

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
 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.
- DATE: 11-25-2013 TIME: 14:50
- CONTRACTOR USE ONLY
5. COST REPORT STATUS
 6. DATE RECEIVED: _____
 7. CONTRACTOR NO: _____
 8. INITIAL REPORT FOR THIS PROVIDER CCN
 9. FINAL REPORT FOR THIS PROVIDER CCN
 10. NPR DATE: _____
 11. CONTRACTOR'S VENDOR CODE: _____
 12. IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED - 0-9.
- 1 - AS SUBMITTED
 - 2 - SETTLED WITHOUT AUDIT
 - 3 - SETTLED WITH AUDIT
 - 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 07/01/2012 AND ENDING 06/30/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		630,550	157,517	30,127	1
2 SUBPROVIDER - IPF		7,329			2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF					5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY		2,748			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		640,627	157,517	30,127	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.

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 P.O. BOX: 1
 2 CITY: MELROSE PARK STATE: IL ZIP CODE: 60160 COUNTY: COOK 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			3	
						V 6	XVIII 7	XIX 8		
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: 07/01/2012				TO: 06/30/2013				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		OUT-OF-STATE		OUT-OF-STATE		MEDICAID	OTHER	MEDICAID
		IN-STATE	IN-STATE	OUT-OF-STATE	OUT-OF-STATE	MEDICAID	MEDICAID			
		MEDICAID PAID	MEDICAID ELIGIBLE UNPAID	MEDICAID PAID	MEDICAID ELIGIBLE UNPAID	MEDICAID HMO PAID	MEDICAID HMO ELIGIBLE UNPAID			
		1	2	3	4	5	6	7	8	9
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	3,222	1,599			5	576	67	24	
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.								25	
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.					1			26	
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.					1			27	
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.								35	
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:			ENDING:		36	
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.								37	
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:			ENDING:		38	
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)								1	2
									N	N 39

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	1 Y	2	3	56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60

61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(SEE INSTRUCTIONS)	Y/N N	IME	DIRECT GME	61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (EXCLUDING OB/GYN AND GENERAL SURGERY) ADDED AS A RESULT OF SECTION 5503. (SEE INSTRUCTIONS)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (SEE INSTRUCTIONS)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (SEE INSTRUCTIONS)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTE AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (LINE 61.04 MINUS LINE 61.03). (SEE INSTRUCTIONS)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (SEE INSTRUCTIONS)				61.06

OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND
 THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (SEE INSTRUCTIONS)
 ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE,
 ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4
 DIRECT GME FTE UNWEIGHTED COUNT.

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT	
1	2	3	4	
				61.10

OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY,
 AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (SEE INSTRUCTIONS)
 ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE,
 ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4
 DIRECT GME FTE UNWEIGHTED COUNT.

61.20

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

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

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS
 THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER
 JULY 1, 2009 AND BEFORE JUNE 30, 2010.

UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
64		64

ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED
 RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY
 CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL
 NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED
 NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN
 COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE
 INSTRUCTIONS)

ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR
 FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME.
 ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF
 UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS
 OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER
 OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL.
 ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)).
 (SEE INSTRUCTIONS)

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTEs NONPROVIDER SITE 3	UNWEIGHTED FTEs IN HOSPITAL 4	RATIO (COL.3+COL.4) 5
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SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS
 EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010

UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
66		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)

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

		V	XIX	
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.	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)?	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- SICAL	OCCUP- ATIONAL	RESPI- RATORY	109
		N	N	N	

MISCELLANEOUS COST REPORTING INFORMATION					
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.		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	
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 51,719 PAID LOSSES: SELF INSURANCE: 355,251			118.01	
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.		N	118.02	
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.		N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR 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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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.

	1	2
	Y	902022 140

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

141	NAME: TRINITY HEALTH HOME OFFICE	CONTRACTOR'S NAME: WISCONSIN PHYSICIANS SERVICE	CONTRACTOR'S NUMBER: 08000	141
142	STREET: 20555 VICTORY PARKWAY	P.O. BOX:		142
143	CITY: 20555 VICTORY PARKWAY	STATE: MI	ZIP CODE: 48152	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?		Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.		Y	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.		N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	149

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

	TITLE XVIII		TITLE	TITLE
	PART A	PART B	V	XIX
	1	2	3	4
155	HOSPITAL	N	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
161.10	CORF			161.10

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs?
 ENTER 'Y' FOR YES OR 'N' FOR NO.

	N	165
--	---	-----

166 IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN
 COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5

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

167 IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.

	Y	167
--	---	-----

168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND 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.

	1.00	169
--	------	-----

170 IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE
 FOR THE REPORTING PERIOD, RESPECTIVELY. (mmddyyyy) (SEE INSTRUCTIONS)

	10/01/2012	09/30/2013	170
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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)	Y		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	2	
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. | N | | 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 |

COST REPORT PREPARER CONTACT INFORMATION

- | | | | |
|---|---------------------------------------|-----------------------------|----|
| 41 FIRST NAME: PATRICK | LAST NAME: FITZGIBBONS | TITLE: MANAGER OF REIMBURSE | 41 |
| 42 EMPLOYER: LOYOLA UNIVERSITY HEALTH SYSTE | | | 42 |
| 43 PHONE NUMBER: 708-216-0746 | E-MAIL ADDRESS: PFITZGIBBONS@LUMC.EDU | | 43 |

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	55,312,808	55,312,808	1,773,410.00	31.19	1
2	NON-PHYSICIAN ANESTHETIST PART A						2
3	NON-PHYSICIAN ANESTHETIST PART B						3
4	PHYSICIAN-PART A ADMINISTRATIVE						4
4.01	PHYSICIAN-PART A - TEACHING						4.01
5	PHYSICIAN-PART B		112,749	112,749	2,294.00	49.15	5
6	NON-PHYSICIAN-PART B						6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF	44	2,002,496	12,352	2,014,848	77,002.00	26.17
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		3,086,883	80,470	3,167,353	66,814.00	47.41
	OTHER WAGES & RELATED COSTS						10
11	CONTRACT LABOR (SEE INSTRUCTIONS)		1,127,922		1,127,922	21,537.00	52.37
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES						12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		1,216,907		1,216,907	12,654.00	96.17
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		2,955,153		2,955,153	46,719.00	63.25
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE						15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING						16
	WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)		15,788,275		15,788,275		17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS		881,108		881,108		19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B						21
22	PHYSICIAN PART A - ADMINISTRATIVE						22
22.01	PHYSICIAN PART A - TEACHING						22.01
23	PHYSICIAN PART B		32,183		32,183		23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						25
	OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS DEPARTMENT		1,222,827	-73,896	1,148,931	32,977.00	34.84
27	ADMINISTRATIVE & GENERAL		7,321,430	-311,192	7,010,238	255,435.00	27.44
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)						28
29	MAINTENANCE & REPAIRS		789,815		789,815	26,652.00	29.63
30	OPERATION OF PLANT		1,049,804		1,049,804	37,375.00	28.09
31	LAUNDRY & LINEN SERVICE		102,671		102,671	6,764.00	15.18
32	HOUSEKEEPING		1,064,043		1,064,043	85,082.00	12.51
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY		782,874	-169,135	613,739	41,987.00	14.62
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35
36	CAFETERIA		93,246	169,135	262,381	25,747.00	10.19
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION		1,713,451		1,713,451	41,523.00	41.27
39	CENTRAL SERVICES AND SUPPLY		537,845	91,328	629,173	29,121.00	21.61
40	PHARMACY		2,120,288		2,120,288	44,931.00	47.19
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		1,208,099		1,208,099	40,636.00	29.73
42	SOCIAL SERVICE		426,393		426,393	11,448.00	37.25
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	55,200,059		55,200,059	1,771,116.00	31.17	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	5,089,379	92,822	5,182,201	143,816.00	36.03	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	50,110,680	-92,822	50,017,858	1,627,300.00	30.74	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	5,299,982		5,299,982	80,910.00	65.50	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	15,788,275		15,788,275		31.57	5
6	TOTAL (SUM OF LINES 3 THRU 5)	71,198,937	-92,822	71,106,115	1,708,210.00	41.63	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	18,432,786	-293,760	18,139,026	679,678.00	26.69	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 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		3
4 QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	4,089,910	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)	7,729,542	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN	299,163	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	99,670	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	34,972	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	258,529	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	4,037,682	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE	47,698	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)		21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT	104,399	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	16,701,565	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 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 14:50

