	50
51 RECOVERY ROOM	615		47,724		47,724	51
52 DELIVERY ROOM & LABOR ROOM	963		180,143		180,143	52
53 ANESTHESIOLOGY	1,257		57,502		57,502	53
54 RADIOLOGY-DIAGNOSTIC	2,180		742,877		742,877	54
56 RADIOISOTOPE	1,016		45,700		45,700	56
56.01 ULTRASOUND	575		110,088		110,088	56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	1,992		325,106		325,106	57
59 CARDIAC CATHETERIZATION	2,313		401,616		401,616	59
60 LABORATORY	6,726		531,245		531,245	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,487		108,874		108,874	65
66 PHYSICAL THERAPY	1,337		234,165		234,165	66
69 ELECTROCARDIOLOGY	1,698		107,353		107,353	69
70 ELECTROENCEPHALOGRAPHY	94		19,459		19,459	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	3,450		281,544		281,544	71
72 IMPL. DEV. CHARGED TO PATIENT			239,834		239,834	72
73 DRUGS CHARGED TO PATIENTS	13,490		144,219		144,219	73
73.01 OUTPATIENT PHARMACY			63,286		63,286	73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	40		74,577		74,577	76.01
76.05 INPATIENT RENAL DIALYSIS			4,637		4,637	76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	27		2,008		2,008	90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE			53,510		53,510	90.02
91 EMERGENCY	3,704	1,813	507,460		507,460	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY			67,747		67,747	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE			40,218		40,218	116
118 SUBTOTALS (SUM OF LINES 1-117)	77,045	32,482	7,674,367		7,674,367	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			17,604		17,604	190
192 PHYSICIANS' PRIVATE OFFICES			25,161		25,161	192
192.01 NON-EMPLOYEE CHILD CARE CENTER			1,428		1,428	192.01
193 NONPAID WORKERS			4,347		4,347	193
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	77,045	32,482	7,722,907		7,722,907	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	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	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	282,312					1
2 CAP REL COSTS-MVBLE EQUIP		3,239,397				2
4 EMPLOYEE BENEFITS	1,996	21,679	51,778,772			4
5 ADMINISTRATIVE & GENERAL	28,225	690,341	7,002,625	-15,482,150	99,271,864	5
6 MAINTENANCE & REPAIRS	1,425	102,217	765,281		1,648,632	6
7 OPERATION OF PLANT	34,211	256,969	914,333		4,983,896	7
8 LAUNDRY & LINEN SERVICE	1,368		102,153		608,415	8
9 HOUSEKEEPING	1,273	13,582	1,078,361		2,528,293	9
10 DIETARY	7,329	27,310	614,611		1,561,935	10
11 CAFETERIA	6,463	3,371	275,309		776,343	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	3,670	10,227	1,376,242		2,106,330	13
14 CENTRAL SERVICES & SUPPLY	8,005	50,127	602,326		1,711,649	14
15 PHARMACY	3,072	4,358	1,915,500		2,952,868	15
16 MEDICAL RECORDS & LIBRARY	2,796	5,041	1,079,103		1,919,782	16
17 SOCIAL SERVICE	1,631	401	298,126		460,279	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	51,244	38,204	9,823,015		14,395,630	30
31 INTENSIVE CARE UNIT	11,000	39,716	4,293,739		5,759,985	31
40 SUBPROVIDER - IPF	3,768	3,301	819,089		1,198,246	40
43 NURSERY	1,294	3,839	391,551		522,362	43
44 SKILLED NURSING FACILITY	12,018	2,931	1,891,528		2,766,744	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	25,429	396,417	2,575,208		5,497,228	50
51 RECOVERY ROOM	1,517	336	389,277		574,159	51
52 DELIVERY ROOM & LABOR ROOM	5,676	38,491	1,292,832		1,948,449	52
53 ANESTHESIOLOGY	467	15,610	36,463		669,050	53
54 RADIOLOGY-DIAGNOSTIC	9,950	490,184	1,434,312		2,980,016	54
56 RADIOISOTOPE	1,902		6,591		590,410	56
56.01 ULTRASOUND	1,914	64,643	442,982		727,832	56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	3,567	209,888	576,965		1,550,800	57
59 CARDIAC CATHETERIZATION	2,063	306,561	619,046		1,662,000	59
60 LABORATORY	9,818	210,917	2,242,869		6,800,145	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,093	41,738	996,066		1,638,610	65
66 PHYSICAL THERAPY	10,916	12,224	1,931,953		2,812,104	66
69 ELECTROCARDIOLOGY	2,058	56,682	382,080		687,383	69
70 ELECTROENCEPHALOGRAPHY	1,043	396	85,475		139,760	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					7,312,715	71
72 IMPL. DEV. CHARGED TO PATIENT					2,870,712	72
73 DRUGS CHARGED TO PATIENTS					3,198,562	73
73.01 OUTPATIENT PHARMACY	1,986	1,533	331,160		2,030,071	73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	3,609	11,812	159,667		284,151	76.01
76.05 INPATIENT RENAL DIALYSIS			7		408,142	76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	92	495			1,633	90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE	2,058	11,974	299,144		820,656	90.02
91 EMERGENCY	13,754	77,652	2,493,069		4,632,806	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		17,689	1,760,579		2,591,844	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE			237,910		451,579	116
118 SUBTOTALS (SUM OF LINES 1-117)	279,700	3,238,856	51,536,547	-15,482,150	98,782,206	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,032	129	30,131		86,405	190
192 PHYSICIANS' PRIVATE OFFICES	1,580		8,629		33,076	192
192.01 NON-EMPLOYEE CHILD CARE CENTER			79,089		81,162	192.01
193 NONPAID WORKERS		412	124,376		289,015	193

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 01/31/2012 10:02

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		NEW CAP- REL COSTS BLDG&FIXT SQUARE FEET 1	NEW CAP- REL COSTS MOV EQUIP (DOLLAR VALUE) 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINI- STRATIVE & GENERAL ACCUM COST 5	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	3,416,247	3,406,098	18,448,180		15,482,150	202
203	UNIT COST MULT-WS B PT I	12.100963	1.051461	0.356288		0.155957	203
204	COST TO BE ALLOC PER B PT II			46,949		1,127,836	204
205	UNIT COST MULT-WS B PT II			0.000907		0.011361	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAINTEN- ANCE AND REPAIRS MAINT REQS 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS	2,087,648					6
7 OPERATION OF PLANT	368,039	214,397				7
8 LAUNDRY & LINEN SERVICE	428	1,368	644,600			8
9 HOUSEKEEPING	208,272	1,273		26,693		9
10 DIETARY	49,721	7,329	114	718	151,422	10
11 CAFETERIA	1,590	6,463		629		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,781	3,670		55		13
14 CENTRAL SERVICES & SUPPLY	98,985	8,005		404		14
15 PHARMACY	2,785	3,072		320		15
16 MEDICAL RECORDS & LIBRARY	2,402	2,796		187		16
17 SOCIAL SERVICE	218	1,631				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	41,595	51,244	282,309	10,430	95,469	30
31 INTENSIVE CARE UNIT	13,168	11,000	47,807	1,120	16,167	31
40 SUBPROVIDER - IPF		3,768	31,333		10,596	40
43 NURSERY		1,294	5,012	245		43
44 SKILLED NURSING FACILITY	2,119	12,018	86,317	2,240	29,190	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	141,946	25,429	166,008	2,628		50
51 RECOVERY ROOM		1,517		254		51
52 DELIVERY ROOM & LABOR ROOM	8,231	5,676	9,217	513		52
53 ANESTHESIOLOGY	55,543	467		37		53
54 RADIOLOGY-DIAGNOSTIC	348,065	9,950	312	667		54
56 RADIOISOTOPE	129	1,902		265		56
56.01 ULTRASOUND	20,324	1,914	73	55		56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	300,248	3,567	170	293		57
59 CARDIAC CATHETERIZATION	79,463	2,063	320			59
60 LABORATORY	228,859	9,818		981		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	4,494	1,093		131		65
66 PHYSICAL THERAPY	2,703	10,916		1,492		66
69 ELECTROCARDIOLOGY	28,007	2,058		284		69
70 ELECTROENCEPHALOGRAPHY	2,528	1,043		29		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 OUTPATIENT PHARMACY	137	1,986				73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	1,862	3,609		368		76.01
76.05 INPATIENT RENAL DIALYSIS						76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		92				90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE	1,287		300			90.02
91 EMERGENCY	66,675	13,754	15,308	952		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	4,322			1,234		101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	634			56		116
118 SUBTOTALS (SUM OF LINES 1-117)	2,087,560	211,785	644,600	26,587	151,422	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	88	1,032				190
192 PHYSICIANS' PRIVATE OFFICES		1,580				192
192.01 NON-EMPLOYEE CHILD CARE CENTER				106		192.01
193 NONPAID WORKERS						193

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		MAINTEN- ANCE AND REPAIRS MAINT REQS 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,905,748	6,097,142	742,597	3,148,925	2,144,177	202
203	UNIT COST MULT-WS B PT I	0.912868	28.438560	1.152028	117.968194	14.160274	203
204	COST TO BE ALLOC PER B PT II	144,145	767,629	28,487	109,321	169,109	204
205	UNIT COST MULT-WS B PT II	0.069047	3.580409	0.044193	4.095493	1.116806	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA (FTES SERVED) 11	NURSING ADMINI- STRATION (DIRECT NRSG HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS) 14	PHARMACY (COSTED REQUIS) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	62,595					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,378	38,339				13
14 CENTRAL SERVICES & SUPPLY	1,699		9,253,424			14
15 PHARMACY	2,360		7,920	3,313,519		15
16 MEDICAL RECORDS & LIBRARY	2,242		1		5,762	16
17 SOCIAL SERVICE	515		162			17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	15,649	15,649	229,969	6,553	920	30
31 INTENSIVE CARE UNIT	4,716	4,716	75,801	4,889	245	31
40 SUBPROVIDER - IPF	1,561	1,561	40,622	1,149	351	40
43 NURSERY	460	460			35	43
44 SKILLED NURSING FACILITY	3,637	3,637				44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,778	3,778	134,650	8,450	923	50
51 RECOVERY ROOM	425	425	53,813	153	46	51
52 DELIVERY ROOM & LABOR ROOM	1,639	1,639	27,335		72	52
53 ANESTHESIOLOGY	99	99	168,735	4,735	94	53
54 RADIOLOGY-DIAGNOSTIC	2,370		53,338	2,850	163	54
56 RADIOISOTOPE	28		5,106	204,976	76	56
56.01 ULTRASOUND	482		6,224	21	43	56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	717		95,940	531	149	57
59 CARDIAC CATHETERIZATION	644			9,229	173	59
60 LABORATORY	4,523		29,579	40	503	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,668		104,893	21,783	186	65
66 PHYSICAL THERAPY	2,924		63,506	121	100	66
69 ELECTROCARDIOLOGY	725		22,003	619	127	69
70 ELECTROENCEPHALOGRAPHY	178		5,724		7	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			3,700,393		258	71
72 IMPL. DEV. CHARGED TO PATIENT			3,932,069			72
73 DRUGS CHARGED TO PATIENTS				2,875,338	1,009	73
73.01 OUTPATIENT PHARMACY	531		117,018			73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	211		2,291		3	76.01
76.05 INPATIENT RENAL DIALYSIS						76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC					2	90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE	638		95,330	3,250		90.02
91 EMERGENCY	3,679	3,679	230,672	143,898	277	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	2,350	2,350	45,910	1,238		101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	346	346	4,420	23,696		116
118 SUBTOTALS (SUM OF LINES 1-117)	62,172	38,339	9,253,424	3,313,519	5,762	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	145					190
192 PHYSICIANS' PRIVATE OFFICES						192
192.01 NON-EMPLOYEE CHILD CARE CENTER						192.01
193 NONPAID WORKERS	278					193

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COST ALLOCATION - STATISTICAL BASIS

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COST CENTER DESCRIPTION		CAFETERIA (FTES SERVED) 11	NURSING ADMINI- STRATION (DIRECT NRSG HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS) 14	PHARMACY (COSTED REQUIS) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,156,870	2,573,692	2,375,664	3,586,693	2,364,388	202
203	UNIT COST MULT-WS B PT I	18.481828	67.129868	0.256734	1.082442	410.341548	203
204	COST TO BE ALLOC PER B PT II	116,649	96,467	487,664	108,774	77,045	204
205	UNIT COST MULT-WS B PT II	1.863551	2.516158	0.052701	0.032827	13.371225	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	SOCIAL SERVICE	I/R-SALARY AND FRINGES (ASSIGNED TIME)	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)	
	(TIME SPENT) 17	21	22	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE	8,708			17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SRVCES-SALARY & FRINGES APPRVD		100		21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			100	22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	5,530	1	1	30
31 INTENSIVE CARE UNIT	571			31
40 SUBPROVIDER - IPF	2,121			40
43 NURSERY				43
44 SKILLED NURSING FACILITY				44
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM				50
51 RECOVERY ROOM				51
52 DELIVERY ROOM & LABOR ROOM				52
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC				54
56 RADIOISOTOPE				56
56.01 ULTRASOUND				56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN				57
59 CARDIAC CATHETERIZATION				59
60 LABORATORY				60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY				65
66 PHYSICAL THERAPY				66
69 ELECTROCARDIOLOGY				69
70 ELECTROENCEPHALOGRAPHY				70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				71
72 IMPL. DEV. CHARGED TO PATIENT				72
73 DRUGS CHARGED TO PATIENTS				73
73.01 OUTPATIENT PHARMACY				73.01
76 LITHOTRIPSY				76
76.01 CARDIAC REHABILITATION				76.01
76.05 INPATIENT RENAL DIALYSIS				76.05
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC				90
90.01 OUTPATIENT INFUSION PROCEDURES				90.01
90.02 WOUND CARE				90.02
91 EMERGENCY	486	99	99	91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
99.10 CORF				99.10
99.20 OUTPATIENT PHYSICAL THERAPY				99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40 OUTPATIENT SPEECH PATHOLOGY				99.40
101 HOME HEALTH AGENCY				101
SPECIAL PURPOSE COST CENTERS				
116 HOSPICE				116
118 SUBTOTALS (SUM OF LINES 1-117)	8,708	100	100	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
192 PHYSICIANS' PRIVATE OFFICES				192
192.01 NON-EMPLOYEE CHILD CARE CENTER				192.01
193 NONPAID WORKERS				193