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	2,993				2,993	1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION)						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		7.29		7.29	5
6 DIRECT NURSING SERVICE		10.16		10.16	6
7 NURSING SUPERVISOR					7
8 PHYSICAL THERAPY SERVICE		3.51		3.51	8
9 PHYSICAL THERAPY SUPERVISOR					9
10 OCCUPATIONAL THERAPY SERVICE		0.50		0.50	10
11 OCCUPATIONAL THERAPY SUPERVISOR					11
12 SPEECH PATHOLOGY SERVICE					12
13 SPEECH PATHOLOGY SUPERVISOR					13
14 MEDICAL SOCIAL SERVICE		0.75		0.75	14
15 MEDICAL SOCIAL SERVICE SUPERVISOR					15
16 HOME HEALTH AIDE		1.44		1.44	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	5,914	161	225	107	6,407	21
22 SKILLED NURSING VISIT CHARGES	1,221,384	33,205	46,591	21,787	1,322,967	22
23 PHYSICAL THERAPY VISITS	3,853	20	17	50	3,940	23
24 PHYSICAL THERAPY VISIT CHARGES	780,098	3,929	3,431	10,448	797,906	24
25 OCCUPATIONAL THERAPY VISITS	538		4	9	551	25
26 OCCUPATIONAL THERAPY VISIT CHARGES	110,368		844	2,017	113,229	26
27 SPEECH PATHOLOGY VISITS	4				4	27
28 SPEECH PATHOLOGY VISIT CHARGES	780				780	28
29 MEDICAL SOCIAL SERVICE VISITS	505	7	11	10	533	29
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	128,077	1,991	2,791	2,698	135,557	30
31 HOME HEALTH AIDE VISITS	1,397	52	2	8	1,459	31
32 HOME HEALTH AIDE VISIT CHARGES	213,222	7,934	289	1,260	222,705	32
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	12,211	240	259	184	12,894	33
34 OTHER CHARGES	38,572	2,123	2,077	1,235	44,007	34
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	2,492,501	49,182	56,023	39,445	2,637,151	35
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	720		94	14	828	36
37 TOTAL NUMBER OF OUTLIER EPISODES		4			4	37
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	38,572	2,123	2,077	1,235	44,007	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 (COLS. 2 + 3)
	GROUP				SNF DAYS	SWING BED SNF DAYS	2 + 3
	1				2	3	4
3	RUX						3
4	RUL						4
5	RVX						5
6	RVL				10		10
7	RHX				9		9
8	RHL				52		52
9	RMX				16		16
10	RML				9		9
11	RLX						11
12	RUC						12
13	RUB				15		15
14	RUA				8		8
15	RVC				1,242		1,242
16	RVB				2,263		2,263
17	RVA				562		562
18	RHC				938		938
19	RHB				1,102		1,102
20	RHA				173		173
21	RMC				366		366
22	RMB				522		522
23	RMA				124		124
24	RLB						24
25	RLA						25
26	ES3						26
27	ES2						27
28	ES1				17		17
29	HE2				10		10
30	HE1						30
31	HD2				4		4
32	HD1				7		7
33	HC2				28		28
34	HC1				7		7
35	HB2						35
36	HB1				1		1
37	LE2				45		45
38	LE1				24		24
39	LD2				30		30
40	LD1						40
41	LC2						41
42	LC1				24		24
43	LB2						43
44	LB1				2		2
45	CE2				16		16
46	CE1				25		25
47	CD2				17		17
48	CD1				6		6
49	CC2				11		11
50	CC1				40		40
51	CB2						51
52	CB1				12		12
53	CA2						53
54	CA1				2		2
55	SE3						55
56	SE2						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				19		19
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		23		23 70
71	PD2				71
72	PD1		7		7 72
73	PC2				73
74	PC1		35		35 74
75	PB2				75
76	PB1		2		2 76
77	PA2				77
78	PA1				78
199	AAA		2		2 199
200	TOTAL		7,827		7,827 200

CBSA AT
 BEGINNING
 OF COST
 REPORTING
 PERIOD
 1

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

SNF SERVICES

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)

ASSOCIATED
 WITH
 DIRECT
 PATIENT
 CARE AND
 RELATED
 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)		7,427,961		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	3,535				3,535 2
3	INPATIENT RESPITE CARE	34				34 3
4	GENERAL INPATIENT CARE	242				242 4
5	TOTAL HOSPICE DAYS	3,811				3,811 5

PART II - CENSUS DATA

	TITLE XVIII 1	TITLE XIX 2	TITLE XVIII SKILLED NURSING FACILITY 3	TITLE XIX NURSING FACILITY 4	ALL OTHER 5	TOTAL (SUM OF COLS. 1, 2 & 5) 6
6	NUMBER OF PATIENTS RECEIVING HOSPICE CARE	107				107 6
7	TOTAL NUMBER OF UNDUPLICATED CONTINUOUS CARE HOURS BILLABLE TO MEDICARE					7
8	AVERAGE LENGTH OF STAY (LINE 5/LINE 6)	35.62				35.62 8
9	UNDUPLICATED CENSUS COUNT	107				107 9

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 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.181594	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				17,576,394	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				69,202,647	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				12,566,785	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.					8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					16
UNCOMPENSATED 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				17,494	18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)					19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	25,707,629		25,707,629		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	4,668,351		4,668,351		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	519,437		519,437		22
23	COST OF CHARITY CARE	4,148,914		4,148,914		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 IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					N 24
25	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			11,232,448		25
26	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			418,433		26
27	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			10,814,015		27
28	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			1,963,760		28
29	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			6,112,674		29
30	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			6,112,674		30
31						31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100		3,497,090	3,497,090		1
2	00200		4,360,169	4,360,169		2
3	00300					3
4	00400	1,222,827	14,003,728	15,226,555	-81,983	4
5	00500	7,321,430	12,676,040	19,997,470	-2,934,155	5
6	00600	789,815	1,867,106	2,656,921		6
7	00700	1,049,804	2,759,424	3,809,228		7
8	00800	102,671	620,114	722,785		8
9	00900	1,064,043	987,941	2,051,984		9
10	01000	782,874	1,329,874	2,112,748	-537,766	10
11	01100	93,246	42,314	135,560	537,766	11
12	01200					12
13	01300	1,713,451	218,845	1,932,296		13
14	01400	537,845	609,841	1,147,686	-233,962	14
15	01500	2,120,288	2,837,991	4,958,279	-2,890,613	15
16	01600	1,208,099	459,221	1,667,320		16
17	01700	426,393	9,823	436,216		17
19	01900					19
20	02000					20
21	02100					21
22	02200				196,554	22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	10,322,014	1,467,998	11,790,012	104,815	30
31	03100	3,505,552	554,453	4,060,005	217,841	31
40	04000	848,734	98,039	946,773	61,418	40
43	04300		3,936	3,936	474,379	43
44	04400	2,002,496	200,477	2,202,973	-79,839	44
ANCILLARY SERVICE COST CENTERS						
50	05000	2,419,842	7,856,772	10,276,614	-5,837,151	50
51	05100	349,156	68,037	417,193		51
52	05200	1,494,857	241,811	1,736,668	-135,704	52
53	05300		247,226	247,226		53
54	05400	1,473,309	291,954	1,765,263	19,461	54
56	05600	467,263	825,453	1,292,716	9,517	56
56.01	03630				13,712	56.01
57	05700	613,111	170,091	783,202		57
59	05900	603,110	1,791,805	2,394,915	-1,233,902	59
60	06000	2,389,573	2,575,709	4,965,282	16,174	60
62.30	06250					62.30
65	06500	994,995	209,060	1,204,055	408	65
66	06600	1,900,796	234,513	2,135,309		66
69	06900	388,650	52,474	441,124	37,746	69
70	07000	99,349	10,208	109,557		70
71	07100				5,092,483	71
72	07200				4,352,099	72
73	07300	375,161		375,161	2,910,737	73
73.01	07301		1,487,161	1,487,161		73.01
74	07400					74
76	03950					76
76.01	03951	174,593	12,159	186,752		76.01
76.05	03954				302,466	76.05
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000					90
90.01	09001					90.01
90.02	09002	383,044	784,080	1,167,124	4,571	90.02
90.03	09003	922,570	626,904	1,549,474		90.03
91	09100	2,913,698	1,190,176	4,103,874	-477,687	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
94	09400					94
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
101	10100	1,800,154	184,335	1,984,489		101
SPECIAL PURPOSE COST CENTERS						
116	11600	268,633	97,459	366,092		116
118		55,143,446	67,561,811	122,705,257	-90,615	118
NONREIMBURSABLE COST CENTERS						
190	19000	31,658	34,304	65,962		190
192	19200	-7,301	244	-7,057	8,632	192
192.01	19201				81,983	192.01

PROVIDER CCN: 14-0008 GOTTIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 14:50

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
193	19300 NONPAID WORKERS	145,005	18,244	163,249	193
200	TOTAL (SUM OF LINES 118-199)	55,312,808	67,614,603	122,927,411	200

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	3,497,090		3,497,090	1
2	00200	CAP REL COSTS-MVBLE EQUIP	4,360,169		4,360,169	2
3	00300	OTHER CAP REL COSTS				3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	15,144,572	4,706,492	19,851,064	4
5	00500	ADMINISTRATIVE & GENERAL	17,063,315	-7,421,045	9,642,270	5
6	00600	MAINTENANCE & REPAIRS	2,656,921		2,656,921	6
7	00700	OPERATION OF PLANT	3,809,228	-1,427	3,807,801	7
8	00800	LAUNDRY & LINEN SERVICE	722,785		722,785	8
9	00900	HOUSEKEEPING	2,051,984		2,051,984	9
10	01000	DIETARY	1,574,982		1,574,982	10
11	01100	CAFETERIA	673,326	-337,864	335,462	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	1,932,296		1,932,296	13
14	01400	CENTRAL SERVICES & SUPPLY	913,724		913,724	14
15	01500	PHARMACY	2,067,666		2,067,666	15
16	01600	MEDICAL RECORDS & LIBRARY	1,667,320	-455	1,666,865	16
17	01700	SOCIAL SERVICE	436,216		436,216	17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	196,554		196,554	22
23	02300	PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS				23
30	03000	ADULTS & PEDIATRICS	11,894,827	-1,262,960	10,631,867	30
31	03100	INTENSIVE CARE UNIT	4,277,846	-187,038	4,090,808	31
40	04000	SUBPROVIDER - IPF	1,008,191	-28,893	979,298	40
43	04300	NURSERY	478,315		478,315	43
44	04400	SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	2,123,134		2,123,134	44
50	05000	OPERATING ROOM	4,439,463	-120,291	4,319,172	50
51	05100	RECOVERY ROOM	417,193		417,193	51
52	05200	DELIVERY ROOM & LABOR ROOM	1,600,964	-3,525	1,597,439	52
53	05300	ANESTHESIOLOGY	247,226	-229,945	17,281	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,784,724	-2,648	1,782,076	54
56	05600	RADIOISOTOPE	1,302,233	-50	1,302,183	56
56.01	03630	ULTRASOUND	13,712		13,712	56.01
57	05700	CT SCAN	783,202	-5,030	778,172	57
59	05900	CARDIAC CATHETERIZATION	1,161,013		1,161,013	59
60	06000	LABORATORY	4,981,456	-8,766	4,972,690	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	1,204,463		1,204,463	65
66	06600	PHYSICAL THERAPY	2,135,309	-36,372	2,098,937	66
69	06900	ELECTROCARDIOLOGY	478,870	-7,457	471,413	69
70	07000	ELECTROENCEPHALOGRAPHY	109,557		109,557	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,092,483		5,092,483	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS	4,352,099		4,352,099	72
73	07300	DRUGS CHARGED TO PATIENTS	3,285,898		3,285,898	73
73.01	07301	OUTPATIENT PHARMACY	1,487,161	-60,606	1,426,555	73.01
74	07400	RENAL DIALYSIS				74
76	03950	LITHOTRIPSY				76
76.01	03951	CARDIAC REHABILITATION	186,752		186,752	76.01
76.05	03954	INPATIENT RENAL DIALYSIS	302,466		302,466	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	1,171,695	-232,965	938,730	90.02
90.03	09003	RIVER FOREST	1,549,474		1,549,474	90.03
91	09100	EMERGENCY	3,626,187	-15,000	3,611,187	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				92
94	09400	HOME PROGRAM DIALYSIS				94
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 SPECIAL PURPOSE COST CENTERS	1,984,489		1,984,489	101
116	11600	HOSPICE	366,092		366,092	116
118		SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	122,614,642	-5,255,845	117,358,797	118
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	65,962		65,962	190
192	19200	PHYSICIANS' PRIVATE OFFICES	1,575		1,575	192
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	81,983		81,983	192.01

PROVIDER CCN: 14-0008 GOTTIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 14:50

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	
193	19300 NONPAID WORKERS	163,249		163,249	193
200	TOTAL (SUM OF LINES 118-199)	122,927,411	-5,255,845	117,671,566	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		2,890,613 1
500 TOTAL RECLASSIFICATIONS					2,890,613 500
CODE LETTER - A					
1 PURCHASED SERVICES	B	INPATIENT RENAL DIALYSIS	76.05		302,466 1
2					2
500 TOTAL RECLASSIFICATIONS					302,466 500
CODE LETTER - B					
1 SHARED DIETARY COST	C	CAFETERIA	11	169,135	368,631 1
500 TOTAL RECLASSIFICATIONS				169,135	368,631 500
CODE LETTER - C					
1 NONEMP CHILD CARE	D	NON-EMPLOYEE CHILD CARE CENTE	192.01	73,896	8,087 1
500 TOTAL RECLASSIFICATIONS				73,896	8,087 500
CODE LETTER - D					
1 RECLASS INTERN AND RESIDENT COST	E	I&R SERVICES-OTHER PRGM COSTS	22		196,554 1
500 TOTAL RECLASSIFICATIONS					196,554 500
CODE LETTER - E					
1 HOUSE STAF PHYS.	F	INTENSIVE CARE UNIT	31		574,456 1
2		OPERATING ROOM	50		368,092 2
3		ADULTS & PEDIATRICS	30		1,291,069 3
4		EMERGENCY	91		15,000 4
5		SUBPROVIDER - IPF	40		61,418 5
6		ELECTROCARDIOLOGY	69		18,958 6
500 TOTAL RECLASSIFICATIONS					2,328,993 500
CODE LETTER - F					
1 PT TRANSPORT	H	CENTRAL SERVICES & SUPPLY	14	91,328	28,590 1
2		ADULTS & PEDIATRICS	30	101,347	31,726 2
3		INTENSIVE CARE UNIT	31	9,616	3,010 3
4		SKILLED NURSING FACILITY	44	12,352	3,867 4
5		DELIVERY ROOM & LABOR ROOM	52	12,721	3,982 5
6		RADIOLOGY-DIAGNOSTIC	54	14,821	4,640 6
7		RADIOISOTOPE	56	7,248	2,269 7
8		ULTRASOUND	56.01	10,443	3,269 8
9		LABORATORY	60	12,318	3,856 9
10		RESPIRATORY THERAPY	65	311	97 10
11		ELECTROCARDIOLOGY	69	14,309	4,479 11
12		CARDIAC CATHETERIZATION	59	1,758	550 12
13		ADULTS & PEDIATRICS	30	14	4 13
14		WOUND CARE	90.02	3,481	1,090 14
15		EMERGENCY	91	12,551	3,929 15
16		PHYSICIANS' PRIVATE OFFICES	192	6,574	2,058 16
500 TOTAL RECLASSIFICATIONS				311,192	97,416 500
CODE LETTER - H					
1 FLOOR STOCK SUPPLIES	I	MEDICAL SUPPLIES CHARGED TO P	71		5,092,483 1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
500 TOTAL RECLASSIFICATIONS					5,092,483 500
CODE LETTER - I					
1 CHEMO INFUSION	J	DRUGS CHARGED TO PATIENTS	73	17,485	2,639 1
500 TOTAL RECLASSIFICATIONS				17,485	2,639 500
CODE LETTER - J					

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----		SALARY	OTHER	
		COST CENTER	LINE #			
	1	2	3	4	5	
1 IMPLANTS	L	IMPL. DEV. CHARGED TO PATIENT	72		4,352,099	1
2						2
3						3
500 TOTAL RECLASSIFICATIONS					4,352,099	500
CODE LETTER - L						
1 NURSERY	M	NURSERY	43	438,735	35,748	1
500 TOTAL RECLASSIFICATIONS				438,735	35,748	500
CODE LETTER - M						
GRAND TOTAL (INCREASES)				1,010,443	15,675,729	

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 DRUGS SOLD TO PTS	A	PHARMACY	15		2,890,613	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A					2,890,613	500
1 PURCHASED SERVICES	B	INTENSIVE CARE UNIT	31		68,176	1
2		ADULTS & PEDIATRICS	30		234,290	2
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					302,466	500
1 SHARED DIETARY COST	C	DIETARY	10	169,135	368,631	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - C				169,135	368,631	500
1 NONEMP CHILD CARE	D	EMPLOYEE BENEFITS DEPARTMENT	4	73,896	8,087	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - D				73,896	8,087	500
1 RECLASS INTERN AND RESIDENT COST	E	ADMINISTRATIVE & GENERAL	5		196,554	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - E					196,554	500
1 HOUSE STAF PHYS.	F	ADMINISTRATIVE & GENERAL	5		2,328,993	1
2						2
3						3
4						4
5						5
6						6
500 TOTAL RECLASSIFICATIONS CODE LETTER - F					2,328,993	500
1 PT TRANSPORT	H	ADMINISTRATIVE & GENERAL	5	311,192	97,416	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				311,192	97,416	500
1 FLOOR STOCK SUPPLIES	I	CENTRAL SERVICES & SUPPLY	14		353,880	1
2		ADULTS & PEDIATRICS	30		590,448	2
3		INTENSIVE CARE UNIT	31		301,065	3
4		NURSERY	43		104	4
5		SKILLED NURSING FACILITY	44		96,058	5
6		OPERATING ROOM	50		2,171,612	6
7		DELIVERY ROOM & LABOR ROOM	52		152,407	7
8		CARDIAC CATHETERIZATION	59		922,457	8
9		EMERGENCY	91		504,452	9
500 TOTAL RECLASSIFICATIONS CODE LETTER - I					5,092,483	500
1 CHEMO INFUSION	J	ADULTS & PEDIATRICS	30	17,485	2,639	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - J				17,485	2,639	500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE		OTHER	WKST A-7 REF.
			LINE #	SALARY		
	1	6	7	8	9	10
1 IMPLANTS	L	OPERATING ROOM	50		4,033,631	1
2		CARDIAC CATHETERIZATION	59		313,753	2
3		EMERGENCY	91		4,715	3
500 TOTAL RECLASSIFICATIONS CODE LETTER - L					4,352,099	500
1 NURSERY	M	ADULTS & PEDIATRICS	30	438,735	35,748	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - M				438,735	35,748	500
GRAND TOTAL (DECREASES)				1,010,443	15,675,729	