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	SOCIAL SERVICE (TIME SPENT) 17	I/R-SALARY AND FRINGES (ASSIGNED TIME) 21	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME) 22	
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 COST TO BE ALLOC PER B PT I	588,205			202
203 UNIT COST MULT-WS B PT I	67.547657			203
204 COST TO BE ALLOC PER B PT II	32,482			204
205 UNIT COST MULT-WS B PT II	3.730133			205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL	RCE	TOTAL	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT	COSTS	DISALLOWANCE	COSTS	
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	23,200,443		23,200,443	23,528	23,223,971	30
31 INTENSIVE CARE UNIT	7,966,869		7,966,869		7,966,869	31
40 SUBPROVIDER - IPF	2,111,027		2,111,027	19,774	2,130,801	40
43 NURSERY	729,047		729,047		729,047	43
44 SKILLED NURSING FACILITY	4,630,342		4,630,342		4,630,342	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	8,454,469		8,454,469		8,454,469	50
51 RECOVERY ROOM	806,051		806,051		806,051	51
52 DELIVERY ROOM & LABOR ROOM	2,669,271		2,669,271		2,669,271	52
53 ANESTHESIOLOGY	937,235		937,235		937,235	53
54 RADIOLOGY-DIAGNOSTIC	4,251,982		4,251,982		4,251,982	54
56 RADIOISOTOPE	1,022,848		1,022,848		1,022,848	56
56.01 ULTRASOUND	949,072		949,072		949,072	56.01
57 COMPUTED TOMOGRAPHY (CT) SC	2,302,544		2,302,544		2,302,544	57
59 CARDIAC CATHETERIZATION	2,145,659		2,145,659		2,145,659	59
60 LABORATORY	8,762,162		8,762,162		8,762,162	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						
65 RESPIRATORY THERAPY	2,102,463		2,102,463		2,102,463	65
66 PHYSICAL THERAPY	3,851,092		3,851,092		3,851,092	66
69 ELECTROCARDIOLOGY	984,013		984,013	12,491	996,504	69
70 ELECTROENCEPHALOGRAPHY	204,579		204,579		204,579	70
71 MEDICAL SUPPLIES CHRGED TO	9,509,069		9,509,069		9,509,069	71
72 IMPL. DEV. CHARGED TO PATIE	4,327,910		4,327,910		4,327,910	72
73 DRUGS CHARGED TO PATIENTS	7,223,819		7,223,819		7,223,819	73
73.01 OUTPATIENT PHARMACY	2,443,135		2,443,135		2,443,135	73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	481,932		481,932		481,932	76.01
76.05 INPATIENT RENAL DIALYSIS	471,795		471,795		471,795	76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	5,325		5,325		5,325	90
90.01 OUTPATIENT INFUSION PROCEDU						90.01
90.02 WOUND CARE	989,947		989,947		989,947	90.02
91 EMERGENCY	6,613,716		6,613,716	5,481	6,619,197	91
92 OBSERVATION BEDS	720,276		720,276		720,276	92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	3,359,892		3,359,892		3,359,892	101
116 HOSPICE	585,598		585,598		585,598	116
200 SUBTOTAL (SEE INSTRUCTIONS)	114,813,582		114,813,582	61,274	114,874,856	200
201 LESS OBSERVATION BEDS	720,276		720,276		720,276	201
202 TOTAL (SEE INSTRUCTIONS)	114,093,306		114,093,306	61,274	114,154,580	202

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 (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	63,630,087		63,630,087			30
31 INTENSIVE CARE UNIT	19,933,500		19,933,500			31
40 SUBPROVIDER - IPF	6,982,969		6,982,969			40
43 NURSERY	2,245,377		2,245,377			43
44 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	6,626,114		6,626,114			44
50 OPERATING ROOM	20,795,795	18,321,071	39,116,866	0.216134	0.216134	0.216134 50
51 RECOVERY ROOM	2,928,449	2,064,887	4,993,336	0.161425	0.161425	0.161425 51
52 DELIVERY ROOM & LABOR ROOM	5,430,172	834,505	6,264,677	0.426083	0.426083	0.426083 52
53 ANESTHESIOLOGY	5,773,496	4,403,203	10,176,699	0.092096	0.092096	0.092096 53
54 RADIOLOGY-DIAGNOSTIC	5,821,632	13,240,144	19,061,776	0.223063	0.223063	0.223063 54
56 RADIOISOTOPE	2,143,619	4,036,688	6,180,307	0.165501	0.165501	0.165501 56
56.01 ULTRASOUND	3,041,251	7,909,790	10,951,041	0.086665	0.086665	0.086665 56.01
57 COMPUTED TOMOGRAPHY (CT) SC	13,311,602	35,504,160	48,815,762	0.047168	0.047168	0.047168 57
59 CARDIAC CATHETERIZATION	23,039,223	9,365,491	32,404,714	0.066214	0.066214	0.066214 59
60 LABORATORY	44,245,797	37,496,878	81,742,675	0.107192	0.107192	0.107192 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	12,658,782	906,020	13,564,802	0.154994	0.154994	0.154994 65
66 PHYSICAL THERAPY	12,921,925	8,547,564	21,469,489	0.179375	0.179375	0.179375 66
69 ELECTROCARDIOLOGY	10,408,528	13,035,508	23,444,036	0.041973	0.041973	0.042506 69
70 ELECTROENCEPHALOGRAPHY	394,287	1,108,861	1,503,148	0.136100	0.136100	0.136100 70
71 MEDICAL SUPPLIES CHRGD TO	51,300,158	22,289,275	73,589,433	0.129218	0.129218	0.129218 71
72 IMPL. DEV. CHARGED TO PATIE	10,417,083	5,324,295	15,741,378	0.274938	0.274938	0.274938 72
73 DRUGS CHARGED TO PATIENTS	96,982,312	16,611,015	113,593,327	0.063594	0.063594	0.063594 73
73.01 OUTPATIENT PHARMACY		2,103,078	2,103,078	1.161695	1.161695	1.161695 73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	265	765,523	765,788	0.629328	0.629328	0.629328 76.01
76.05 INPATIENT RENAL DIALYSIS	3,400,030	79,499	3,479,529	0.135592	0.135592	0.135592 76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		163,124	163,124	0.032644	0.032644	0.032644 90
90.01 OUTPATIENT INFUSION PROCEDU						90.01
90.02 WOUND CARE	13,722	4,035,999	4,049,721	0.244448	0.244448	0.244448 90.02
91 EMERGENCY	13,421,719	28,253,065	41,674,784	0.158698	0.158698	0.158830 91
92 OBSERVATION BEDS	1,216,545	6,463,812	7,680,357	0.093782	0.093782	0.093782 92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		3,891,321	3,891,321			101
116 HOSPICE	150,616	948,791	1,099,407			116
200 SUBTOTAL (SEE INSTRUCTIONS)	439,235,055	247,703,567	686,938,622			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	439,235,055	247,703,567	686,938,622			202

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 01/31/2012 10:02

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	CAP-REL COST	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT (COL.1 MINUS COL.2)	(COL.1 MINUS COL.2)	(COL.3 + COL.4)	PGM DAYS	(COL.5 x COL.6)	
	1	2	3	5	6	7	
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	1,469,280		1,469,280	49.00	15,624	765,576	30
31 INTENSIVE CARE UNIT	361,392		361,392	74.16	2,680	198,749	31
32 CORONARY CARE UNIT							32
33 BURN INTENSIVE CARE UNIT							33
34 SURGICAL INTENSIVE CARE UNIT							34
35 OTHER SPECIAL CARE (SPECIFY)							35
40 SUBPROVIDER - IPF	111,754		111,754	34.68	2,985	103,520	40
41 SUBPROVIDER - IRF							41
42 SUBPROVIDER I							42
43 NURSERY	34,325		34,325	22.93			43
44 SKILLED NURSING FACILITY	303,002		303,002	32.46	7,527	244,326	44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	2,279,753		2,279,753		28,816	1,312,171	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0008) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX [] IRF

COST CENTER DESCRIPTION	CAP-REL	TOTAL	RATIO OF	INPATIENT	CAPITAL	
	COST	CHARGES	COST TO			
	(FROM WKST	(FROM WKST	CHARGES	PROGRAM	(COL. 3 x	
	B, PT. II,	C, PT. I,	(COL.1 +	CHARGES	COL.4)	
	COL. 26)	COL. 8)	COL.2)			
	1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,003,722	39,116,866	0.025660	7,165,707	183,872	50
51 RECOVERY ROOM	47,724	4,993,336	0.009558	2,070,890	19,794	51
52 DELIVERY ROOM & LABOR ROOM	180,143	6,264,677	0.028755	23,425	674	52
53 ANESTHESIOLOGY	57,502	10,176,699	0.005650	2,124,421	12,003	53
54 RADIOLOGY-DIAGNOSTIC	742,877	19,061,776	0.038972	5,034,320	196,198	54
56 RADIOISOTOPE	45,700	6,180,307	0.007394	1,173,829	8,679	56
56.01 ULTRASOUND	110,088	10,951,041	0.010053	1,144,770	11,508	56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	325,106	48,815,762	0.006660	7,433,587	49,508	57
59 CARDIAC CATHETERIZATION	401,616	32,404,714	0.012394	6,191,475	76,737	59
60 LABORATORY	531,245	81,742,675	0.006499	24,006,426	156,018	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						
65 RESPIRATORY THERAPY	108,874	13,564,802	0.008026	6,176,488	49,572	65
66 PHYSICAL THERAPY	234,165	21,469,489	0.010907	3,070,355	33,488	66
69 ELECTROCARDIOLOGY	107,353	23,444,036	0.004579	6,243,580	28,589	69
70 ELECTROENCEPHALOGRAPHY	19,459	1,503,148	0.012945	217,816	2,820	70
71 MEDICAL SUPPLIES CHRGED TO PA	281,544	73,589,433	0.003826	35,310,725	135,099	71
72 IMPL. DEV. CHARGED TO PATIENT	239,834	15,741,378	0.015236	5,378,114	81,941	72
73 DRUGS CHARGED TO PATIENTS	144,219	113,593,327	0.001270	45,607,889	57,922	73
73.01 OUTPATIENT PHARMACY	63,286	2,103,078	0.030092			73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	74,577	765,788	0.097386			76.01
76.05 INPATIENT RENAL DIALYSIS	4,637	3,479,529	0.001333			76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	2,008	163,124	0.012310			90
90.01 OUTPATIENT INFUSION PROCEDURE						90.01
90.02 WOUND CARE	53,510	4,049,721	0.013213	1,793	24	90.02
91 EMERGENCY	507,460	41,674,784	0.012177	7,853,906	95,637	91
92 OBSERVATION BEDS	45,569	7,680,357	0.005933			92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	5,332,218	582,529,847	582,529,847	166,229,516	1,200,083	200

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
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APPORIONMENT 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	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
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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	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	29,986		15,624		30
31 INTENSIVE CARE UNIT	4,873		2,680		31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF	3,222		2,985		40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY	1,497				43
44 SKILLED NURSING FACILITY	9,336		7,527		44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	48,914		28,816		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5	COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
56 RADIOISOTOPE						56
56.01 ULTRASOUND						56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGD TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 OUTPATIENT PHARMACY						73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION						76.01
76.05 INPATIENT RENAL DIALYSIS						76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
90.01 OUTPATIENT INFUSION PROCEDURE						90.01
90.02 WOUND CARE						90.02
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[XX] HOSPITAL (14-0008)	[] SUB (OTHER)	[] ICF/MR	[] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	39,116,866			7,165,707		3,807,597	50
51 RECOVERY ROOM	4,993,336			2,070,890		1,510,221	51
52 DELIVERY ROOM & LABOR ROOM	6,264,677			23,425		4,802	52
53 ANESTHESIOLOGY	10,176,699			2,124,421		1,201,255	53
54 RADIOLOGY-DIAGNOSTIC	19,061,776			5,034,320		4,322,280	54
56 RADIOISOTOPE	6,180,307			1,173,829		1,318,062	56
56.01 ULTRASOUND	10,951,041			1,144,770		921,230	56.01
57 COMPUTED TOMOGRAPHY (CT) SCA	48,815,762			7,433,587		9,451,606	57
59 CARDIAC CATHETERIZATION	32,404,714			6,191,475		4,403,849	59
60 LABORATORY	81,742,675			24,006,426		1,302,055	60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	13,564,802			6,176,488		856,707	65
66 PHYSICAL THERAPY	21,469,489			3,070,355		89,227	66
69 ELECTROCARDIOLOGY	23,444,036			6,243,580		3,267,703	69
70 ELECTROENCEPHALOGRAPHY	1,503,148			217,816		102,138	70
71 MEDICAL SUPPLIES CHRGED TO P	73,589,433			35,310,725		9,238,265	71
72 IMPL. DEV. CHARGED TO PATIEN	15,741,378			5,378,114		1,769,646	72
73 DRUGS CHARGED TO PATIENTS	113,593,327			45,607,889		6,035,155	73
73.01 OUTPATIENT PHARMACY	2,103,078						73.01
76 LITHOTRIPSY							76
76.01 CARDIAC REHABILITATION	765,788						76.01
76.05 INPATIENT RENAL DIALYSIS	3,479,529						76.05
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	163,124					11,943	90
90.01 OUTPATIENT INFUSION PROCEDUR							90.01
90.02 WOUND CARE	4,049,721			1,793		573,181	90.02
91 EMERGENCY	41,674,784			7,853,906		6,268,072	91
92 OBSERVATION BEDS	7,680,357					1,698,877	92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	582,529,847			166,229,516		58,153,871	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0008) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS			
	COST TO CHARGE FROM WKST C, PT I, COL. 9	RATIO	PPS REIMBURSED SERVICES	COST REIMB. SERVICES SUBJECT TO DED & COINS	COST REIMB. SVCS NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SUBJECT TO DED & COINS	COST SVCS NOT SUBJECT TO DED & COINS
	1		2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.216134		3,807,597			822,951		50
51 RECOVERY ROOM	0.161425		1,510,221			243,787		51
52 DELIVERY ROOM & LABOR ROOM	0.426083		4,802			2,046		52
53 ANESTHESIOLOGY	0.092096		1,201,255			110,631		53
54 RADIOLOGY-DIAGNOSTIC	0.223063		4,322,280			964,141		54
56 RADIOISOTOPE	0.165501		1,318,062			218,141		56
56.01 ULTRASOUND	0.086665		921,230			79,838		56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.047168		9,451,606			445,813		57
59 CARDIAC CATHETERIZATION	0.066214		4,403,849			291,596		59
60 LABORATORY	0.107192		1,302,055			139,570		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65 RESPIRATORY THERAPY	0.154994		856,707			132,784		65
66 PHYSICAL THERAPY	0.179375		89,227			16,005		66
69 ELECTROCARDIOLOGY	0.041973		3,267,703			137,155		69
70 ELECTROENCEPHALOGRAPHY	0.136100		102,138			13,901		70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.129218		9,238,265			1,193,750		71
72 IMPL. DEV. CHARGED TO PATIENT	0.274938		1,769,646			486,543		72
73 DRUGS CHARGED TO PATIENTS	0.063594		6,035,155		13,081	383,800		73
73.01 OUTPATIENT PHARMACY	1.161695							73.01
76 LITHOTRIPSY								76
76.01 CARDIAC REHABILITATION	0.629328							76.01
76.05 INPATIENT RENAL DIALYSIS	0.135592							76.05
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
90 CLINIC	0.032644		11,943			390		90
90.01 OUTPATIENT INFUSION PROCEDURES								90.01
90.02 WOUND CARE	0.244448		573,181			140,113		90.02
91 EMERGENCY	0.158698		6,268,072			994,730		91
92 OBSERVATION BEDS	0.093782		1,698,877			159,324		92
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)			58,153,871		13,081	6,977,009		832 200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)			58,153,871		13,081	6,977,009		832 202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S008) [] TEFRA
 BOXES [] TITLE XIX [] IRF