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	12,500,000					12,500,000		1
2 LAND IMPROVEMENTS	860,417	126,726		126,726		987,143		2
3 BUILDINGS AND FIXTURES	49,369,723	629,018		629,018	4,224,042	45,774,699		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	4,607,294	3,724,412		3,724,412		8,331,706		5
6 MOVABLE EQUIPMENT	17,465,481	8,403,974		8,403,974	660,266	25,209,189		6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	84,802,915	12,884,130		12,884,130	4,884,308	92,802,737		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	84,802,915	12,884,130		12,884,130	4,884,308	92,802,737		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	3,497,090						3,497,090 1
2 CAP REL COSTS-MVBLE EQUIP	4,360,169						4,360,169 2
3 TOTAL (SUM OF LINES 1-2)	7,857,259						7,857,259 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	67,216,517		67,216,517	0.724295				1
2 CAP REL COSTS-MVBLE EQUIP	25,586,220		25,586,220	0.275705				2
3 TOTAL (SUM OF LINES 1-2)	92,802,737		92,802,737	1.000000				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	3,497,090						3,497,090 1
2 CAP REL COSTS-MVBLE EQUIP	4,360,169						4,360,169 2
3 TOTAL	7,857,259						7,857,259 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	94,060	ADMINISTRATIVE & GENERAL	5	7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-1,427	OPERATION OF PLANT	7	8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,148,587			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	4,554,330			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-332,768	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	-455	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES	B	-5,096	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		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33					33
34					34
35					35
35.04 VOLUNTEER SALARIES (632.186)	A	-257,688	ADMINISTRATIVE & GENERAL	5	35.04
35.07 MISC INCOME A&G	B	-5,712,004	ADMINISTRATIVE & GENERAL	5	35.07
35.10 OUTSIDE SERVICES PT	B	-7,782	PHYSICAL THERAPY	66	35.10
35.15 WEST TOWNS (958.729)	A	-540,870	ADMINISTRATIVE & GENERAL	5	35.15
35.19 EMPLOYEE DAY CARE REVENUE	B	-467,022	EMPLOYEE BENEFITS DEPARTMENT	4	35.19
36 NON ALLOWABLE TAXES	A	-45,421	ADMINISTRATIVE & GENERAL	5	36
37					37
38 AHA LOBBYING FEES	A	-27,867	ADMINISTRATIVE & GENERAL	5	38
39 HOME OFFICE LOBBYING FEES	A	-11,760	ADMINISTRATIVE & GENERAL	5	39
40 OB/GYN OTHER REV	B	-2,719	ADULTS & PEDIATRICS	30	40
41 ADVERTISING	A	-301,738	ADMINISTRATIVE & GENERAL	5	41
42					42
42.01 MED STAFF CONTRIBUTION ADD BACK	A	110,601	ADMINISTRATIVE & GENERAL	5	42.01
43					43
44					44
44.02 INTERDEPT RENT CONFERENCE	A	-60,366	ADMINISTRATIVE & GENERAL	5	44.02
44.03 INTERDEPT RENT AUDIOLOGY	A	-28,590	PHYSICAL THERAPY	66	44.03
44.05 INTERDEPT RENT OP PHARMACY	A	-60,606	OUTPATIENT PHARMACY	73.01	44.05
44.06 EMPLOYEE HEALTH CENTER	B	-2,070	EMPLOYEE BENEFITS DEPARTMENT	4	44.06
45					45
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-5,255,845			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	5	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE OPERATING	4,489,334	4,489,334	1
2	5	ADMINISTRATIVE & GENERAL	TIS OPERATING EXPENSE	408,592	408,592	2
3	5	ADMINISTRATIVE & GENERAL	MALPRACTICE INSURANCE	406,970	717,550	3
3.01	4	EMPLOYEE BENEFITS DEPARTMENT	PENSION	7,957,970	2,782,386	5,175,584
4	5	ADMINISTRATIVE & GENERAL	WORKERS COMPENSATION	725,266	1,065,204	-339,938
4.01	5	ADMINISTRATIVE & GENERAL	PROPERTY INSURANCE	317,407	347,706	-30,299
4.02	5	ADMINISTRATIVE & GENERAL	INTEGRATED RISK INSURANCE	212,119	334,302	-122,183
4.03	5	ADMINISTRATIVE & GENERAL	EMPLOYEE HEALTH STOP LOSS	472,090	290,344	181,746
5	TOTALS (SUM OF LINES 1-4)			14,989,748	10,435,418	4,554,330
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.

----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----

SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
6	B	TRINITY HEALTH	TRINITY HEALTH		
7					
8					
9					
10					

(1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

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

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		
1	2	3	4	5	6	7	8	9		
1	52 DELIVERY ROOM & LABOR RO	AGGREGATE	3,525	3,525				1		
2	57 CT SCAN	AGGREGATE	5,030	5,030				2		
3	90.02 WOUND CARE	AGGREGATE	232,965	232,965				3		
4	30 ADULTS & PEDIATRICS	OB COVERAGE	363,500	363,500				4		
5	50 OPERATING ROOM	AGGREGATE	109,224	109,224				5		
6	91 EMERGENCY	ER	15,000	15,000				6		
7	56 RADIOISOTOPE	AGGREGATE	50	50				7		
8	60 LABORATORY	AGGREGATE	8,766	8,766				8		
9	30 ADULTS & PEDIATRICS	MOONLIGHTERS	887,377	887,377				9		
10	54 RADIOLOGY-DIAGNOSTIC	AGGREGATE	2,648	2,648				10		
11	50 OPERATING ROOM	TRAUMA CALL	160,425		160,425	208,000	2,496	249,600	12,480	11
12	53 ANESTHESIOLOGY	TRAUMA CALL	780,000		780,000	200,300	5,712	550,055	27,503	12
13	69 ELECTROCARDIOLOGY	CHAIR	18,958		18,958	177,200	135	11,501	575	13
14	40 SUBPROVIDER - IPF	DIRECTOR	22,247		22,247	154,100	159	11,780	589	14
15	30 ADULTS & PEDIATRICS	CR CHAIR	3,000	3,000						15
16	5 ADMINISTRATIVE & GENERAL	MISC	101,797		101,797	177,200	727	61,935	3,097	16
17	5 ADMINISTRATIVE & GENERAL	QA	17,610		17,610	177,200	126	10,734	537	17
18	30 ADULTS & PEDIATRICS	CHAIR	10,000		10,000	196,400	71	6,704	335	18
19	30 ADULTS & PEDIATRICS	ORTHO CHAIR	9,583		9,583	196,400	69	6,515	326	19
20	50 OPERATING ROOM	DIRECTOR	66,667		66,667	208,000	556	55,600	2,780	20
21	50 OPERATING ROOM	TRAUMA CALL	126,000		126,000	208,000	3,150	315,000	15,750	21
22	40 SUBPROVIDER - IPF	CALL	39,170		39,170	154,100	280	20,744	1,037	22
23	31 INTENSIVE CARE UNIT	ICU	574,456		574,456	196,400	4,103	387,418	19,371	23
24	50 OPERATING ROOM	VASCULAR	15,000		15,000	208,000	249	24,900	1,245	24
200	TOTAL		3,572,998	1,631,085	1,941,913		17,833	1,712,486	85,625	200

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	
10	11	12	13	14	15	16	17	18	
1	52 DELIVERY ROOM & LABOR RO	AGGREGATE						3,525	1
2	57 CT SCAN	AGGREGATE						5,030	2
3	90.02 WOUND CARE	AGGREGATE						232,965	3
4	30 ADULTS & PEDIATRICS	OB COVERAGE						363,500	4
5	50 OPERATING ROOM	AGGREGATE						109,224	5
6	91 EMERGENCY	ER						15,000	6
7	56 RADIOISOTOPE	AGGREGATE						50	7
8	60 LABORATORY	AGGREGATE						8,766	8
9	30 ADULTS & PEDIATRICS	MOONLIGHTERS						887,377	9
10	54 RADIOLOGY-DIAGNOSTIC	AGGREGATE						2,648	10
11	50 OPERATING ROOM	TRAUMA CALL				249,600			11
12	53 ANESTHESIOLOGY	TRAUMA CALL				550,055	229,945	229,945	12
13	69 ELECTROCARDIOLOGY	CHAIR				11,501	7,457	7,457	13
14	40 SUBPROVIDER - IPF	DIRECTOR				11,780	10,467	10,467	14
15	30 ADULTS & PEDIATRICS	CR CHAIR						3,000	15
16	5 ADMINISTRATIVE & GENERAL	MISC				61,935	39,862	39,862	16
17	5 ADMINISTRATIVE & GENERAL	QA				10,734	6,876	6,876	17
18	30 ADULTS & PEDIATRICS	CHAIR				6,704	3,296	3,296	18
19	30 ADULTS & PEDIATRICS	ORTHO CHAIR				6,515	3,068	3,068	19
20	50 OPERATING ROOM	DIRECTOR				55,600	11,067	11,067	20
21	50 OPERATING ROOM	TRAUMA CALL				315,000			21
22	40 SUBPROVIDER - IPF	CALL				20,744	18,426	18,426	22
23	31 INTENSIVE CARE UNIT	ICU				387,418	187,038	187,038	23
24	50 OPERATING ROOM	VASCULAR				24,900			24
200	TOTAL					1,712,486	517,502	2,148,587	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 DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	3,497,090	3,497,090				1
2 CAP REL COSTS-MVBLE EQUIP	4,360,169		4,360,169			2
4 EMPLOYEE BENEFITS DEPARTMENT	19,851,064	23,615	29,180	19,903,859		4
5 ADMINISTRATIVE & GENERAL	9,642,270	333,930	929,186	2,693,752	13,599,138	5
6 MAINTENANCE & REPAIRS	2,656,921	16,859	137,582	290,594	3,101,956	6
7 OPERATION OF PLANT	3,807,801	443,497	345,875	386,251	4,983,424	7
8 LAUNDRY & LINEN SERVICE	722,785	16,185		37,775	776,745	8
9 HOUSEKEEPING	2,051,984	15,061	18,281	391,490	2,476,816	9
10 DIETARY	1,574,982	86,709	36,759	288,040	1,986,490	10
11 CAFETERIA	335,462	76,464	4,537	34,308	450,771	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,932,296	43,420	13,765	630,425	2,619,906	13
14 CENTRAL SERVICES & SUPPLY	913,724	94,707	67,470	197,888	1,273,789	14
15 PHARMACY	2,067,666	36,345	5,866	780,111	2,889,988	15
16 MEDICAL RECORDS & LIBRARY	1,666,865	33,079	6,785	444,492	2,151,221	16
17 SOCIAL SERVICE	436,216	19,296	540	156,881	612,933	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD	196,554				196,554	22
23 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS						23
30 ADULTS & PEDIATRICS	10,631,867	650,847	51,422	3,797,761	15,131,897	30
31 INTENSIVE CARE UNIT	4,090,808	130,141	53,457	1,289,787	5,564,193	31
40 SUBPROVIDER - IPF	979,298		4,443	312,272	1,296,013	40
43 NURSERY	478,315	15,309	5,167		498,791	43
44 SKILLED NURSING FACILITY	2,123,134	142,185	3,945	736,772	3,006,036	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,319,172	300,851	533,569	890,325	6,043,917	50
51 RECOVERY ROOM	417,193	17,948	452	128,464	564,057	51
52 DELIVERY ROOM & LABOR ROOM	1,597,439	67,153	51,808	549,998	2,266,398	52
53 ANESTHESIOLOGY	17,281	5,255	21,011		43,817	53
54 RADIOLOGY-DIAGNOSTIC	1,782,076	117,718	659,778	542,070	3,101,642	54
56 RADIOISOTOPE	1,302,183	22,503			1,324,686	56
56.01 ULTRASOUND	13,712	22,645	87,008	171,919	295,284	56.01
57 CT SCAN	778,172	42,201	282,505	225,580	1,328,458	57
59 CARDIAC CATHETERIZATION	1,161,013	24,407	412,625	221,900	1,819,945	59
60 LABORATORY	4,972,690	116,157	283,890	879,188	6,251,925	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,204,463	12,931	56,179	366,086	1,639,659	65
66 PHYSICAL THERAPY	2,098,937	129,147	16,453	699,354	2,943,891	66
69 ELECTROCARDIOLOGY	471,413	24,348	76,297	142,995	715,053	69
70 ELECTROENCEPHALOGRAPHY	109,557	12,340	533	36,553	158,983	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,092,483				5,092,483	71
72 IMPL. DEV. CHARGED TO PATIENTS	4,352,099				4,352,099	72
73 DRUGS CHARGED TO PATIENTS	3,285,898				3,285,898	73
73.01 OUTPATIENT PHARMACY	1,426,555	23,496	2,063	138,032	1,590,146	73.01
74 RENAL DIALYSIS						74
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	186,752	42,698	15,899	64,237	309,586	76.01
76.05 INPATIENT RENAL DIALYSIS	302,466				302,466	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		1,088	666		1,754	90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE	938,730	24,348	16,117	140,932	1,120,127	90.02
90.03 RIVER FOREST	1,549,474	118,310	104,518	339,438	2,111,740	90.03
91 EMERGENCY	3,611,187	162,724		1,072,028	4,845,939	91
92 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92
94 HOME PROGRAM DIALYSIS						94
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	1,984,489		23,809	662,325	2,670,623	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	366,092			98,837	464,929	116
118 SUBTOTALS (SUM OF LINES 1-117)	117,358,797	3,466,187	4,359,440	19,838,860	117,262,166	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	65,962	12,210	174	11,648	89,994	190

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
 11/25/2013 14:50

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 DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	
192 PHYSICIANS' PRIVATE OFFICES	1,575				1,575	192
192.01 NON-EMPLOYEE CHILD CARE CENTER	81,983				81,983	192.01
193 NONPAID WORKERS	163,249	18,693	555	53,351	235,848	193
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	117,671,566	3,497,090	4,360,169	19,903,859	117,671,566	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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	13,599,138					5
6 MAINTENANCE & REPAIRS	405,333	3,507,289				6
7 OPERATION OF PLANT	651,184	1,545,694	7,180,302			7
8 LAUNDRY & LINEN SERVICE	101,497	2,223	43,376	923,841		8
9 HOUSEKEEPING	323,646	473,680	40,364		3,314,506	9
10 DIETARY	259,575	185,708	232,384	50,408	89,510	10
11 CAFETERIA	58,902	2,547	204,925		78,415	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	342,343	41,263	116,366		6,857	13
14 CENTRAL SERVICES & SUPPLY	166,446	146,432	253,818	23,686	50,365	14
15 PHARMACY	377,635	4,437	97,405	9,262	39,893	15
16 MEDICAL RECORDS & LIBRARY	281,100	18,446	88,654		23,313	16
17 SOCIAL SERVICE	80,092	2,314	51,715			17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD	25,684					22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,977,277	34,589	1,744,288	17	1,300,274	30
31 INTENSIVE CARE UNIT	727,073	28,277	348,782		139,626	31
40 SUBPROVIDER - IPF	169,350	10,914				40
43 NURSERY	65,177	9,879	41,029		30,543	43
44 SKILLED NURSING FACILITY	392,799	8,305	381,060	17	279,253	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	789,759		806,288	793,303	327,623	50
51 RECOVERY ROOM	73,705	4,928	48,100		31,665	51
52 DELIVERY ROOM & LABOR ROOM	296,150	14,725	179,971	17,891	63,954	52
53 ANESTHESIOLOGY	5,726		14,807	63	4,613	53
54 RADIOLOGY-DIAGNOSTIC	405,292	507,175	315,489	736	83,152	54
56 RADIOISOTOPE	173,097	668	60,307	218	33,037	56
56.01 ULTRASOUND	38,585	452	60,688	201	6,857	56.01
57 CT SCAN	173,590	253	113,100	908	36,527	57
59 CARDIAC CATHETERIZATION	237,812	56,719	65,412	328		59
60 LABORATORY	816,939	232,612	311,303		122,298	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	214,254	57	34,656		16,331	65
66 PHYSICAL THERAPY	384,678	8,853	346,118		186,002	66
69 ELECTROCARDIOLOGY	93,436	31,076	65,254		35,405	69
70 ELECTROENCEPHALOGRAPHY	20,774		33,071		3,615	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	665,435					71
72 IMPL. DEV. CHARGED TO PATIENTS	568,689					72
73 DRUGS CHARGED TO PATIENTS	429,368					73
73.01 OUTPATIENT PHARMACY	207,784	662	62,971			73.01
74 RENAL DIALYSIS						74
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	40,454	8,279	114,432		45,877	76.01
76.05 INPATIENT RENAL DIALYSIS	39,523					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	229		2,917			90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE	146,367	838	65,254	627		90.02
90.03 RIVER FOREST	275,941	3,973	317,074			90.03
91 EMERGENCY	633,219	106,744	436,104	26,176	118,682	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	348,970	7,279			153,838	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	60,752	1,984			6,981	116
118 SUBTOTALS (SUM OF LINES 1-117)	13,545,641	3,501,985	7,097,482	923,841	3,314,506	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,760	5,304	32,722			190
192 PHYSICIANS' PRIVATE OFFICES	206					192

PROVIDER CCN: 14-0008 GOTTIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
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VERSION: 2013.11
11/25/2013 14:50

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	
192.01 NON-EMPLOYEE CHILD CARE CENTER	10,713					192.01
193 NONPAID WORKERS	30,818					193
200 CROSS FOOT ADJUSTMENTS			50,098			200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	13,599,138	3,507,289	7,180,302	923,841	3,314,506	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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	2,804,075					10
11 CAFETERIA		795,560				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		17,514	3,144,249			13
14 CENTRAL SERVICES & SUPPLY		21,594	87,265	2,023,395		14
15 PHARMACY		29,995	121,215	159,394	3,729,224	15
16 MEDICAL RECORDS & LIBRARY		28,495	115,154	4	2,214,770	16
17 SOCIAL SERVICE		6,545	26,452	11		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,769,901	198,891	803,768	146,780	15,779	30
31 INTENSIVE CARE UNIT	251,352	59,939	242,225	72,553	9,053	31
40 SUBPROVIDER - IPF	209,479	19,840	80,177	4,529	142	40
43 NURSERY		5,846	23,627	20		43
44 SKILLED NURSING FACILITY	573,343	46,225	186,805	21,567	440	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		48,017	194,047	683,458	16,888	50
51 RECOVERY ROOM		5,402	21,829	10,311	364	51
52 DELIVERY ROOM & LABOR ROOM		20,831	84,183	38,569	2,237	52
53 ANESTHESIOLOGY		1,258	5,085	43,803	4,304	53
54 RADIOLOGY-DIAGNOSTIC		30,122	121,729	13,411	2,869	54
56 RADIOISOTOPE		356	1,438	10,239	212,828	56
56.01 ULTRASOUND		6,126	24,757	8,929	430	56.01
57 CT SCAN		9,113	36,827	19,873	530	57
59 CARDIAC CATHETERIZATION		8,185	33,077	204,699	15,864	59
60 LABORATORY		57,486	232,312	320,219	390	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		21,200	85,672	34,428	5,277	65
66 PHYSICAL THERAPY		37,163	150,184	14,427	170	66
69 ELECTROCARDIOLOGY		9,214	37,238	6,638	236	69
70 ELECTROENCEPHALOGRAPHY		2,262	9,142	1,897	20	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 OUTPATIENT PHARMACY		6,749	27,273	17,290	1,077,342	73.01
74 RENAL DIALYSIS						74
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION		2,682	10,837	1,020		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		8,109	32,769	22,670	19,694	90.02
90.03 RIVER FOREST				10,672	85,253	90.03
91 EMERGENCY		46,759	188,962	147,932	22,133	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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		29,868	120,702	7,068	951	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE		4,398	17,771	975	21,260	116
118 SUBTOTALS (SUM OF LINES 1-117)	2,804,075	790,184	3,122,522	2,023,386	3,729,224	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,843	7,448			190
192 PHYSICIANS' PRIVATE OFFICES						192