COST CENTER DESCRIPTION	CAP-REL	TOTAL	RATIO OF	INPATIENT PROGRAM CHARGES	CAPITAL	
	COST (FROM WKST B, PT. II, COL. 26)	CHARGES (FROM WKST C, PT. I, COL. 8)	COST TO CHARGES (COL.1 ÷ COL.2)		(COL.3 x COL.4)	
	1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,003,722	39,116,866	0.025660			50
51 RECOVERY ROOM	47,724	4,993,336	0.009558	24,267	232	51
52 DELIVERY ROOM & LABOR ROOM	180,143	6,264,677	0.028755			52
53 ANESTHESIOLOGY	57,502	10,176,699	0.005650			53
54 RADIOLOGY-DIAGNOSTIC	742,877	19,061,776	0.038972	37,022	1,443	54
56 RADIOISOTOPE	45,700	6,180,307	0.007394	2,343	17	56
56.01 ULTRASOUND	110,088	10,951,041	0.010053	6,806	68	56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	325,106	48,815,762	0.006660	103,658	690	57
59 CARDIAC CATHETERIZATION	401,616	32,404,714	0.012394	410	5	59
60 LABORATORY	531,245	81,742,675	0.006499	508,761	3,306	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	108,874	13,564,802	0.008026	20,493	164	65
66 PHYSICAL THERAPY	234,165	21,469,489	0.010907	21,290	232	66
69 ELECTROCARDIOLOGY	107,353	23,444,036	0.004579	18,816	86	69
70 ELECTROENCEPHALOGRAPHY	19,459	1,503,148	0.012945	36,670	475	70
71 MEDICAL SUPPLIES CHRGED TO PA	281,544	73,589,433	0.003826	64,134	245	71
72 IMPL. DEV. CHARGED TO PATIENT	239,834	15,741,378	0.015236			72
73 DRUGS CHARGED TO PATIENTS	144,219	113,593,327	0.001270	1,650,908	2,097	73
73.01 OUTPATIENT PHARMACY	63,286	2,103,078	0.030092			73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	74,577	765,788	0.097386			76.01
76.05 INPATIENT RENAL DIALYSIS	4,637	3,479,529	0.001333			76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	2,008	163,124	0.012310			90
90.01 OUTPATIENT INFUSION PROCEDURE						90.01
90.02 WOUND CARE	53,510	4,049,721	0.013213			90.02
91 EMERGENCY	507,460	41,674,784	0.012177	47,862	583	91
92 OBSERVATION BEDS	45,569	7,680,357	0.005933			92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	5,332,218	582,529,847	582,529,847	2,543,440	9,643	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S008) [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5	COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
56 RADIOISOTOPE						56
56.01 ULTRASOUND						56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGD TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 OUTPATIENT PHARMACY						73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION						76.01
76.05 INPATIENT RENAL DIALYSIS						76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
90.01 OUTPATIENT INFUSION PROCEDURE						90.01
90.02 WOUND CARE						90.02
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[] HOSPITAL	[] SUB (OTHER)	[] ICF/MR	[] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[XX] IPF (14-S008)	[] SNF		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	39,116,866						50
51 RECOVERY ROOM	4,993,336			24,267			51
52 DELIVERY ROOM & LABOR ROOM	6,264,677						52
53 ANESTHESIOLOGY	10,176,699						53
54 RADIOLOGY-DIAGNOSTIC	19,061,776			37,022			54
56 RADIOISOTOPE	6,180,307			2,343			56
56.01 ULTRASOUND	10,951,041			6,806			56.01
57 COMPUTED TOMOGRAPHY (CT) SCA	48,815,762			103,658			57
59 CARDIAC CATHETERIZATION	32,404,714			410			59
60 LABORATORY	81,742,675			508,761			60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	13,564,802			20,493			65
66 PHYSICAL THERAPY	21,469,489			21,290			66
69 ELECTROCARDIOLOGY	23,444,036			18,816			69
70 ELECTROENCEPHALOGRAPHY	1,503,148			36,670			70
71 MEDICAL SUPPLIES CHRGED TO P	73,589,433			64,134			71
72 IMPL. DEV. CHARGED TO PATIEN	15,741,378						72
73 DRUGS CHARGED TO PATIENTS	113,593,327			1,650,908			73
73.01 OUTPATIENT PHARMACY	2,103,078						73.01
76 LITHOTRIPSY							76
76.01 CARDIAC REHABILITATION	765,788						76.01
76.05 INPATIENT RENAL DIALYSIS	3,479,529						76.05
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	163,124						90
90.01 OUTPATIENT INFUSION PROCEDUR							90.01
90.02 WOUND CARE	4,049,721						90.02
91 EMERGENCY	41,674,784			47,862			91
92 OBSERVATION BEDS	7,680,357						92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	582,529,847			2,543,440			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [XX] IPF (14-S008) [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE FROM PT I, COL. 9	PPS REIMBURSED SERVICES	COST REIMB. SERVICES DED & COINS	COST REIMB. SVCS NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SUBJECT TO DED & COINS	COST SVCS NOT SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.216134						50
51 RECOVERY ROOM	0.161425						51
52 DELIVERY ROOM & LABOR ROOM	0.426083						52
53 ANESTHESIOLOGY	0.092096						53
54 RADIOLOGY-DIAGNOSTIC	0.223063						54
56 RADIOISOTOPE	0.165501						56
56.01 ULTRASOUND	0.086665						56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.047168						57
59 CARDIAC CATHETERIZATION	0.066214						59
60 LABORATORY	0.107192						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.154994						65
66 PHYSICAL THERAPY	0.179375						66
69 ELECTROCARDIOLOGY	0.041973						69
70 ELECTROENCEPHALOGRAPHY	0.136100						70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.129218						71
72 IMPL. DEV. CHARGED TO PATIENT	0.274938						72
73 DRUGS CHARGED TO PATIENTS	0.063594						73
73.01 OUTPATIENT PHARMACY	1.161695						73.01
76 LITHOTRIPSY							76
76.01 CARDIAC REHABILITATION	0.629328						76.01
76.05 INPATIENT RENAL DIALYSIS	0.135592						76.05
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.032644						90
90.01 OUTPATIENT INFUSION PROCEDURES							90.01
90.02 WOUND CARE	0.244448						90.02
91 EMERGENCY	0.158698						91
92 OBSERVATION BEDS	0.093782						92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-5526) [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
56 RADIOISOTOPE						56
56.01 ULTRASOUND						56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGD TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 OUTPATIENT PHARMACY						73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION						76.01
76.05 INPATIENT RENAL DIALYSIS						76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
90.01 OUTPATIENT INFUSION PROCEDURE						90.01
90.02 WOUND CARE						90.02
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[] HOSPITAL	[] SUB (OTHER)	[] ICF/MR	[] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[XX] SNF (14-5526)		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT PGM	O/P PGM		
	CHARGES (FROM WKST C, PT. I, COL. 8)	COST TO CHARGES (COL. 5 ÷ COL. 7)	OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	PASS-THRU COSTS (COL. 8 x COL. 10)	PASS-THRU COSTS (COL. 9 x COL. 12)	
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	39,116,866					50
51	RECOVERY ROOM	4,993,336					51
52	DELIVERY ROOM & LABOR ROOM	6,264,677					52
53	ANESTHESIOLOGY	10,176,699		24,774			53
54	RADIOLOGY-DIAGNOSTIC	19,061,776		222,821			54
56	RADIOISOTOPE	6,180,307		31,212			56
56.01	ULTRASOUND	10,951,041		44,860			56.01
57	COMPUTED TOMOGRAPHY (CT) SCA	48,815,762					57
59	CARDIAC CATHETERIZATION	32,404,714		24,872			59
60	LABORATORY	81,742,675		1,801,129			60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	13,564,802		556,391			65
66	PHYSICAL THERAPY	21,469,489		6,255,634			66
69	ELECTROCARDIOLOGY	23,444,036		84,579			69
70	ELECTROENCEPHALOGRAPHY	1,503,148		16,165			70
71	MEDICAL SUPPLIES CHRGED TO P	73,589,433		2,930,050			71
72	IMPL. DEV. CHARGED TO PATIEN	15,741,378					72
73	DRUGS CHARGED TO PATIENTS	113,593,327		5,487,745			73
73.01	OUTPATIENT PHARMACY	2,103,078					73.01
76	LITHOTRIPSY						76
76.01	CARDIAC REHABILITATION	765,788					76.01
76.05	INPATIENT RENAL DIALYSIS	3,479,529					76.05
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	163,124					90
90.01	OUTPATIENT INFUSION PROCEDUR						90.01
90.02	WOUND CARE	4,049,721					90.02
91	EMERGENCY	41,674,784					91
92	OBSERVATION BEDS	7,680,357					92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	582,529,847		17,480,232			200

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 01/31/2012 10:02

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	CAP-REL	REDUCED	TOTAL	PER	INPAT	INPAT PGM	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)	PATIENT DAYS	DIEM (COL.3 + COL.4)	PGM DAYS	CAP COST (COL.5 x COL.6)
	1	2	3	4	5	6	7
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS							30
31 INTENSIVE CARE UNIT							31
32 CORONARY CARE UNIT							32
33 BURN INTENSIVE CARE UNIT							33
34 SURGICAL INTENSIVE CARE UNIT							34
35 OTHER SPECIAL CARE (SPECIFY)							35
40 SUBPROVIDER - IPF							40
41 SUBPROVIDER - IRF							41
42 SUBPROVIDER I							42
43 NURSERY							43
44 SKILLED NURSING FACILITY							44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)							200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0008) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [XX] OTHER

COST CENTER DESCRIPTION	CAP-REL	TOTAL	RATIO OF	INPATIENT PROGRAM CHARGES	CAPITAL
	COST (FROM WKST B, PT. II, COL. 26) 1	CHARGES (FROM WKST C, PT. I, COL. 8) 2	COST TO CHARGES (COL.1 ÷ COL.2) 3		(COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
51 RECOVERY ROOM					51
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
56 RADIOISOTOPE					56
56.01 ULTRASOUND					56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
59 CARDIAC CATHETERIZATION					59
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
69 ELECTROCARDIOLOGY					69
70 ELECTROENCEPHALOGRAPHY					70
71 MEDICAL SUPPLIES CHRGED TO PA					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
73.01 OUTPATIENT PHARMACY					73.01
76 LITHOTRIPSY					76
76.01 CARDIAC REHABILITATION					76.01
76.05 INPATIENT RENAL DIALYSIS					76.05
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
90.01 OUTPATIENT INFUSION PROCEDURE					90.01
90.02 WOUND CARE					90.02
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)					200

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 01/31/2012 10:02

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	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
01/31/2012 10:02

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	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5	COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
56 RADIOISOTOPE						56
56.01 ULTRASOUND						56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGD TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 OUTPATIENT PHARMACY						73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION						76.01
76.05 INPATIENT RENAL DIALYSIS						76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
90.01 OUTPATIENT INFUSION PROCEDURE						90.01
90.02 WOUND CARE						90.02
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	39,116,866						50
51 RECOVERY ROOM	4,993,336						51
52 DELIVERY ROOM & LABOR ROOM	6,264,677						52
53 ANESTHESIOLOGY	10,176,699						53
54 RADIOLOGY-DIAGNOSTIC	19,061,776						54
56 RADIOISOTOPE	6,180,307						56
56.01 ULTRASOUND	10,951,041						56.01
57 COMPUTED TOMOGRAPHY (CT) SCA	48,815,762						57
59 CARDIAC CATHETERIZATION	32,404,714						59
60 LABORATORY	81,742,675						60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	13,564,802						65
66 PHYSICAL THERAPY	21,469,489						66
69 ELECTROCARDIOLOGY	23,444,036						69
70 ELECTROENCEPHALOGRAPHY	1,503,148						70
71 MEDICAL SUPPLIES CHRGED TO P	73,589,433						71
72 IMPL. DEV. CHARGED TO PATIEN	15,741,378						72
73 DRUGS CHARGED TO PATIENTS	113,593,327						73
73.01 OUTPATIENT PHARMACY	2,103,078						73.01
76 LITHOTRIPSY							76
76.01 CARDIAC REHABILITATION	765,788						76.01
76.05 INPATIENT RENAL DIALYSIS	3,479,529						76.05
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	163,124						90
90.01 OUTPATIENT INFUSION PROCEDUR							90.01
90.02 WOUND CARE	4,049,721						90.02
91 EMERGENCY	41,674,784						91
92 OBSERVATION BEDS	7,680,357						92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	582,529,847						200

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0008) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	29,986	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	29,986	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	29,986	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	15,624	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	23,223,971	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	23,223,971	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	64,345,156	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	64,345,156	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.360928	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	2,145.84	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	23,223,971	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0008) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 774.49 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 12,100,632 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 12,100,632 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT	7,966,869	4,873	1,634.90	2,680	4,381,532	43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					18,831,806	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					35,313,970	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 964,325 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 1,200,083 51
 52 TOTAL PROGRAM EXCLUDABLE COST 2,164,408 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 33,149,562 53

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

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 930 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 774.49 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 720,276 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	1,469,280	23,223,971	0.063266	720,276	45,569	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S008) [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,222	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,222	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,222	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,985	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,130,801	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,130,801	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,130,801	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S008) [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	661.33 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	1,974,070 39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)	40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	1,974,070 41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	206,267 48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	2,180,337 49
PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	103,520 50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	9,643 51
52	TOTAL PROGRAM EXCLUDABLE COST	113,163 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	2,067,174 53
TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES	54
55	TARGET AMOUNT PER DISCHARGE	55
56	TARGET AMOUNT (LINE 54 x LINE 55)	56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	57
58	BONUS PAYMENT (SEE INSTRUCTIONS)	58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET	59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E	61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)	62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	63
PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)	67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)	68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)	69

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-5526) [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	9,336	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	9,336	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	9,336	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	7,527	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	4,630,342	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,630,342	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	4,630,342	37

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
01/31/2012 10:02

WORKSHEET D-1
PARTS III & IV

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-5526) [] TEFRA
BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