PROVIDER CCN: 14-0008 GOTTIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 14:50

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

COST CENTER DESCRIPTION	DIETARY 10	CAFETERIA 11	NURSING ADMINI- STRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	
192.01 NON-EMPLOYEE CHILD CARE CENTER						192.01
193 NONPAID WORKERS						193
200 CROSS FOOT ADJUSTMENTS		3,533	14,279	9		200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,804,075	795,560	3,144,249	2,023,395	3,729,224	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	I/R-OTHER PROGRAM COSTS 22	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	4,921,157					16
17 SOCIAL SERVICE		780,062				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD			222,238			22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	785,745	495,377	2,222	24,406,805	-2,222	30
31 INTENSIVE CARE UNIT	209,247	51,150		7,703,470		31
40 SUBPROVIDER - IPF	299,779	189,999		2,280,222		40
43 NURSERY	29,892			704,804		43
44 SKILLED NURSING FACILITY				4,895,850		44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	788,308			10,491,608		50
51 RECOVERY ROOM	39,287			799,648		51
52 DELIVERY ROOM & LABOR ROOM	61,493			3,046,402		52
53 ANESTHESIOLOGY	80,283			203,759		53
54 RADIOLOGY-DIAGNOSTIC	139,214			4,720,831		54
56 RADIOISOTOPE	64,909			1,881,783		56
56.01 ULTRASOUND	36,725			479,034		56.01
57 CT SCAN	127,257			1,846,436		57
59 CARDIAC CATHETERIZATION	147,754			2,589,795		59
60 LABORATORY	429,598			8,775,082		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	158,857			2,210,391		65
66 PHYSICAL THERAPY	85,407			4,156,893		66
69 ELECTROCARDIOLOGY	108,467			1,102,017		69
70 ELECTROENCEPHALOGRAPHY	5,978			235,742		70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	220,350			5,978,268		71
72 IMPL. DEV. CHARGED TO PATIENTS				4,920,788		72
73 DRUGS CHARGED TO PATIENTS	861,759			4,577,025		73
73.01 OUTPATIENT PHARMACY				2,990,217		73.01
74 RENAL DIALYSIS						74
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	2,562			535,729		76.01
76.05 INPATIENT RENAL DIALYSIS				341,989		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	1,708			6,608		90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE				1,416,455		90.02
90.03 RIVER FOREST				2,804,653		90.03
91 EMERGENCY	236,578	43,536	220,016	7,072,780	-220,016	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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				3,339,299		101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE				579,050		116
118 SUBTOTALS (SUM OF LINES 1-117)	4,921,157	780,062	222,238	117,093,433	-222,238	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				149,071		190
192 PHYSICIANS' PRIVATE OFFICES				1,781		192

PROVIDER CCN: 14-0008 GOTTlieb MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 14:50

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	I/R-OTHER PROGRAM COSTS 22	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25
192.01 NON-EMPLOYEE CHILD CARE CENTER				92,696	192.01
193 NONPAID WORKERS				334,585	193
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	4,921,157	780,062	222,238	117,671,566	-222,238 202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION		TOTAL	
		26	
GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS DEPARTMENT		4
5	ADMINISTRATIVE & GENERAL		5
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SERVICES-SALARY & FRINGES APPRVD		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)		23
INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS	24,404,583	30
31	INTENSIVE CARE UNIT	7,703,470	31
40	SUBPROVIDER - IPF	2,280,222	40
43	NURSERY	704,804	43
44	SKILLED NURSING FACILITY	4,895,850	44
ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM	10,491,608	50
51	RECOVERY ROOM	799,648	51
52	DELIVERY ROOM & LABOR ROOM	3,046,402	52
53	ANESTHESIOLOGY	203,759	53
54	RADIOLOGY-DIAGNOSTIC	4,720,831	54
56	RADIOISOTOPE	1,881,783	56
56.01	ULTRASOUND	479,034	56.01
57	CT SCAN	1,846,436	57
59	CARDIAC CATHETERIZATION	2,589,795	59
60	LABORATORY	8,775,082	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	2,210,391	65
66	PHYSICAL THERAPY	4,156,893	66
69	ELECTROCARDIOLOGY	1,102,017	69
70	ELECTROENCEPHALOGRAPHY	235,742	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,978,268	71
72	IMPL. DEV. CHARGED TO PATIENTS	4,920,788	72
73	DRUGS CHARGED TO PATIENTS	4,577,025	73
73.01	OUTPATIENT PHARMACY	2,990,217	73.01
74	RENAL DIALYSIS		74
76	LITHOTRIPSY		76
76.01	CARDIAC REHABILITATION	535,729	76.01
76.05	INPATIENT RENAL DIALYSIS	341,989	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	6,608	90
90.01	OUTPATIENT INFUSION PROCEDURES		90.01
90.02	WOUND CARE	1,416,455	90.02
90.03	RIVER FOREST	2,804,653	90.03
91	EMERGENCY	6,852,764	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		92
OTHER REIMBURSABLE COST CENTERS			
94	HOME PROGRAM DIALYSIS		94
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	3,339,299	101
SPECIAL PURPOSE COST CENTERS			
116	HOSPICE	579,050	116
118	SUBTOTALS (SUM OF LINES 1-117)	116,871,195	118
NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	149,071	190
192	PHYSICIANS' PRIVATE OFFICES	1,781	192

PROVIDER CCN: 14-0008 GOTTIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 14:50

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

COST CENTER DESCRIPTION	TOTAL	
	26	
192.01 NON-EMPLOYEE CHILD CARE CENTER	92,696	192.01
193 NONPAID WORKERS	334,585	193
200 CROSS FOOT ADJUSTMENTS		200
201 NEGATIVE COST CENTER		201
202 TOTAL (SUM OF LINES 118-201)	117,449,328	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 DEPARTMENT 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT		23,615	29,180	52,795	52,795	4
5 ADMINISTRATIVE & GENERAL	47,130	333,930	929,186	1,310,246	7,146	5
6 MAINTENANCE & REPAIRS	771	16,859	137,582	155,212	771	6
7 OPERATION OF PLANT	210	443,497	345,875	789,582	1,025	7
8 LAUNDRY & LINEN SERVICE		16,185		16,185	100	8
9 HOUSEKEEPING	31,663	15,061	18,281	65,005	1,039	9
10 DIETARY	544	86,709	36,759	124,012	764	10
11 CAFETERIA		76,464	4,537	81,001	91	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		43,420	13,765	57,185	1,672	13
14 CENTRAL SERVICES & SUPPLY	244,437	94,707	67,470	406,614	525	14
15 PHARMACY	18,840	36,345	5,866	61,051	2,069	15
16 MEDICAL RECORDS & LIBRARY		33,079	6,785	39,864	1,179	16
17 SOCIAL SERVICE		19,296	540	19,836	416	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	149,400	650,847	51,422	851,669	10,072	30
31 INTENSIVE CARE UNIT	20,510	130,141	53,457	204,108	3,421	31
40 SUBPROVIDER - IPF	12,424		4,443	16,867	828	40
43 NURSERY	897	15,309	5,167	21,373		43
44 SKILLED NURSING FACILITY	18,528	142,185	3,945	164,658	1,954	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	73,095	300,851	533,569	907,515	2,362	50
51 RECOVERY ROOM	9,468	17,948	452	27,868	341	51
52 DELIVERY ROOM & LABOR ROOM	14,807	67,153	51,808	133,768	1,459	52
53 ANESTHESIOLOGY	9,911	5,525	21,011	36,447		53
54 RADIOLOGY-DIAGNOSTIC		117,718	659,778	777,496	1,438	54
56 RADIOISOTOPE		22,503		22,503		56
56.01 ULTRASOUND		22,645	87,008	109,653	456	56.01
57 CT SCAN		42,201	282,505	324,706	598	57
59 CARDIAC CATHETERIZATION	16,104	24,407	412,625	453,136	589	59
60 LABORATORY	50,126	116,157	283,890	450,173	2,332	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	15,445	12,931	56,179	84,555	971	65
66 PHYSICAL THERAPY		129,147	16,453	145,600	1,855	66
69 ELECTROCARDIOLOGY		24,348	76,297	100,645	379	69
70 ELECTROENCEPHALOGRAPHY		12,340	533	12,873	97	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 OUTPATIENT PHARMACY		23,496	2,063	25,559	366	73.01
74 RENAL DIALYSIS						74
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION		42,698	15,899	58,597	170	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		1,088	666	1,754		90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE		24,348	16,117	40,465	374	90.02
90.03 RIVER FOREST		118,310	104,518	222,828	900	90.03
91 EMERGENCY	103,503	162,724		266,227	2,844	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	901		23,809	24,710	1,757	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	23,936			23,936	262	116
118 SUBTOTALS (SUM OF LINES 1-117)	862,650	3,466,187	4,359,440	8,688,277	52,622	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		12,210	174	12,384	31	190
192 PHYSICIANS' PRIVATE OFFICES						192

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
 11/25/2013 14:50

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 DEPARTMENT 4	
192.01 NON-EMPLOYEE CHILD CARE CENTER						192.01
193 NONPAID WORKERS		18,693	555	19,248	142	193
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	862,650	3,497,090	4,360,169	8,719,909	52,795	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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	1,317,392					5
6 MAINTENANCE & REPAIRS	39,265	195,248				6
7 OPERATION OF PLANT	63,080	86,049	939,736			7
8 LAUNDRY & LINEN SERVICE	9,832	124	5,677	31,918		8
9 HOUSEKEEPING	31,352	26,369	5,283		129,048	9
10 DIETARY	25,145	10,338	30,414	1,742	3,485	10
11 CAFETERIA	5,706	142	26,820		3,053	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	33,163	2,297	15,230		267	13
14 CENTRAL SERVICES & SUPPLY	16,124	8,152	33,219	818	1,961	14
15 PHARMACY	36,581	247	12,748	320	1,553	15
16 MEDICAL RECORDS & LIBRARY	27,230	1,027	11,603		908	16
17 SOCIAL SERVICE	7,759	129	6,768			17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD	2,488					22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	191,578	1,926	228,286	1	50,624	30
31 INTENSIVE CARE UNIT	70,432	1,574	45,647		5,436	31
40 SUBPROVIDER - IPF	16,405	608				40
43 NURSERY	6,314	550	5,370		1,189	43
44 SKILLED NURSING FACILITY	38,050	462	49,872	1	10,873	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	76,504		105,524	27,408	12,756	50
51 RECOVERY ROOM	7,140	274	6,295		1,233	51
52 DELIVERY ROOM & LABOR ROOM	28,688	820	23,554	618	2,490	52
53 ANESTHESIOLOGY	555		1,938	2	180	53
54 RADIOLOGY-DIAGNOSTIC	39,261	28,234	41,290	25	3,237	54
56 RADIOISOTOPE	16,768	37	7,893	8	1,286	56
56.01 ULTRASOUND	3,738	25	7,943	7	267	56.01
57 CT SCAN	16,816	14	14,802	31	1,422	57
59 CARDIAC CATHETERIZATION	23,037	3,157	8,561	11		59
60 LABORATORY	79,137	12,949	40,742		4,762	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	20,755	3	4,536		636	65
66 PHYSICAL THERAPY	37,264	493	45,299		7,242	66
69 ELECTROCARDIOLOGY	9,051	1,730	8,540		1,378	69
70 ELECTROENCEPHALOGRAPHY	2,012		4,328		141	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	64,461					71
72 IMPL. DEV. CHARGED TO PATIENTS	55,089					72
73 DRUGS CHARGED TO PATIENTS	41,593					73
73.01 OUTPATIENT PHARMACY	20,128	37	8,241			73.01
74 RENAL DIALYSIS						74
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	3,919	461	14,977		1,786	76.01
76.05 INPATIENT RENAL DIALYSIS	3,829					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	22		382			90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE	14,179	47	8,540	22		90.02
90.03 RIVER FOREST	26,730	221	41,498			90.03
91 EMERGENCY	61,340	5,942	57,076	904	4,621	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	33,805	405			5,990	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	5,885	110			272	116
118 SUBTOTALS (SUM OF LINES 1-117)	1,312,210	194,953	928,896	31,918	129,048	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,139	295	4,283			190
192 PHYSICIANS' PRIVATE OFFICES	20					192

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
 11/25/2013 14:50

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	
192.01 NON-EMPLOYEE CHILD CARE CENTER	1,038					192.01
193 NONPAID WORKERS	2,985		6,557			193
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,317,392	195,248	939,736	31,918	129,048	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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	195,900					10
11 CAFETERIA		116,813				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		2,572	112,386			13
14 CENTRAL SERVICES & SUPPLY		3,171	3,119	473,703		14
15 PHARMACY		4,404	4,333	37,316	160,622	15
16 MEDICAL RECORDS & LIBRARY		4,184	4,116	1	95,393	16
17 SOCIAL SERVICE		961	945	3		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	123,650	29,201	28,732	34,363	680	30
31 INTENSIVE CARE UNIT	17,560	8,801	8,658	16,985	390	31
40 SUBPROVIDER - IPF	14,635	2,913	2,866	1,060	6	40
43 NURSERY		858	844	5		43
44 SKILLED NURSING FACILITY	40,055	6,787	6,677	5,049	19	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		7,050	6,936	160,009	727	50
51 RECOVERY ROOM		793	780	2,414	16	51
52 DELIVERY ROOM & LABOR ROOM		3,059	3,009	9,029	96	52
53 ANESTHESIOLOGY		185	182	10,255	185	53
54 RADIOLOGY-DIAGNOSTIC		4,423	4,351	3,140	124	54
56 RADIOISOTOPE		52	51	2,397	9,167	56
56.01 ULTRASOUND		899	885	2,090	19	56.01
57 CT SCAN		1,338	1,316	4,653	23	57
59 CARDIAC CATHETERIZATION		1,202	1,182	47,922	683	59
60 LABORATORY		8,441	8,304	74,967	17	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		3,113	3,062	8,060	227	65
66 PHYSICAL THERAPY		5,457	5,368	3,377	7	66
69 ELECTROCARDIOLOGY		1,353	1,331	1,554	10	69
70 ELECTROENCEPHALOGRAPHY		332	327	444	1	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 OUTPATIENT PHARMACY		991	975	4,048	46,402	73.01
74 RENAL DIALYSIS						74
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION		394	387	239		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		1,191	1,171	5,307	848	90.02
90.03 RIVER FOREST				2,498	3,672	90.03
91 EMERGENCY		6,866	6,754	34,633	953	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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		4,386	4,314	1,655	41	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE		646	635	228	916	116
118 SUBTOTALS (SUM OF LINES 1-117)	195,900	116,023	111,610	473,701	160,622	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		271	266			190
192 PHYSICIANS' PRIVATE OFFICES						192

PROVIDER CCN: 14-0008 GOTTIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 14:50

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

COST CENTER DESCRIPTION	DIETARY 10	CAFETERIA 11	NURSING ADMINI- STRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	
192.01 NON-EMPLOYEE CHILD CARE CENTER						192.01
193 NONPAID WORKERS		519	510	2		193
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	195,900	116,813	112,386	473,703	160,622	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	I/R-OTHER PROGRAM COSTS 22	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS DEPARTMENT					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	185,505				16
17 SOCIAL SERVICE		36,817			17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SERVICES-SALARY & FRINGES APPRVD					21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD			2,488		22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	29,619	23,381		1,603,782	30
31 INTENSIVE CARE UNIT	7,888	2,414		393,314	31
40 SUBPROVIDER - IPF	11,300	8,967		76,455	40
43 NURSERY	1,127			37,630	43
44 SKILLED NURSING FACILITY				324,457	44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	29,716			1,336,507	50
51 RECOVERY ROOM	1,481			48,635	51
52 DELIVERY ROOM & LABOR ROOM	2,318			208,908	52
53 ANESTHESIOLOGY	3,026			52,955	53
54 RADIOLOGY-DIAGNOSTIC	5,248			908,267	54
56 RADIOISOTOPE	2,447			62,609	56
56.01 ULTRASOUND	1,384			127,366	56.01
57 CT SCAN	4,797			370,516	57
59 CARDIAC CATHETERIZATION	5,570			545,050	59
60 LABORATORY	16,194			698,018	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	5,988			131,906	65
66 PHYSICAL THERAPY	3,219			255,181	66
69 ELECTROCARDIOLOGY	4,089			130,060	69
70 ELECTROENCEPHALOGRAPHY	225			20,780	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,306			72,767	71
72 IMPL. DEV. CHARGED TO PATIENTS				55,089	72
73 DRUGS CHARGED TO PATIENTS	32,484			74,077	73
73.01 OUTPATIENT PHARMACY				106,747	73.01
74 RENAL DIALYSIS					74
76 LITHOTRIPSY					76
76.01 CARDIAC REHABILITATION	97			81,027	76.01
76.05 INPATIENT RENAL DIALYSIS				3,829	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	64			2,222	90
90.01 OUTPATIENT INFUSION PROCEDURES					90.01
90.02 WOUND CARE				72,144	90.02
90.03 RIVER FOREST				298,347	90.03
91 EMERGENCY	8,918	2,055		459,133	91
92 OBSERVATION BEDS (NON-DISTINCT PART)					92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
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				77,063	101
SPECIAL PURPOSE COST CENTERS					
116 HOSPICE				32,890	116
118 SUBTOTALS (SUM OF LINES 1-117)	185,505	36,817		8,667,731	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				18,669	190
192 PHYSICIANS' PRIVATE OFFICES				20	192