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

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COSTS (LINE 37)	4,630,342	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	495.97	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	3,733,166	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (LINE 14 x LINE 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (LINE 72 + LINE 73)	3,733,166	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (FROM WKST B, PART II, COL. 26, LINE 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (LINE 75 ÷ LINE 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (LINE 9 x LINE 76)		77
78	INPATIENT ROUTINE SERVICE COST (LINE 74 MINUS LINE 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (FROM PROVIDER RECORDS)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (LINE 78 MINUS LINE 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (LINE 9 x LINE 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (SEE INSTRUCTIONS)	3,733,166	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	2,197,447	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	5,930,613	86

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0008) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	29,986	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	29,986	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	29,986	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	4,012	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	1,497	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	789	16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	23,200,443	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	23,200,443	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	64,345,156	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	64,345,156	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.360562	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	2,145.84	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	23,200,443	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0008) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 773.71 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 3,104,125 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 3,104,125 41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (COL. 1 ÷ COL. 2)	PROGRAM DAYS	PROGRAM COST (COL. 3 x COL. 4)
	1	2	3	4	5
42 NURSERY (TITLES V AND XIX ONLY)	729,047	1,497	487.01	789	384,251 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	7,966,869	4,873	1,634.90	182	297,552 43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					3,785,928 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 51
 52 TOTAL PROGRAM EXCLUDABLE COST 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53

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

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 930 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	ROUTINE COST (FROM LINE 27)	COL. 1 ÷ COL. 2	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)
	1	2	3	4
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST				
90 CAPITAL-RELATED COST				90
91 NURSING SCHOOL COST				91
92 ALLIED HEALTH COST				92
93 ALL OTHER MEDICAL EDUCATION				93

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-0008) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		34,435,537		30
31 INTENSIVE CARE UNIT		10,872,760		31
40 SUBPROVIDER - IPF				40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.216134	7,165,707	1,548,753	50
51 RECOVERY ROOM	0.161425	2,070,890	334,293	51
52 DELIVERY ROOM & LABOR ROOM	0.426083	23,425	9,981	52
53 ANESTHESIOLOGY	0.092096	2,124,421	195,651	53
54 RADIOLOGY-DIAGNOSTIC	0.223063	5,034,320	1,122,971	54
56 RADIOISOTOPE	0.165501	1,173,829	194,270	56
56.01 ULTRASOUND	0.086665	1,144,770	99,211	56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.047168	7,433,587	350,627	57
59 CARDIAC CATHETERIZATION	0.066214	6,191,475	409,962	59
60 LABORATORY	0.107192	24,006,426	2,573,297	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.154994	6,176,488	957,319	65
66 PHYSICAL THERAPY	0.179375	3,070,355	550,745	66
69 ELECTROCARDIOLOGY	0.042506	6,243,580	265,390	69
70 ELECTROENCEPHALOGRAPHY	0.136100	217,816	29,645	70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.129218	35,310,725	4,562,781	71
72 IMPL. DEV. CHARGED TO PATIENT	0.274938	5,378,114	1,478,648	72
73 DRUGS CHARGED TO PATIENTS	0.063594	45,607,889	2,900,388	73
73.01 OUTPATIENT PHARMACY	1.161695			73.01
76 LITHOTRIPSY				76
76.01 CARDIAC REHABILITATION	0.629328			76.01
76.05 INPATIENT RENAL DIALYSIS	0.135592			76.05
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.032644			90
90.01 OUTPATIENT INFUSION PROCEDURES				90.01
90.02 WOUND CARE	0.244448	1,793	438	90.02
91 EMERGENCY	0.158830	7,853,906	1,247,436	91
92 OBSERVATION BEDS	0.093782			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		166,229,516	18,831,806	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		166,229,516		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S008) [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
40 SUBPROVIDER - IPF		6,572,511		40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.216134			50
51 RECOVERY ROOM	0.161425	24,267	3,917	51
52 DELIVERY ROOM & LABOR ROOM	0.426083			52
53 ANESTHESIOLOGY	0.092096			53
54 RADIOLOGY-DIAGNOSTIC	0.223063	37,022	8,258	54
56 RADIOISOTOPE	0.165501	2,343	388	56
56.01 ULTRASOUND	0.086665	6,806	590	56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.047168	103,658	4,889	57
59 CARDIAC CATHETERIZATION	0.066214	410	27	59
60 LABORATORY	0.107192	508,761	54,535	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.154994	20,493	3,176	65
66 PHYSICAL THERAPY	0.179375	21,290	3,819	66
69 ELECTROCARDIOLOGY	0.042506	18,816	800	69
70 ELECTROENCEPHALOGRAPHY	0.136100	36,670	4,991	70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.129218	64,134	8,287	71
72 IMPL. DEV. CHARGED TO PATIENT	0.274938			72
73 DRUGS CHARGED TO PATIENTS	0.063594	1,650,908	104,988	73
73.01 OUTPATIENT PHARMACY	1.161695			73.01
76 LITHOTRIPSY				76
76.01 CARDIAC REHABILITATION	0.629328			76.01
76.05 INPATIENT RENAL DIALYSIS	0.135592			76.05
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.032644			90
90.01 OUTPATIENT INFUSION PROCEDURES				90.01
90.02 WOUND CARE	0.244448			90.02
91 EMERGENCY	0.158830	47,862	7,602	91
92 OBSERVATION BEDS	0.093782			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		2,543,440	206,267	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		2,543,440		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-5526) [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
40 SUBPROVIDER - IPF				40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.216134			50
51 RECOVERY ROOM	0.161425			51
52 DELIVERY ROOM & LABOR ROOM	0.426083			52
53 ANESTHESIOLOGY	0.092096	24,774	2,282	53
54 RADIOLOGY-DIAGNOSTIC	0.223063	222,821	49,703	54
56 RADIOISOTOPE	0.165501	31,212	5,166	56
56.01 ULTRASOUND	0.086665	44,860	3,888	56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.047168			57
59 CARDIAC CATHETERIZATION	0.066214	24,872	1,647	59
60 LABORATORY	0.107192	1,801,129	193,067	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.154994	556,391	86,237	65
66 PHYSICAL THERAPY	0.179375	6,255,634	1,122,104	66
69 ELECTROCARDIOLOGY	0.041973	84,579	3,550	69
70 ELECTROENCEPHALOGRAPHY	0.136100	16,165	2,200	70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.129218	2,930,050	378,615	71
72 IMPL. DEV. CHARGED TO PATIENT	0.274938			72
73 DRUGS CHARGED TO PATIENTS	0.063594	5,487,745	348,988	73
73.01 OUTPATIENT PHARMACY	1.161695			73.01
76 LITHOTRIPSY				76
76.01 CARDIAC REHABILITATION	0.629328			76.01
76.05 INPATIENT RENAL DIALYSIS	0.135592			76.05
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.032644			90
90.01 OUTPATIENT INFUSION PROCEDURES				90.01
90.02 WOUND CARE	0.244448			90.02
91 EMERGENCY	0.158698			91
92 OBSERVATION BEDS	0.093782			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		17,480,232	2,197,447	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		17,480,232		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-0008) [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS
	1	2	(COL.1 x COL.2) 3
INPATIENT ROUTINE SERVICE COST CENTERS			
30 ADULTS & PEDIATRICS			30
31 INTENSIVE CARE UNIT			31
40 SUBPROVIDER - IPF			40
43 NURSERY			43
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM	0.216134		50
51 RECOVERY ROOM	0.161425		51
52 DELIVERY ROOM & LABOR ROOM	0.426083		52
53 ANESTHESIOLOGY	0.092096		53
54 RADIOLOGY-DIAGNOSTIC	0.223063		54
56 RADIOISOTOPE	0.165501		56
56.01 ULTRASOUND	0.086665		56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.047168		57
59 CARDIAC CATHETERIZATION	0.066214		59
60 LABORATORY	0.107192		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY	0.154994		65
66 PHYSICAL THERAPY	0.179375		66
69 ELECTROCARDIOLOGY	0.041973		69
70 ELECTROENCEPHALOGRAPHY	0.136100		70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.129218		71
72 IMPL. DEV. CHARGED TO PATIENT	0.274938		72
73 DRUGS CHARGED TO PATIENTS	0.063594		73
73.01 OUTPATIENT PHARMACY	1.161695		73.01
76 LITHOTRIPSY			76
76.01 CARDIAC REHABILITATION	0.629328		76.01
76.05 INPATIENT RENAL DIALYSIS	0.135592		76.05
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
90 CLINIC	0.032644		90
90.01 OUTPATIENT INFUSION PROCEDURES			90.01
90.02 WOUND CARE	0.244448		90.02
91 EMERGENCY	0.158698		91
92 OBSERVATION BEDS	0.093782		92
OTHER REIMBURSABLE COST CENTERS			
200 TOTAL (SUM OF LINES 50-94 AND 96-98)			200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES			201
202 NET CHARGES (LINE 200 MINUS LINE 201)			202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

CHECK [XX] HOSPITAL (14-0008)
 APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	24,465,976	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	870,871	2
3	MANAGED CARE SIMULATED PAYMENTS	3,790,238	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	206.45	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)	2.54	5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.	0.57	7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)	1.97	9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	4.57	10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)	1.97	12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	1.10	13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	1.19	14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	1.42	15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT	1.42	18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)	0.006878	19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)	0.005097	20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)	0.005097	21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	78,609	22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)	2.60	24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)	78,609	29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0367	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.1407	31
32	SUM OF LINES 30 AND 31	0.1774	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0428	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	1,047,144	34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	26,462,600	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	26,462,600	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	2,044,363	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0008)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)	51,776	52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	28,558,739	59
60	PRIMARY PAYER PAYMENTS	3,900	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	28,554,839	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	2,360,420	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	181,606	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	521,829	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	365,280	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	243,861	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	26,378,093	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	26,378,093	71
72	INTERIM PAYMENTS	25,984,933	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	393,160	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: [] HOSPITAL [XX] IPF (14-S008) [] IRF
 [] SUB (OTHER) [] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)		21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)		30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)		32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)		40
41	INTERIM PAYMENTS		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (14-0008) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A PART B

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		25,781,223		5,662,113	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.	.01 03/04/2011	152,520			3.01
	.02 06/24/2011	51,190	06/24/2011	1,355	3.02
	PROGRAM .03				3.03
	TO .04				3.04
	PROVIDER .05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE	03/04/2011	233	3.50
	.51				3.51
	PROVIDER .52				3.52
	TO .53				3.53
	PROGRAM .54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
	.99	203,710		1,122	3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		25,984,933		5,663,235	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE		NONE	5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50	NONE		NONE	5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
	.99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01			248,228	6.01
	TO .01				
	PROVIDER .02				
	TO .02	-25,984,933			6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				5,911,463	7

8 NAME OF CONTRACTOR: _____ CONTRACTOR NUMBER: _____ DATE: _____

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [XX] IPF (14-S008) [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		2,412,621		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		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.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE	NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		2,412,621		4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE	NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM	16,904		6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		2,429,525		7

8 NAME OF CONTRACTOR: _____ CONTRACTOR NUMBER: _____ DATE: _____

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] IPF [XX] SNF (14-5526)
 BOX: [] IRF [] SWING BED SNF

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3,384,434		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.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE	NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		3,384,434		4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE	NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM			6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		3,384,434		7

8 NAME OF CONTRACTOR: _____ CONTRACTOR NUMBER: _____ DATE: _____

PROVIDER CCN: 14-0008 GOTTlieb MEMORIAL HOSPITAL
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
01/31/2012 10:02

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK
APPLICABLE BOX

HOSPITAL (14-0008) CAH

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	6,701 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	18,304 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	2,733 3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	33,929 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	686,938,622 5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	23,341,315 6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30	INITIAL/INTERIM HIT PAYMENT(S)	30
31	OTHER ADJUSTMENTS (SPECIFY)	31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART II

CHECK [] HOSPITAL
APPLICABLE BOX: [XX] IPF (14-S008)

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (EXCLUDING OUTLIER, ECT, AND MEDICAL EDUCATION PAYMENTS)	2,522,088	1
2	NET IPF PPS OUTLIER PAYMENT		2
3	NET IPF PPS ECT PAYMENT		3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004 (SEE INSTRUCTIONS)		4
5	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTEs IN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		8
9	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	8.827397	9
10	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{(1 + (\text{LINE 8}/\text{LINE 9})) \text{ RAISED TO THE POWER OF } .5150 - 1\}$		10
11	MEDICAL EDUCATION ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1, 2, 3 AND 11)	2,522,088	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		15
16	SUBTOTAL (SEE INSTRUCTIONS)	2,522,088	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (LINE 16 LESS LINE 17)	2,522,088	18
19	DEDUCTIBLES	90,124	19
20	SUBTOTAL (LINE 18 MINUS LINE 19)	2,431,964	20
21	COINSURANCE	19,343	21
22	SUBTOTAL (LINE 20 MINUS LINE 21)	2,412,621	22
23	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	24,148	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	16,904	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	11,953	25
26	SUBTOTAL (SUM OF LINES 22 AND 24)	2,429,525	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		27
28	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	2,429,525	31
32	INTERIM PAYMENTS	2,412,621	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS THE SUM OF LINES 32 AND 33)	16,904	34
35	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

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

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VI

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

1	PROSPECTIVE PAYMENT AMOUNT		
2	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	3,611,982	1
3	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
4	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
5	SUBTOTAL (SUM OF LINES 1-3)	3,611,982	4
6	COMPUTATION OF NET COST OF COVERED SERVICES		
7	MEDICAL AND OTHER SERVICES		5
8	DEDUCTIBLES		6
9	COINSURANCE	227,548	7
10	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		8
11	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		9
12	ALLOWABLE REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		10
13	UTILIZATION REVIEW		11
14	SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS)	3,384,434	12
15	INPATIENT PRIMARY PAYER PAYMENTS		13
16	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		14
17	SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	3,384,434	15
18	INTERIM PAYMENTS	3,384,434	16
19	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		17
20	BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS THE SUM OF LINES 16 AND 17)		18
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (14-0008) [] SNF [] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [XX] OTHER
 [] SUB (OTHER)

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

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	3,785,928 1
2	MEDICAL AND OTHER SERVICES	2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	3,785,928 4
5	INPATIENT PRIMARY PAYER PAYMENTS	5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	3,785,928 7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	8
9	ANCILLARY SERVICE CHARGES	9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION	11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	12
CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000 15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	3,785,928 18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16)	21
PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS	22
23	OUTLIER PAYMENTS	23
24	PROGRAM CAPITAL PAYMENTS	24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)	25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)	27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)	28
29	SUM OF LINES 27 AND 21	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)	31
32	DEDUCTIBLES	32
33	COINSURANCE	33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	34
35	UTILIZATION REVIEW	35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	40
41	INTERIM PAYMENTS	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	43

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

WORKSHEET E-4

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

COMPUTATION OF TOTAL DIRECT GME AMOUNT			
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996		1.54 1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)		2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA		3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		0.23 3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))		4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		4.02
5	FTE ADJUSTMENT CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)		1.31 5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)		4.57 6
7	ENTER THE LESSER OF LINE 5 OR LINE 6		1.31 7
		PRIMARY CARE 1	TOTAL 3
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	3.16	1.41 4.57 8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	0.91	0.40 1.31 9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		10
11	TOTAL WEIGHTED FTE COUNT	0.91	0.40 11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)	1.10	12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)	1.19	13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)	1.07	0.13 14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	1.07	0.13 17
18	PER RESIDENT AMOUNT	78,373.19	78,373.19 18
19	APPROVED AMOUNT FOR RESIDENT COSTS	83,859	10,189 94,048 19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)		20
21	GME FTE WEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		3.26 21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)		22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)		23
24	MULTIPLY LINE 22 TIMES LINE 23		24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)		94,048 25
COMPUTATION OF PROGRAM PATIENT LOAD			
		INPATIENT PART A	MANAGED CARE
26	INPATIENT DAYS	21,289	2,733 26
27	TOTAL INPATIENT DAYS	37,151	37,151 27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.573040	0.073565 28
29	PROGRAM DIRECT GME AMOUNT	53,893	6,919 29
30	REDUCTION FOR NURSING/ALLIED HEALTH		978 30
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			
31	NET PROGRAM DIRECT GME AMOUNT		59,834 31
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)		32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)		33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)		34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)		35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)		36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME			
PART A REASONABLE COST			
37	REASONABLE COST (SEE INSTRUCTIONS)		44,839,455 37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)		38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		3,900 40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)		44,835,555 41
PART B REASONABLE COST			
42	REASONABLE COST (SEE INSTRUCTIONS)		6,977,841 42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)		6,977,841 44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)		51,813,396 45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)		0.865327 46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)		0.134673 47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B			
48	TOTAL PROGRAM GME PAYMENT (LINE 31)		59,834 48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)		51,776 49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)		8,058 50

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

WORKSHEET E-4

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

1	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996				1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA				3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)				3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))				4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)				4.02
5	FTE ADJUSTMENT CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)				5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)				6
7	ENTER THE LESSER OF LINE 5 OR LINE 6				7
		PRIMARY CARE	OTHER	TOTAL	
		1	2	3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR				8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6				9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR				10
11	TOTAL WEIGHTED FTE COUNT				11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)				12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)				13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)				14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS				15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				16
17	ADJUSTED ROLLING AVERAGE FTE COUNT				17
18	PER RESIDENT AMOUNT				18
19	APPROVED AMOUNT FOR RESIDENT COSTS				19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE WEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)				25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT	MANAGED		
		PART A	CARE		
26	INPATIENT DAYS				26
27	TOTAL INPATIENT DAYS	4,194			27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.112891			28
29	PROGRAM DIRECT GME AMOUNT				29
30	REDUCTION FOR NURSING/ALLIED HEALTH				30
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
31	NET PROGRAM DIRECT GME AMOUNT				31
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)				33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	PART A REASONABLE COST				
37	REASONABLE COST (SEE INSTRUCTIONS)				37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)				38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)				39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)				40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)				41
	PART B REASONABLE COST				
42	REASONABLE COST (SEE INSTRUCTIONS)				42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)				43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)				44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)				45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)				46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)				47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (LINE 31)				48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)				49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)				50

BALANCE SHEET

WORKSHEET G

ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	1	2	3	4	
CURRENT ASSETS					
1 CASH ON HAND AND IN BANKS	37,677,018				1
2 TEMPORARY INVESTMENTS					2
3 NOTES RECEIVABLE					3
4 ACCOUNTS RECEIVABLE	14,350,998				4
5 OTHER RECEIVABLES					5
6 ALLOWANCE FOR UNCOLLECTIBLE					
NOTES & ACCOUNTS RECEIVABLE	-2,000,500				6
7 INVENTORY	2,759,414				7
8 PREPAID EXPENSES	3,167,018				8
9 OTHER CURRENT ASSETS	10,169,302				9
10 DUE FROM OTHER FUNDS					10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	66,123,250				11
FIXED ASSETS					
12 LAND	4,894,899				12
13 LAND IMPROVEMENTS	5,280,884				13
14 ACCUMULATED DEPRECIATION	-4,930,924				14
15 BUILDINGS	26,316,205				15
16 ACCUMULATED DEPRECIATION	-22,792,557				16
17 LEASEHOLD IMPROVEMENTS					17
18 ACCUMULATED AMORTIZATION					18
19 FIXED EQUIPMENT	94,666,886				19
20 ACCUMULATED DEPRECIATION	-63,403,315				20
21 AUTOMOBILES AND TRUCKS					21
22 ACCUMULATED DEPRECIATION					22
23 MAJOR MOVABLE EQUIPMENT	52,766,624				23
24 ACCUMULATED DEPRECIATION	-40,424,573				24
25 MINOR EQUIPMENT DEPRECIABLE	39,017				25
26 ACCUMULATED DEPRECIATION	-22,709				26
27 HIT DESIGNATED ASSETS					27
28 ACCUMULATED DEPRECIATION					28
29 MINOR EQUIPMENT-NONDEPRECIABLE					29
30 TOTAL FIXED ASSETS (SUM OF LINES 12-29)	52,390,437				30
OTHER ASSETS					
31 INVESTMENTS					31
32 DEPOSITS ON LEASES					32
33 DUE FROM OWNERS/OFFICERS					33
34 OTHER ASSETS	553,421				34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	553,421				35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	119,067,108				36
LIABILITIES AND FUND BALANCES					
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	1	2	3	4	
CURRENT LIABILITIES					
37 ACCOUNTS PAYABLE	8,252,106				37
38 SALARIES, WAGES & FEES PAYABLE	6,030,429				38
39 PAYROLL TAXES PAYABLE	1,584,595				39
40 NOTES & LOANS PAYABLE (SHORT TERM)	18,048,865				40
41 DEFERRED INCOME					41
42 ACCELERATED PAYMENTS					42
43 DUE TO OTHER FUNDS	15,500,000				43
44 OTHER CURRENT LIABILITIES	890,669				44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	50,306,664				45
LONG-TERM LIABILITIES					
46 MORTGAGE PAYABLE					46
47 NOTES PAYABLE					47
48 UNSECURED LOANS					48
49 OTHER LONG TERM LIABILITIES	10,016,722				49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	10,016,722				50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	60,323,386				51
CAPITAL ACCOUNTS					
52 GENERAL FUND BALANCE	58,743,722				52
53 SPECIFIC PURPOSE FUND BALANCE					53
54 DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED					54
55 DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED					55
56 GOVERNING BODY CREATED - ENDOWMENT FUND BAL					56
57 PLANT FUND BALANCE - INVESTED IN PLANT					57
58 PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION					58
59 TOTAL FUND BALANCES (SUM OF LINES 52-58)	58,743,722				59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	119,067,108				60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		35,911,790							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		-4,125,105							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		31,786,685							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		31,786,685							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)		-26,957,037							12
13									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		-26,957,037							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		58,743,722							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	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	65,664,405		65,664,405	2
3 SUBPROVIDER IPF	6,982,074		6,982,074	3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY	6,445,454		6,445,454	7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	79,091,933		79,091,933	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	19,741,411		19,741,411	12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	19,741,411		19,741,411	17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	98,833,344		98,833,344	18
19 ANCILLARY SERVICES	370,157,825	240,248,768	610,406,593	19
20 OUTPATIENT SERVICES				20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY		3,891,321	3,891,321	23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
28 OTHER (SPECIFY)				28
TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	468,991,169	244,140,089	713,131,258	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		119,550,589	29
30 ADD (SPECIFY)			30
31 BAD DEBTS	7,648,974		31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		7,648,974	36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		127,199,563	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	713,131,258	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	590,056,800	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	123,074,458	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	127,199,563	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-4,125,105	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF 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		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (DAY CARE)		24
24.01	OTHER (REFERENCE LAB)		24.01
24.02	OTHER (MISCELLANEOUS)		24.02
24.03	OTHER (GAIN ON DISPOSALS)		24.03
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)		25
26	TOTAL (LINE 5 PLUS LINE 25)	-4,125,105	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	-4,125,105	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7255

WORKSHEET H

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR- TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF (COLS.1-5) 6
GENERAL SERVICE COST CENTER						
1 CAPITAL RELATED-BLDGS & FIXTURES						1
2 CAPITAL RELATED-MOVABLE EQUIPMENT						2
3 PLANT OPERATION & MAINTENANCE						3
4 TRANSPORTATION (SEE INSTRUCTIONS)						4
5 ADMINISTRATIVE AND GENERAL	432,748		41,067		74,513	548,328
HHA REIMBURSABLE SERVICES						
6 SKILLED NURSING CARE	796,477					796,477
7 PHYSICAL THERAPY	392,326					392,326
8 OCCUPATIONAL THERAPY	32,033					32,033
9 SPEECH PATHOLOGY	681					681
10 MEDICAL SOCIAL SERVICES	56,561					56,561
11 HOME HEALTH AIDE	60,767					60,767
12 SUPPLIES (SEE INSTRUCTIONS)					58,799	58,799
13 DRUGS						13
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
24 TOTAL (SUM OF LINES 1-23)	1,771,593		41,067		133,312	1,945,972

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7255

WORKSHEET H
 (CONTINUED)

	RECLASS- IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
1					1
2					2
3					3
4					4
5		548,328		548,328	5
6		796,477		796,477	6
7		392,326		392,326	7
8		32,033		32,033	8
9		681		681	9
10		56,561		56,561	10
11		60,767		60,767	11
12		58,799		58,799	12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24		1,945,972		1,945,972	24

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 14-7255

WORKSHEET H-1
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL COSTS BLDG & FIXTURES	CAP REL COSTS MVBL EQUIPMENT	PLANT OPERATN MAINT	& TRANSPORT- ATION	SUBTOTAL (COLS.0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS.4A+5) 6	
	0	1	2	3	4	4A	5	6	
GENERAL SERVICE COST CENTER									
1 CAPITAL RELATED-BLDGS & FIXT									1
2 CAPITAL RELATED-MOVABLE EQUIP									2
3 PLANT OPERATION & MAINTENANCE									3
4 TRANSPORTATION (SEE INSTR.)									4
5 ADMINISTRATIVE AND GENERAL	548,328					548,328	548,328		5
HHA REIMBURSABLE SERVICES									
6 SKILLED NURSING CARE	796,477					796,477	312,477	1,108,954	6
7 PHYSICAL THERAPY	392,326					392,326	153,919	546,245	7
8 OCCUPATIONAL THERAPY	32,033					32,033	12,567	44,600	8
9 SPEECH PATHOLOGY	681					681	267	948	9
10 MEDICAL SOCIAL SERVICES	56,561					56,561	22,190	78,751	10
11 HOME HEALTH AIDE	60,767					60,767	23,840	84,607	11
12 SUPPLIES (SEE INSTRUCTIONS)	58,799					58,799	23,068	81,867	12
13 DRUGS									13
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
24 TOTAL (SUM OF LINES 1-23)	1,945,972					1,945,972		1,945,972	24

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7255

WORKSHEET H-1
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL 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-BLDGS & FIXT							1
2 CAPITAL RELATED-MOVABLE EQUIP							2
3 PLANT OPERATION & MAINTENANCE							3
4 TRANSPORTATION (SEE INSTR.)							4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES					-548,328	1,397,644	5
6 SKILLED NURSING CARE						796,477	6
7 PHYSICAL THERAPY						392,326	7
8 OCCUPATIONAL THERAPY						32,033	8
9 SPEECH PATHOLOGY						681	9
10 MEDICAL SOCIAL SERVICES						56,561	10
11 HOME HEALTH AIDE						60,767	11
12 SUPPLIES (SEE INSTRUCTIONS)						58,799	12
13 DRUGS							13
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 (SUM OF LINES 1-23)					-548,328	1,397,644	24
25 COST TO BE ALLOC (PER W/S H)						548,328	25
26 UNIT COST MULTIPLIER						0.392323	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7255

WORKSHEET H-2
 PART I

HHA COST CENTER	SUBTOTAL (SUM OF COL. 4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (SUM OF COL. 4A-23) 26	ALLOCATED HHA A&G (SEE PT.2) 27	TOTAL HHA COSTS 28	
1 ADMINISTRATIVE AND GENERAL	545,898		545,898			1
2 SKILLED NURSING CARE	1,609,931		1,609,931	312,317	1,922,248	2
3 PHYSICAL THERAPY	793,017		793,017	153,841	946,858	3
4 OCCUPATIONAL THERAPY	64,749		64,749	12,561	77,310	4
5 SPEECH PATHOLOGY	1,377		1,377	267	1,644	5
6 MEDICAL SOCIAL SERVICES	114,328		114,328	22,179	136,507	6
7 HOME HEALTH AIDE	122,830		122,830	23,828	146,658	7
8 SUPPLIES	107,762		107,762	20,905	128,667	8
9 DRUGS						9
10 DME						10
11 HOME DIALYSIS AIDE SERVICES						11
12 RESPIRATORY THERAPY						12
13 PRIVATE DUTY NURSING						13
14 CLINIC						14
15 HEALTH PROMOTION ACTIVITIES						15
16 DAY CARE PROGRAM						16
17 HOME DELIVERED MEALS PROGRAM						17
18 HOMEMAKER SERVICE						18
19 ALL OTHERS						19
20 TOTAL (SUM OF LINES 1-19)	3,359,892		3,359,892	545,898	3,359,892	20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.				0.193994		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7255

WORKSHEET H-2
 PART II

HHA COST CENTER	NEW CAP- REL COSTS BLDG&FIXT SQUARE FEET	NEW CAP- REL COSTS MOV EQUIP (DOLLAR VALUE)	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINI- STRATIVE & GENERAL ACCUM COST	MAINTEN- ANCE AND REPAIRS MAINT REQS	OPERATION OF PLANT SQUARE FEET
	1	2	3	4	4A	5	6	7
1 ADMINISTRATIVE AND GENERAL		17,689		421,734		168,858	4,322	1
2 SKILLED NURSING CARE				796,477		1,392,728		2
3 PHYSICAL THERAPY				392,326		686,026		3
4 OCCUPATIONAL THERAPY				32,033		56,013		4
5 SPEECH PATHOLOGY				681		1,191		5
6 MEDICAL SOCIAL SERVICES				56,561		98,903		6
7 HOME HEALTH AIDE				60,767		106,258		7
8 SUPPLIES						81,867		8
9 DRUGS								9
10 DME								10
11 HOME DIALYSIS AIDE SERVICES								11
12 RESPIRATORY THERAPY								12
13 PRIVATE DUTY NURSING								13
14 CLINIC								14
15 HEALTH PROMOTION ACTIVITIES								15
16 DAY CARE PROGRAM								16
17 HOME DELIVERED MEALS PROGRAM								17
18 HOMEMAKER SERVICE								18
19 ALL OTHERS								19
19.50 TELEMEDICINE								19.50
20 TOTAL (SUM OF LINES 1-19)		17,689		1,760,579		2,591,844	4,322	20
21 TOTAL COST TO BE ALLOCATED		18,599		627,273		404,216	3,945	21
22 UNIT COST MULTIPLIER							0.912772	22
22 UNIT COST MULTIPLIER		1.051444		0.356288		0.155957		22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7255

WORKSHEET H-2
 PART II

HHA COST CENTER	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (FTES SERVED) 11	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED 12	NURSING ADMINI- STRATION (DIRECT NRSG HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS) 14	PHARMACY (COSTED REQUIS) 15	
1 ADMINISTRATIVE AND GENERAL		1,234		2,350		2,350			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							45,910	1,238	8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIES									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGRAM									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
19.50 TELEMEDICINE									19.50
20 TOTAL (SUM OF LINES 1-19)		1,234		2,350		2,350	45,910	1,238	20
21 TOTAL COST TO BE ALLOCATED		145,573		43,432		157,755	11,787	1,340	21
22 UNIT COST MULTIPLIER							0.256741		22
22 UNIT COST MULTIPLIER		117.968395		18.481702		67.129787		1.082391	22

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7255

WORKSHEET H-3
 PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)		(COL.3 ÷ COL.4)	
			1	2	3	4	5	
1	SKILLED NURSING CARE	2	1,922,248		1,922,248	9,311	206.45	1
2	PHYSICAL THERAPY	3	946,858	203,001	1,149,859	6,206	185.28	2
3	OCCUPATIONAL THERAPY	4	77,310		77,310	682	113.36	3
4	SPEECH PATHOLOGY	5	1,644		1,644	12	137.00	4
5	MEDICAL SOCIAL SERVICES	6	136,507		136,507	601	227.13	5
6	HOME HEALTH AIDE	7	146,658		146,658	2,182	67.21	6
7	TOTAL (SUM OF LINES 1-6)		3,231,225	203,001	3,434,226	18,994		7

PATIENT SERVICES

8	SKILLED NURSING CARE							8
9	PHYSICAL THERAPY							9
10	OCCUPATIONAL THERAPY							10
11	SPEECH PATHOLOGY							11
12	MEDICAL SOCIAL SERVICES							12
13	HOME HEALTH AIDE							13
14	TOTAL (SUM OF LINES 8-13)							14

SUPPLIES AND DRUGS COST COMPUTATIONS

OTHER PATIENT SERVICES		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL CHARGES (FROM HHA RECORD)	RATIO (COL.3 ÷ COL.4)	
		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)			
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	128,667	14,383	143,050			15
16	COST OF DRUGS	9		143	143			16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7255

WORKSHEET H-3
 PARTS I & II
 (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION	PROGRAM VISITS				COST OF SERVICES			TOTAL PROGRAM COST (SUM OF COLS. 9-10)
	PART B		PART B		PART B			
PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR		
	6	7	8	9	10	11	12	
1 SKILLED NURSING CARE	4,289	3,062		885,464	632,150		1,517,614	
2 PHYSICAL THERAPY	3,239	1,392		600,122	257,910		858,032	
3 OCCUPATIONAL THERAPY	385	172		43,644	19,498		63,142	
4 SPEECH PATHOLOGY	17	10		2,329	1,370		3,699	
5 MEDICAL SOCIAL SERVICES	336	167		76,316	37,931		114,247	
6 HOME HEALTH AIDE	792	1,356		53,230	91,137		144,367	
7 TOTAL (SUM OF LINES 1-6)	9,058	6,159		1,661,105	1,039,996		2,701,101	

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS				
		PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
		1	2	3	4	
8 SKILLED NURSING CARE	16974	4,289	3,062			8
9 PHYSICAL THERAPY	16974	3,239	1,392			9
10 OCCUPATIONAL THERAPY	16974	385	172			10
11 SPEECH PATHOLOGY	16974	17	10			11
12 MEDICAL SOCIAL SERVICES	16974	336	167			12
13 HOME HEALTH AIDE	16974	792	1,356			13
14 TOTAL (SUM OF LINES 8-13)		9,058	6,159			14

SUPPLIES AND DRUGS COST COMPUTATIONS	PROGRAM COVERED CHARGES				COST OF SERVICES		
	PART B		PART B		PART B		
OTHER PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
	6	7	8	9	10	11	
15 COST OF MEDICAL SUPPLIES	99,715						15
16 COST OF DRUGS							16

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

FROM WKST C, PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL. 1 x COL. 2)	TRANSFER TO PART I AS INDICATED	
1 PHYSICAL THERAPY	0.179375	1,131,711	203,001	COL 2, LINE 2	1
2 OCCUPATIONAL THERAPY		101,463		COL 2, LINE 3	2
3 SPEECH PATHOLOGY		2,340		COL 2, LINE 4	3
4 MEDICAL SUPPLIES CHRGD TO PAT	0.129218	111,310	14,383	COL 2, LINE 15	4
5 DRUGS CHARGED TO PATIENTS	0.063594	2,250	143	COL 2, LINE 16	5
5.01 OUTPATIENT PHARMACY	1.161695			COL 2, LINE 16	5.01

CALCULATION OF HHA REMBURSEMENT SETTLEMENT

HHA NO.: 14-7255

WORKSHEET H-4
 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 PART A & PART B SERVICES				1
2 REASONABLE COST OF SERVICES (SEE INSTRUCTIONS)				2
3 TOTAL CHARGES	1,827,394			2
CUSTOMARY CHARGES				
4 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (FROM YOUR RECORDS)				3
5 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
6 RATIO OF LINE 3 TO LINE 4 (NOT TO EXCEED 1.000000)				5
7 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	1,827,394			6
8 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 1)	1,827,394			7
9 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 1 EXCEEDS LINE 6)				8
9 PRIMARY PAYER PAYMENTS				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10 TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	1,492,425	915,513	11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	4,910		12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	13,801	18,342	13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES	4,978	3,232	14
15 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	1,071		15
16 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17 TOTAL OTHER PAYMENTS			17
18 DME PAYMENTS			18
19 OXYGEN PAYMENTS			19
20 PROSTHETIC AND ORTHOTIC PAYMENTS			20
21 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
22 SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	1,517,185	937,087	22
23 EXCESS REASONABLE COST (FROM LINE 8)			23
24 SUBTOTAL (LINE 22 MINUS LINE 23)	1,517,185	937,087	24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26 NET COST (LINE 24 MINUS LINE 25)	1,517,185	937,087	26
27 REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
28 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
29 TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	1,517,185	937,087	29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	1,517,185	937,087	31
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)	1,517,185	937,087	32
33 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 32 AND 33)			34
35 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			35

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

HHA NO.: 14-7255

WORKSHEET H-5

DESCRIPTION	PART A		PART B		
	MO/DAY/YR 1	AMOUNT 2	MO/DAY/YR 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,517,185		937,087	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.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE		NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)		1,517,185		937,087	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 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.)	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM				6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		1,517,185		937,087	7
8 NAME OF CONTRACTOR: _____		CONTRACTOR NUMBER: _____		DATE: _____	

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE NO.: 14-1561

WORKSHEET K

	SALARIES (FROM WKST K-1) 1	EMPLOYEE BENEFITS (FROM WKST K-2) 2	TRANS- PORTATION (SEE INSTR.) 3	CONTRACTED SERVICES (FROM WKST K-3) 4	OTHER 5	TOTAL (COLS. 1-5) 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 INPATIENT CARE SERVICE	107,329			18,157	42,535	168,021
7 INPATIENT - GENERAL CARE						7
8 INPATIENT - RESPITE CARE						8
9 VISITING SERVICES PHYSICIAN SERVICES						9
10 NURSING CARE	84,049		3,562			87,611
11 NURSING CARE-CONTINUOUS HOME CARE						11
12 PHYSICAL THERAPY						12
13 OCCUPATIONAL THERAPY						13
14 SPEECH/LANGUAGE PATHOLOGY	20,288					20,288
15 MEDICAL SOCIAL SERVICES	6,160					6,160
16 SPIRITUAL COUNSELING						16
17 DIETARY COUNSELING	17,535					17,535
18 COUNSELING - OTHER	16,438					16,438
19 HOME HEALTH AIDE AND HOMEMAKER						19
20 HH AIDE & HOMEMAKER-CONT. HOME CARE						20
21 OTHER						21
22 OTHER HOSPICE SERVICE COSTS DRUGS, BIOLOGICAL & INFUSION THERAPY					24,397	24,397
23 ANALGESICS						23
24 SEDATIVES/HYPNOTICS						24
25 OTHER - SPECIFY						25
26 DURABLE MEDICAL EQUIPMENT/OXYGEN						26
27 PATIENT TRANSPORTATION						27
28 IMAGING SERVICES						28
29 LABS AND DIAGNOSTICS						29
30 MEDICAL SUPPLIES					4,765	4,765
31 OUTPATIENT SERVICES (INCLUDING E/R DEPT.)						31
32 RADIATION THERAPY						32
33 CHEMOTHERAPY						33
34 OTHER						34
35 HOSPICE NONREIMBURSABLE SERVICE BEREAVEMENT PROGRAM COSTS						35
36 VOLUNTEER PROGRAM COSTS						36
37 FUNDRAISING						37
38 OTHER PROGRAM COSTS						38
39 TOTAL (SUM OF LINES 1-38)	251,799		3,562	18,157	71,697	345,215

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE NO.: 14-1561

WORKSHEET K
 (CONTINUED)

	RECLASSIFI- CATION 7	SUBTOTAL (COL.6 ± COL.7) 8	ADJUST- MENTS 9	TOTAL (COL.8 ± COL.9) 10	
1					1
2					2
3					3
4					4
5					5
6		168,021		168,021	6
7					7
8					8
9	21,600	21,600		21,600	9
10		87,611		87,611	10
11					11
12					12
13					13
14		20,288		20,288	14
15		6,160		6,160	15
16					16
17		17,535		17,535	17
18		16,438		16,438	18
19					19
20					20
21					21
22		24,397		24,397	22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30		4,765		4,765	30
31					31
32					32
33					33
34					34
35					35
36					36
37					37
38					38
39	43,200	366,815		366,815	39

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								1
2	CAP REL COSTS-BLDG AND FIXT.								2
3	CAP REL COSTS-MOVABLE EQUIP.								3
4	PLANT OPERATION & MAINT.								4
5	TRANSPORTATION - STAFF								5
6	VOLUNTEER SERVICE COORD.								6
7	ADMINISTRATIVE AND GENERAL			92,068			240	15,021	107,329
8	INPATIENT CARE SERVICE								7
9	INPATIENT - GENERAL CARE								8
10	INPATIENT - RESPITE CARE								9
11	VISITING SERVICES								10
12	PHYSICIAN SERVICES								11
13	NURSING CARE				83,770			279	84,049
14	NURSING CARE-CONT.HOME CARE								12
15	PHYSICAL THERAPY								13
16	OCCUPATIONAL THERAPY								14
17	SPEECH/LANGUAGE PATHOLOGY							20,288	20,288
18	MEDICAL SOCIAL SERVICES							6,160	6,160
19	SPIRITUAL COUNSELING								16
20	DIETARY COUNSELING							17,535	17,535
21	COUNSELING - OTHER						16,438		16,438
22	HH AIDE AND HOMEMAKER								19
23	HH AIDE & HMKR-CONT.HME CARE								20
24	OTHER								21
25	OTHER HOSPICE SERVICE COSTS								22
26	DRUGS, BIOL. & INFUS. THER.								23
27	ANALGESICS								24
28	SEDATIVES / HYPNOTICS								25
29	OTHER - SPECIFY								26
30	DURABLE MED. EQUIP./OXYGEN								27
31	PATIENT TRANSPORTATION								28
32	IMAGING SERVICES								29
33	LABS AND DIAGNOSTICS								30
34	MEDICAL SUPPLIES								31
35	OUTPAT.SERV.(INCL.E/R DEPT.)								32
36	RADIATION THERAPY								33
37	CHEMOTHERAPY								34
38	OTHER								35
39	HOSPICE NONREIMBURSABLE SERVICE								36
40	BEREAVEMENT PROGRAM COSTS								37
41	VOLUNTEER PROGRAM COSTS								38
42	FUNDRAISING								39
43	OTHER PROGRAM COSTS								38
44	TOTAL (SUM OF LINES 1-38)			92,068	83,770		16,678	59,283	251,799

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								18,157
8	INPATIENT CARE SERVICE								18,157
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								11
15	PHYSICAL THERAPY								12
16	OCCUPATIONAL THERAPY								13
17	SPEECH/LANGUAGE PATHOLOGY								14
18	MEDICAL SOCIAL SERVICES								15
19	SPIRITUAL COUNSELING								16
20	DIETARY COUNSELING								17
21	COUNSELING - OTHER								18
22	HH AIDE AND HOMEMAKER								19
23	HH AIDE & HMKR-CONT.HME CARE								20
24	OTHER								21
25	OTHER HOSPICE SERVICE COSTS								
26	DRUGS, BIOL. & INFUS. THER.								22
27	ANALGESICS								23
28	SEDATIVES / HYPNOTICS								24
29	OTHER - SPECIFY								25
30	DURABLE MED. EQUIP./OXYGEN								26
31	PATIENT TRANSPORTATION								27
32	IMAGING SERVICES								28
33	LABS AND DIAGNOSTICS								29
34	MEDICAL SUPPLIES								30
35	OUTPAT.SERV.(INCL.E/R DEPT.)								31
36	RADIATION THERAPY								32
37	CHEMOTHERAPY								33
38	OTHER								34
39	HOSPICE NONREIMBURSABLE SERVICE								
40	BEREAVEMENT PROGRAM COSTS								35
41	VOLUNTEER PROGRAM COSTS								36
42	FUNDRAISING								37
43	OTHER PROGRAM COSTS								38
44	TOTAL (SUM OF LINES 1-38)								18,157
45									18,157
46									39

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

HOSPICE NO.: 14-1561

WORKSHEET K-4
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL COSTS	CAP REL BLDGCOSTS	CAP REL MVBL EQUIPMENT	PLANT OPERATN & MAINT	TRANSPOR- TATION	VOLUNTEER SERV. CO- ORDINATOR	SUBTOTAL (COLS.0-5) 5A	ADMIN & GENERAL 6	TOTAL (COL.5 ± COL.6) 7
1	GENERAL SERVICE COST CENTER									1
2	CAP REL COSTS-BLDG AND FIXT.									2
3	CAP REL COSTS-MOVABLE EQUIP.									3
4	PLANT OPERATION & MAINT.									4
5	TRANSPORTATION - STAFF									5
6	VOLUNTEER SERVICE COORD.									6
7	ADMINISTRATIVE AND GENERAL	168,021						168,021	168,021	7
8	INPATIENT CARE SERVICE									8
9	INPATIENT - GENERAL CARE									9
10	INPATIENT - RESPITE CARE									10
11	VISITING SERVICES									11
12	PHYSICIAN SERVICES	21,600						21,600	18,256	39,856
13	NURSING CARE	87,611						87,611	74,051	161,662
14	NURSING CARE-CONTINUOUS HOME									12
15	PHYSICAL THERAPY									13
16	OCCUPATIONAL THERAPY									14
17	SPEECH/LANGUAGE PATHOLOGY	20,288						20,288	17,147	37,435
18	MEDICAL SOCIAL SERVICES	6,160						6,160	5,206	11,366
19	SPIRITUAL COUNSELING									16
20	DIETARY COUNSELING	17,535						17,535	14,821	32,356
21	COUNSELING - OTHER	16,438						16,438	13,893	30,331
22	HH AIDE AND HOMEMAKER									19
23	HH AIDE & HMKR-CONT. HOME CA									20
24	OTHER									21
25	OTHER HOSPICE SERVICE COSTS									22
26	DRUGS, BIOL. & INFUS. THER.	24,397						24,397	20,620	45,017
27	ANALGESICS									23
28	SEDATIVES / HYPNOTICS									24
29	OTHER - SPECIFY									25
30	DURABLE MED. EQUIP./OXYGEN									26
31	PATIENT TRANSPORTATION									27
32	IMAGING SERVICES									28
33	LABS AND DIAGNOSTICS									29
34	MEDICAL SUPPLIES	4,765						4,765	4,027	8,792
35	OUTPAT.SERV.(INCL.E/R DEPT.)									30
36	RADIATION THERAPY									31
37	CHEMOTHERAPY									32
38	OTHER									33
39	HOSPICE NONREIMBURSABLE SERV.									34
40	BEREAVEMENT PROGRAM COSTS									35
41	VOLUNTEER PROGRAM COSTS									36
42	FUNDRAISING									37
43	OTHER PROGRAM COSTS									38
44	TOTAL (SUM OF LINES 1-38)	366,815						366,815		366,815

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

WORKSHEET K-5
 PART I

HOSPICE COST CENTER	SUBTOTAL (COLS. 4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (COLS. 24 ± 25) 26	ALLOC HOSP A&G (SEE PART II) 27	TOTAL HOSP COSTS (COL 26 ± 27) 28	
1 ADMINISTRATIVE AND GENERAL	71,386		71,386			1
2 INPATIENT - GENERAL CARE						2
3 INPATIENT - RESPITE CARE						3
4 PHYSICIAN SERVICES	53,257		53,257	7,393	60,650	4
5 NURSING CARE	246,366		246,366	34,203	280,569	5
6 NURSING CARE-CONTINUOUS HOM						6
7 PHYSICAL THERAPY						7
8 OCCUPATIONAL THERAPY						8
9 SPEECH/LANGUAGE PATHOLOGY	43,273		43,273	6,007	49,280	9
10 MEDICAL SOCIAL SERV. - DIRE	21,034		21,034	2,920	23,954	10
11 SPIRITUAL COUNSELING	2,397		2,397	333	2,730	11
12 DIETARY COUNSELING	37,402		37,402	5,192	42,594	12
13 COUNSELING - OTHER	41,885		41,885	5,815	47,700	13
14 HOME HLTH AIDE & HOMEMAKERS	6,397		6,397	888	7,285	14
15 HH AIDE & HMKR-CONT. HOME C						15
16 OTHER						16
17 DRUGS,BIOLOGICALS & INFUSIO	52,038		52,038	7,224	59,262	17
18 ANALGESICS						18
19 SEDATIVES / HYPNOTICS						19
20 OTHER - SPECIFY						20
21 DURABLE MED. EQUIP./OXYGEN						21
22 PATIENT TRANSPORTATION						22
23 IMAGING SERVICES						23
24 LABS AND DIAGNOSTICS						24
25 MEDICAL SUPPLIES	10,163		10,163	1,411	11,574	25
26 OUTPAT. SERV.(INCL.E/R DEPT						26
27 RADIATION THERAPY						27
28 CHEMOTHERAPY						28
29 OTHER						29
30 BEREAVEMENT PROGRAM COSTS						30
31 VOLUNTEER PROGRAM COSTS						31
32 FUNDRAISING						32
33 OTHER PROGRAM COSTS						33
34 TOTALS (SUM OF LINES 1-33)	585,598		585,598		585,598	34
35 UNIT COST MULTIPLIER				0.138826		35

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
 STATISTICAL BASIS

HOSPICE NO.: 14-1561

WORKSHEET K-5
 PART II

HOSPICE COST CENTER	NEW CAP- REL COSTS BLDG&FIXT SQUARE FEET	NEW CAP- REL COSTS MOV EQUIP (DOLLAR VALUE)	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINI- STRATIVE & GENERAL ACCUM COST	MAINTEN- ANCE AND REPAIRS MAINT REQS	OPERATION OF PLANT SQUARE FEET
	1	2	3	4	4A	5	6	7
1 ADMINISTRATIVE AND GENERAL				107,329		36,129		1
2 INPATIENT - GENERAL CARE								2
3 INPATIENT - RESPITE CARE								3
4 PHYSICIAN SERVICES						39,856	634	4
5 NURSING CARE				84,049		189,956		5
6 NURSING CARE-CONTINUOUS HOM								6
7 PHYSICAL THERAPY								7
8 OCCUPATIONAL THERAPY								8
9 SPEECH/LANGUAGE PATHOLOGY						37,435		9
10 MEDICAL SOCIAL SERV. - DIRE				20,288		18,196		10
11 SPIRITUAL COUNSELING				6,160		2,074		11
12 DIETARY COUNSELING						32,356		12
13 COUNSELING - OTHER				17,535		36,234		13
14 HOME HLTH AIDE & HOMEMAKERS				16,438		5,534		14
15 HH AIDE & HMKR-CONT. HOME C								15
16 OTHER								16
17 DRUGS,BIOLOGICALS & INFUSIO						45,017		17
18 ANALGESICS								18
19 SEDATIVES / HYPNOTICS								19
20 OTHER - SPECIFY								20
21 DURABLE MED. EQUIP./OXYGEN								21
22 PATIENT TRANSPORTATION								22
23 IMAGING SERVICES								23
24 LABS AND DIAGNOSTICS								24
25 MEDICAL SUPPLIES						8,792		25
26 OUTPAT. SERV.(INCL.E/R DEPT								26
27 RADIATION THERAPY								27
28 CHEMOTHERAPY								28
29 OTHER								29
30 BEREAVEMENT PROGRAM COSTS								30
31 VOLUNTEER PROGRAM COSTS								31
32 FUNDRAISING								32
33 OTHER PROGRAM COSTS								33
34 TOTALS (SUM OF LINES 1-33)				251,799		451,579	634	34
35 TOTAL COST TO BE ALLOCATED				84,764		70,427	579	35
36 UNIT COST MULTIPLIER				0.336634		0.155957	0.913249	36

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
 STATISTICAL BASIS

HOSPICE NO.: 14-1561

WORKSHEET K-5
 PART II

HOSPICE COST CENTER	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (FTES SERVED) 11	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED 12	NURSING OF ADMINI- STRATION (DIRECT NRSG HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS) 14	PHARMACY (COSTED REQUIS) 15
1 ADMINISTRATIVE AND GENERAL				346		346		1
2 INPATIENT - GENERAL CARE								2
3 INPATIENT - RESPITE CARE								3
4 PHYSICIAN SERVICES		56						4
5 NURSING CARE							4,420	5
6 NURSING CARE-CONTINUOUS HOM								6
7 PHYSICAL THERAPY								7
8 OCCUPATIONAL THERAPY								8
9 SPEECH/LANGUAGE PATHOLOGY								9
10 MEDICAL SOCIAL SERV. - DIRE								10
11 SPIRITUAL COUNSELING								11
12 DIETARY COUNSELING								12
13 COUNSELING - OTHER								13
14 HOME HLTH AIDE & HOMEMAKERS								14
15 HH AIDE & HMKR-CONT. HOME C								15
16 OTHER								16
17 DRUGS,BIOLOGICALS & INFUSIO								17
18 ANALGESICS								18
19 SEDATIVES / HYPNOTICS								19
20 OTHER - SPECIFY								20
21 DURABLE MED. EQUIP./OXYGEN								21
22 PATIENT TRANSPORTATION								22
23 IMAGING SERVICES								23
24 LABS AND DIAGNOSTICS								24
25 MEDICAL SUPPLIES								25
26 OUTPAT. SERV.(INCL.E/R DEPT								26
27 RADIATION THERAPY								27
28 CHEMOTHERAPY								28
29 OTHER								29
30 BEREAVEMENT PROGRAM COSTS								30
31 VOLUNTEER PROGRAM COSTS								31
32 FUNDRAISING								32
33 OTHER PROGRAM COSTS								33
34 TOTALS (SUM OF LINES 1-33)		56		346		346	4,420	34
35 TOTAL COST TO BE ALLOCATED		6,606		6,395		23,227	1,135	35
36 UNIT COST MULTIPLIER		117.964286		18.482659		67.130058	0.256787	36

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 (PROVIDER RECORDS) 2	HOSPICE SHARED ANCILLARY COSTS (COL.1 x 2) 3	
ANCILLARY SERVICE COST CENTERS					
1	PHYSICAL THERAPY	66	0.179375	5	1
2	OCCUPATIONAL THERAPY	67			2
3	SPEECH/LANGUAGE PATHOLOGY	68			3
4	DRUGS, BIOLOGICALS AND INFUSION	73	0.063594		4
4.01	OUTPATIENT PHARMACY	73.01	1.161695		4.01
5	DURABLE MEDICAL EQUIPMENT/OXYGEN	96			5
6	LABS AND DIAGNOSTICS	60	0.107192		6
7	MEDICAL SUPPLIES	71	0.129218	23,139	2,990
8	OUTPATIENT SERVICES (INCL. E/R DEPT)	93			8
9	RADIATION THERAPY	55			9
10	LITHOTRIPSY	76			10
10.01	CARDIAC REHABILITATION	76.01	0.629328		10.01
10.05	INPATIENT RENAL DIALYSIS	76.05	0.135592		10.05
10.97	CARDIAC REHABILITATION	76.97			10.97
10.98	HYPERBARIC OXYGEN THERAPY	76.98			10.98
10.99	LITHOTRIPSY	76.99			10.99
11	TOTALS (SUM OF LINES 1-10)				2,991

PROVIDER CCN: 14-0008 GOTTlieb MEMORIAL HOSPITAL
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
01/31/2012 10:02

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 (SEE INSTRUCTIONS)				588,589	1
2 TOTAL UNDUPLICATED DAYS (WKST S-9, COL. 6, LINE 5)				4,362	2
3 AVERAGE COST PER DIEM (LINE 1 DIVIDED BY LINE 2)				134.94	3
4 UNDUPLICATED MEDICARE DAYS (WKST S-9, COL. 1, LINE 5)	4,362				4
5 AGGREGATE MEDICARE COST (LINE 3 TIMES LINE 4)	588,608				5
6 UNDUPLICATED MEDICAID DAYS (WKST S-9, COL. 2, LINE 5)					6
7 AGGREGATE MEDICAID COST (LINE 3 TIMES LINE 6)					7
8 UNDUPLICATED SNF DAYS (WKST S-9, COL. 3, LINE 5)					8
9 AGGREGATE SNF COST (LINE 3 TIMES LINE 8)					9
10 UNDUPLICATED NF DAYS (WKST S-9, COL. 4, LINE 5)					10
11 AGGREGATE NF COST (LINE 3 TIMES LINE 10)					11
12 OTHER UNDUPLICATED DAYS (WKST S-9, COL. 5, LINE 5)					12
13 AGGREGATE COST FOR OTHER DAYS (LINE 3 TIMES LINE 12)					13

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-000) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
 BOXES [] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	CAPITAL DRG OTHER THAN OUTLIER	1,995,445	1
2	CAPITAL DRG OUTLIER PAYMENTS	40,338	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	92.96	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	1.42	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	0.0043	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	8,580	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	2,044,363	12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (SEE INSTRUCTIONS)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (SEE INSTRUCTIONS)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 1 PLUS LINE 2)		3
4	CAPITAL COST PAYMENT FACTOR (SEE INSTRUCTIONS)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 3 TIMES LINE 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (SEE INSTRUCTIONS)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 5 PLUS LINE 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (FROM PART I, LINE 12 AS APPLICABLE)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 8 LESS LINE 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST L, PART III, LINE 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 10 PLUS LINE 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (IF LINE 12 IS POSITIVE, ENTER THE AMOUNT ON THIS LINE)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (IF LINE 12 IS NEGATIVE, ENTER THE AMOUNT ON THIS LINE)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (SEE INSTRUCTIONS)		17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
40 SUBPROVIDER - IPF					40
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
51 RECOVERY ROOM					51
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
56 RADIOISOTOPE					56
56.01 ULTRASOUND					56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
59 CARDIAC CATHETERIZATION					59
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
69 ELECTROCARDIOLOGY					69
70 ELECTROENCEPHALOGRAPHY					70
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
73.01 OUTPATIENT PHARMACY					73.01
76 LITHOTRIPSY					76
76.01 CARDIAC REHABILITATION					76.01
76.05 INPATIENT RENAL DIALYSIS					76.05
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
90.01 OUTPATIENT INFUSION PROCEDURES					90.01
90.02 WOUND CARE					90.02
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAP					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY					101
SPECIAL PURPOSE COST CENTERS					
116 HOSPICE					116
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
192 PHYSICIANS' PRIVATE OFFICES					192
192.01 NON-EMPLOYEE CHILD CARE CENTER					192.01
193 NONPAID WORKERS					193

PROVIDER CCN: 14-0008 GOTTIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
01/31/2012 10:02

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	0	2A	24	25	26	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)						202
203 TOTAL STATISTICAL BASIS						203
204 UNIT COST MULTIPLIER						204
204 UNIT COST MULTIPLIER						204

***** REPORT 97 ***** UTILIZATION STATISTICS *****

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL	7
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6		
UTILIZATION PERCENTAGES BASED ON DAYS								
30 ADULTS & PEDIATRICS	52.10		13.38				65.48	30
31 INTENSIVE CARE UNIT	55.00		3.73				58.73	31
43 NURSERY			52.71				52.71	43
UTILIZATION PERCENTAGES BASED ON CHARGES								
50 OPERATING ROOM	18.32	9.73					28.05	50
51 RECOVERY ROOM	41.47	30.24					71.71	51
52 DELIVERY ROOM & LABOR ROOM	0.37	0.08					0.45	52
53 ANESTHESIOLOGY	20.88	11.80					32.68	53
54 RADIOLOGY-DIAGNOSTIC	26.41	22.68					49.09	54
56 RADIOISOTOPE	18.99	21.33					40.32	56
56.01 ULTRASOUND	10.45	8.41					18.86	56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	15.23	19.36					34.59	57
59 CARDIAC CATHETERIZATION	19.11	13.59					32.70	59
60 LABORATORY	29.37	1.59					30.96	60
65 RESPIRATORY THERAPY	45.53	6.32					51.85	65
66 PHYSICAL THERAPY	14.30	0.42					14.72	66
69 ELECTROCARDIOLOGY	26.63	13.94					40.57	69
70 ELECTROENCEPHALOGRAPHY	14.49	6.79					21.28	70
71 MEDICAL SUPPLIES CHRGD TO PATI	47.98	12.55					60.53	71
72 IMPL. DEV. CHARGED TO PATIENT	34.17	11.24					45.41	72
73 DRUGS CHARGED TO PATIENTS	40.15	5.31					45.46	73
90 CLINIC		7.32					7.32	90
90.02 WOUND CARE	0.04	14.15					14.19	90.02
91 EMERGENCY	18.85	15.04					33.89	91
92 OBSERVATION BEDS		22.12					22.12	92
200 TOTAL CHARGES	28.54	9.98					38.52	200

***** REPORT 97 ***** UTILIZATION STATISTICS *****

SUBPROVIDER-IPF

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
40 SUBPROVIDER - IPF	92.64						92.64 40
UTILIZATION PERCENTAGES BASED ON CHARGES							
51 RECOVERY ROOM	0.49						0.49 51
54 RADIOLOGY-DIAGNOSTIC	0.19						0.19 54
56 RADIOISOTOPE	0.04						0.04 56
56.01 ULTRASOUND	0.06						0.06 56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.21						0.21 57
60 LABORATORY	0.62						0.62 60
65 RESPIRATORY THERAPY	0.15						0.15 65
66 PHYSICAL THERAPY	0.10						0.10 66
69 ELECTROCARDIOLOGY	0.08						0.08 69
70 ELECTROENCEPHALOGRAPHY	2.44						2.44 70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.09						0.09 71
73 DRUGS CHARGED TO PATIENTS	1.45						1.45 73
91 EMERGENCY	0.11						0.11 91
200 TOTAL CHARGES	0.44						0.44 200

***** REPORT 97 ***** UTILIZATION STATISTICS *****

SNF / NF

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
44 SKILLED NURSING FACILITY	80.62						80.62 44
UTILIZATION PERCENTAGES BASED ON CHARGES							
53 ANESTHESIOLOGY	0.24						0.24 53
54 RADIOLOGY-DIAGNOSTIC	1.17						1.17 54
56 RADIOISOTOPE	0.51						0.51 56
56.01 ULTRASOUND	0.41						0.41 56.01
59 CARDIAC CATHETERIZATION	0.08						0.08 59
60 LABORATORY	2.20						2.20 60
65 RESPIRATORY THERAPY	4.10						4.10 65
66 PHYSICAL THERAPY	29.14						29.14 66
69 ELECTROCARDIOLOGY	0.36						0.36 69
70 ELECTROENCEPHALOGRAPHY	1.08						1.08 70
71 MEDICAL SUPPLIES CHRGED TO PATI	3.98						3.98 71
73 DRUGS CHARGED TO PATIENTS	4.83						4.83 73
200 TOTAL CHARGES	3.00						3.00 200

COST CENTER	---	DIRECT COSTS	---	ALLOCATED OVERHEAD	---	TOTAL COSTS	---	
	AMOUNT	%	AMOUNT	%	AMOUNT	%		
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT	3,416,247	2.98	-3,416,247	-6.35		1	
2	CAP REL COSTS-MVBLE EQUIP	3,406,098	2.97	-3,406,098	-6.33		2	
3	OTHER CAPITAL RELATED COSTS						3	
4	EMPLOYEE BENEFITS	18,401,231	16.04	-18,401,231	-34.19		4	
5	ADMINISTRATIVE & GENERAL	11,919,783	10.39	-11,919,783	-22.14		5	
6	MAINTENANCE & REPAIRS	1,251,251	1.09	-1,251,251	-2.32		6	
7	OPERATION OF PLANT	3,973,951	3.46	-3,973,951	-7.38		7	
8	LAUNDRY & LINEN SERVICE	555,465	0.48	-555,465	-1.03		8	
9	HOUSEKEEPING	2,114,400	1.84	-2,114,400	-3.93		9	
10	DIETARY	1,225,553	1.07	-1,225,553	-2.28		10	
11	CAFETERIA	596,501	0.52	-596,501	-1.11		11	
12	MAINTENANCE OF PERSONNEL						12	
13	NURSING ADMINISTRATION	1,560,827	1.36	-1,560,827	-2.90		13	
14	CENTRAL SERVICES & SUPPLY	1,347,472	1.17	-1,347,472	-2.50		14	
15	PHARMACY	2,228,642	1.94	-2,228,642	-4.14		15	
16	MEDICAL RECORDS & LIBRARY	1,496,177	1.30	-1,496,177	-2.78		16	
17	SOCIAL SERVICE	333,901	0.29	-333,901	-0.62		17	
19	NONPHYSICIAN ANESTHETISTS						19	
20	NURSING SCHOOL						20	
21	I&R SRVCES-SALARY & FRINGES APP						21	
22	I&R SRVCES-OTHER PRGM COSTS APP						22	
23	PARAMED ED PRGM-(SPECIFY)						23	
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	10,235,512	8.92	12,964,931	24.09	23,200,443	20.22	
31	INTENSIVE CARE UNIT	4,055,306	3.53	3,911,563	7.27	7,966,869	6.94	
40	SUBPROVIDER - IPF	857,347	0.75	1,253,680	2.33	2,111,027	1.84	
43	NURSERY	363,161	0.32	365,886	0.68	729,047	0.64	
44	SKILLED NURSING FACILITY	1,944,304	1.69	2,686,038	4.99	4,630,342	4.04	
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	3,855,180	3.36	4,599,289	8.54	8,454,469	7.37	
51	RECOVERY ROOM	416,754	0.36	389,297	0.72	806,051	0.70	
52	DELIVERY ROOM & LABOR ROOM	1,378,671	1.20	1,290,600	2.40	2,669,271	2.33	
53	ANESTHESIOLOGY	633,995	0.55	303,240	0.56	937,235	0.82	
54	RADIOLOGY-DIAGNOSTIC	1,833,174	1.60	2,418,808	4.49	4,251,982	3.71	
56	RADIOISOTOPE	565,046	0.49	457,802	0.85	1,022,848	0.89	
56.01	ULTRASOUND	478,872	0.42	470,200	0.87	949,072	0.83	
57	COMPUTED TOMOGRAPHY (CT) SCAN	1,081,381	0.94	1,221,163	2.27	2,302,544	2.01	
59	CARDIAC CATHETERIZATION	1,094,140	0.95	1,051,519	1.95	2,145,659	1.87	
60	LABORATORY	5,660,460	4.93	3,101,702	5.76	8,762,162	7.64	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30	
65	RESPIRATORY THERAPY	1,226,612	1.07	875,851	1.63	2,102,463	1.83	
66	PHYSICAL THERAPY	1,978,825	1.72	1,872,267	3.48	3,851,092	3.36	
69	ELECTROCARDIOLOGY	466,749	0.41	517,264	0.96	984,013	0.86	
70	ELECTROENCEPHALOGRAPHY	96,269	0.08	108,310	0.20	204,579	0.18	
71	MEDICAL SUPPLIES CHRGD TO PATI	7,312,715	6.37	2,196,354	4.08	9,509,069	8.29	
72	IMPL. DEV. CHARGED TO PATIENT	2,870,712	2.50	1,457,198	2.71	4,327,910	3.77	
73	DRUGS CHARGED TO PATIENTS	3,198,562	2.79	4,025,257	7.48	7,223,819	6.30	
73.01	OUTPATIENT PHARMACY	1,886,438	1.64	556,697	1.03	2,443,135	2.13	
76	LITHOTRIPSY						76	
76.01	CARDIAC REHABILITATION	171,172	0.15	310,760	0.58	481,932	0.42	
76.05	INPATIENT RENAL DIALYSIS	408,140	0.36	63,655	0.12	471,795	0.41	
76.97	CARDIAC REHABILITATION						76.97	
76.98	HYPERBARIC OXYGEN THERAPY						76.98	
76.99	LITHOTRIPSY						76.99	
90	CLINIC					5,325	0.01	5,325
90.01	OUTPATIENT INFUSION PROCEDURES						90.01	
90.02	WOUND CARE	676,581	0.59	313,366	0.58	989,947	0.86	
91	EMERGENCY	3,496,470	3.05	3,117,246	5.79	6,613,716	5.76	
92	OBSERVATION BEDS						92	
OTHER REIMBURSABLE COST CENTERS								
OUTPATIENT SERVICE COST CENTERS								
99.10	CORF						99.10	
99.20	OUTPATIENT PHYSICAL THERAPY						99.20	
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30	
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40	
101	HOME HEALTH AGENCY	1,945,972	1.70	1,413,920	2.63	3,359,892	2.93	
SPECIAL PURPOSE COST CENTERS								
116	HOSPICE	366,815	0.32	218,783	0.41	585,598	0.51	
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CAN	63,046	0.05	68,943	0.13	131,989	0.12	
192	PHYSICIANS' PRIVATE OFFICES	10,882	0.01	72,285	0.13	83,167	0.07	
192.01	NON-EMPLOYEE CHILD CARE CENTER	52,984	0.05	53,341	0.10	106,325	0.09	
193	NONPAID WORKERS	244,268	0.21	94,959	0.18	339,227	0.30	
200	CROSS FOOT ADJUSTMENTS						200	
201	NEGATIVE COST CENTER						201	
202	TOTAL	114,754,014	100.00			114,754,014	100.00	

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL RELATED COSTS 1	TOTAL CHARGES 2	RATIO CAPITAL COST TO CHARGES 3	INPATIENT PROGRAM CHARGES 4	MEDICARE INPATIENT PPS CAPITAL COSTS 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,003,722	39,116,866	0.025660	7,165,707	183,872	50
51 RECOVERY ROOM	47,724	4,993,336	0.009558	2,070,890	19,794	51
52 DELIVERY ROOM & LABOR ROOM	180,143	6,264,677	0.028755	23,425	674	52
53 ANESTHESIOLOGY	57,502	10,176,699	0.005650	2,124,421	12,003	53
54 RADIOLOGY-DIAGNOSTIC	742,877	19,061,776	0.038972	5,034,320	196,198	54
56 RADIOISOTOPE	45,700	6,180,307	0.007394	1,173,829	8,679	56
56.01 ULTRASOUND	110,088	10,951,041	0.010053	1,144,770	11,508	56.01
57 COMPUTED TOMOGRAPHY (CT) SCAN	325,106	48,815,762	0.006660	7,433,587	49,508	57
59 CARDIAC CATHETERIZATION	401,616	32,404,714	0.012394	6,191,475	76,737	59
60 LABORATORY	531,245	81,742,675	0.006499	24,006,426	156,018	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	108,874	13,564,802	0.008026	6,176,488	49,572	65
66 PHYSICAL THERAPY	234,165	21,469,489	0.010907	3,070,355	33,488	66
69 ELECTROCARDIOLOGY	107,353	23,444,036	0.004579	6,243,580	28,589	69
70 ELECTROENCEPHALOGRAPHY	19,459	1,503,148	0.012945	217,816	2,820	70
71 MEDICAL SUPPLIES CHRGED TO PATI	281,544	73,589,433	0.003826	35,310,725	135,099	71
72 IMPL. DEV. CHARGED TO PATIENT	239,834	15,741,378	0.015236	5,378,114	81,941	72
73 DRUGS CHARGED TO PATIENTS	144,219	113,593,327	0.001270	45,607,889	57,922	73
73.01 OUTPATIENT PHARMACY	63,286	2,103,078	0.030092			73.01
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	74,577	765,788	0.097386			76.01
76.05 INPATIENT RENAL DIALYSIS	4,637	3,479,529	0.001333			76.05
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	2,008	163,124	0.012310			90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE	53,510	4,049,721	0.013213	1,793	24	90.02
91 EMERGENCY	507,460	41,674,784	0.012177	7,853,906	95,637	91
92 OBSERVATION BEDS	45,569	7,680,357	0.005933			92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL	5,332,218	582,529,847		166,229,516	1,200,083	200

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL	SWING-BED	REDUCED	TOTAL	PER	INPATIENT	MEDICARE
	RELATED	ADJUSTMENT	CAPITAL	PATIENT			INPATIENT
	COSTS	AMOUNT	RELATED	DAYS	DIEM	PROGRAM	PPS CAPITAL
	1	2	COST	4	5	DAYS	COSTS
			3			6	7
INPATIENT ROUTINE SERVICE COST CENTERS							
30 ADULTS & PEDIATRICS	1,469,280		1,469,280	29,986	49.00	15,624	765,576 30
31 INTENSIVE CARE UNIT	361,392		361,392	4,873	74.16	2,680	198,749 31
200 TOTAL	1,830,672		1,830,672	34,859		18,304	964,325 200
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS							964,325
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS							1,200,083
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS							2,164,408
MEDICARE DISCHARGES (WKST S-3, PART I, LINE 14, COLUMN 13)							3,015
MEDICARE PATIENT DAYS (WKST S-3, PART I, LINE 14, COLUMN 6 - WKST S-3, PART I, LINE 5, COLUMN 6)							18,304
PER DISCHARGE CAPITAL COSTS							717.88
PER DIEM CAPITAL COSTS							118.25

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (TITLE XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (WORKSHEET D-1 PART II LINE 53)	33,149,562
2. HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-3 FOR HOSPITAL TITLE XVIII COMPONENT)	211,537,813
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.157

COST TO CHARGE RATIO FOR PSYCH SUBPROVIDER

1. TOTAL MEDICARE COSTS (WKST D-1 PART II LINE 49 - (WKST D PART III COLUMN 9 LINE 41 + WKST D PART IV COL 11 LINE 200))	2,180,337
2. TOTAL MEDICARE CHARGES (WKST D-3 LINE 40 COLUMN 2 PLUS WKST D-3 LINE 202 COLUMN 2) (SEE CR 5619)	9,115,951
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.239

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (WKST D PART I LINES 30-35, COLUMN 7 + WKST D PART II, LINE 200, COLUMN 5)	2,164,408
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	0.010

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPSS. (WKST D, PART V, COLUMNS 2, 2.01, 2.02 x COLUMN 1 LESS LINES 61, 66-68, 74, 94, 95 & 96)	6,961,004
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPSS. (WKST D, PART V, LINE 202, COLUMNS 2, 2.01, & 2.02 LESS LINES 61, 66-68, 74, 94, 95 & 96)	58,064,644
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.120