PROVIDER CCN: 14-0008 GOTTlieb MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 14:50

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	I/R-OTHER PROGRAM COSTS 22	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25
192.01 NON-EMPLOYEE CHILD CARE CENTER				1,038	192.01
193 NONPAID WORKERS				29,963	193
200 CROSS FOOT ADJUSTMENTS			2,488	2,488	200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	185,505	36,817	2,488	8,719,909	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION		TOTAL	
		26	
GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS DEPARTMENT		4
5	ADMINISTRATIVE & GENERAL		5
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SERVICES-SALARY & FRINGES APPRVD		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)		23
INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS	1,603,782	30
31	INTENSIVE CARE UNIT	393,314	31
40	SUBPROVIDER - IPF	76,455	40
43	NURSERY	37,630	43
44	SKILLED NURSING FACILITY	324,457	44
ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM	1,336,507	50
51	RECOVERY ROOM	48,635	51
52	DELIVERY ROOM & LABOR ROOM	208,908	52
53	ANESTHESIOLOGY	52,955	53
54	RADIOLOGY-DIAGNOSTIC	908,267	54
56	RADIOISOTOPE	62,609	56
56.01	ULTRASOUND	127,366	56.01
57	CT SCAN	370,516	57
59	CARDIAC CATHETERIZATION	545,050	59
60	LABORATORY	698,018	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	131,906	65
66	PHYSICAL THERAPY	255,181	66
69	ELECTROCARDIOLOGY	130,060	69
70	ELECTROENCEPHALOGRAPHY	20,780	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	72,767	71
72	IMPL. DEV. CHARGED TO PATIENTS	55,089	72
73	DRUGS CHARGED TO PATIENTS	74,077	73
73.01	OUTPATIENT PHARMACY	106,747	73.01
74	RENAL DIALYSIS		74
76	LITHOTRIPSY		76
76.01	CARDIAC REHABILITATION	81,027	76.01
76.05	INPATIENT RENAL DIALYSIS	3,829	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	2,222	90
90.01	OUTPATIENT INFUSION PROCEDURES		90.01
90.02	WOUND CARE	72,144	90.02
90.03	RIVER FOREST	298,347	90.03
91	EMERGENCY	459,133	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		92
OTHER REIMBURSABLE COST CENTERS			
94	HOME PROGRAM DIALYSIS		94
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	77,063	101
SPECIAL PURPOSE COST CENTERS			
116	HOSPICE	32,890	116
118	SUBTOTALS (SUM OF LINES 1-117)	8,667,731	118
NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,669	190
192	PHYSICIANS' PRIVATE OFFICES	20	192

PROVIDER CCN: 14-0008 GOTTlieb MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 14:50

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

COST CENTER DESCRIPTION	TOTAL	
	26	
192.01 NON-EMPLOYEE CHILD CARE CENTER	1,038	192.01
193 NONPAID WORKERS	29,963	193
200 CROSS FOOT ADJUSTMENTS	2,488	200
201 NEGATIVE COST CENTER		201
202 TOTAL (SUM OF LINES 118-201)	8,719,909	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 DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINI- STRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	295,587					1
2 CAP REL COSTS-MVBLE EQUIP		3,239,400				2
4 EMPLOYEE BENEFITS DEPARTMENT	1,996	21,679	54,097,282			4
5 ADMINISTRATIVE & GENERAL	28,225	690,341	7,321,430	-13,599,138	104,072,428	5
6 MAINTENANCE & REPAIRS	1,425	102,217	789,815		3,101,956	6
7 OPERATION OF PLANT	37,486	256,969	1,049,804		4,983,424	7
8 LAUNDRY & LINEN SERVICE	1,368		102,671		776,745	8
9 HOUSEKEEPING	1,273	13,582	1,064,043		2,476,816	9
10 DIETARY	7,329	27,310	782,874		1,986,490	10
11 CAFETERIA	6,463	3,371	93,246		450,771	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	3,670	10,227	1,713,451		2,619,906	13
14 CENTRAL SERVICES & SUPPLY	8,005	50,127	537,845		1,273,789	14
15 PHARMACY	3,072	4,358	2,120,288		2,889,988	15
16 MEDICAL RECORDS & LIBRARY	2,796	5,041	1,208,099		2,151,221	16
17 SOCIAL SERVICE	1,631	401	426,393		612,933	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)					196,554	23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	55,012	38,204	10,322,014		15,131,897	30
31 INTENSIVE CARE UNIT	11,000	39,716	3,505,552		5,564,193	31
40 SUBPROVIDER - IPF		3,301	848,734		1,296,013	40
43 NURSERY	1,294	3,839			498,791	43
44 SKILLED NURSING FACILITY	12,018	2,931	2,002,496		3,006,036	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	25,429	396,417	2,419,842		6,043,917	50
51 RECOVERY ROOM	1,517	336	349,156		564,057	51
52 DELIVERY ROOM & LABOR ROOM	5,676	38,491	1,494,857		2,266,398	52
53 ANESTHESIOLOGY	467	15,610			43,817	53
54 RADIOLOGY-DIAGNOSTIC	9,950	490,184	1,473,309		3,101,642	54
56 RADIOISOTOPE	1,902				1,324,686	56
56.01 ULTRASOUND	1,914	64,643	467,263		295,284	56.01
57 CT SCAN	3,567	209,888	613,111		1,328,458	57
59 CARDIAC CATHETERIZATION	2,063	306,561	603,110		1,819,945	59
60 LABORATORY	9,818	210,917	2,389,573		6,251,925	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,093	41,738	994,995		1,639,659	65
66 PHYSICAL THERAPY	10,916	12,224	1,900,796		2,943,891	66
69 ELECTROCARDIOLOGY	2,058	56,685	388,650		715,053	69
70 ELECTROENCEPHALOGRAPHY	1,043	396	99,349		158,983	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS					5,092,483	71
72 IMPL. DEV. CHARGED TO PATIENTS					4,352,099	72
73 DRUGS CHARGED TO PATIENTS					3,285,898	73
73.01 OUTPATIENT PHARMACY	1,986	1,533	375,161		1,590,146	73.01
74 RENAL DIALYSIS						74
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	3,609	11,812	174,593		309,586	76.01
76.05 INPATIENT RENAL DIALYSIS					302,466	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			1,754	90
90.01 OUTPATIENT INFUSION PROCEDURES						90.01
90.02 WOUND CARE	2,058	11,974	383,044		1,120,127	90.02
90.03 RIVER FOREST	10,000	77,652	922,570		2,111,740	90.03
91 EMERGENCY	13,754		2,913,698		4,845,939	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	1,800,154		2,670,623	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE			268,633		464,929	116
118 SUBTOTALS (SUM OF LINES 1-117)	292,975	3,238,859	53,920,619	-13,599,138	103,663,028	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,032	129	31,658		89,994	190

PROVIDER CCN: 14-0008 GOTTSLIEB MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
 11/25/2013 14:50

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 DEPARTMENT GROSS SALARIES 4	RECON- CILIATION 5A	ADMINI- STRATIVE & GENERAL ACCUM COST 5	
192	PHYSICIANS' PRIVATE OFFICES					1,575	192
192.01	NON-EMPLOYEE CHILD CARE CENTER					81,983	192.01
193	NONPAID WORKERS	1,580	412	145,005		235,848	193
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	3,497,090	4,360,169	19,903,859		13,599,138	202
203	UNIT COST MULT-WS B PT I	11.831001	1.345980	0.367927		0.130670	203
204	COST TO BE ALLOC PER B PT II			52,795		1,317,392	204
205	UNIT COST MULT-WS B PT II			0.000976		0.012658	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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS	1,234,014					6
7 OPERATION OF PLANT	543,841	226,455				7
8 LAUNDRY & LINEN SERVICE	782	1,368	160,694			8
9 HOUSEKEEPING	166,661	1,273		26,587		9
10 DIETARY	65,340	7,329	8,768	718	148,263	10
11 CAFETERIA	896	6,463		629		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	14,518	3,670		55		13
14 CENTRAL SERVICES & SUPPLY	51,521	8,005	4,120	404		14
15 PHARMACY	1,561	3,072	1,611	320		15
16 MEDICAL RECORDS & LIBRARY	6,490	2,796		187		16
17 SOCIAL SERVICE	814	1,631				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	12,170	55,012	3	10,430	93,582	30
31 INTENSIVE CARE UNIT	9,949	11,000		1,120	13,290	31
40 SUBPROVIDER - IPF	3,840				11,076	40
43 NURSERY	3,476	1,294		245		43
44 SKILLED NURSING FACILITY	2,922	12,018	3	2,240	30,315	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		25,429	137,988	2,628		50
51 RECOVERY ROOM	1,734	1,517		254		51
52 DELIVERY ROOM & LABOR ROOM	5,181	5,676	3,112	513		52
53 ANESTHESIOLOGY		467	11	37		53
54 RADIOLOGY-DIAGNOSTIC	178,446	9,950	128	667		54
56 RADIOISOTOPE	235	1,902	38	265		56
56.01 ULTRASOUND	159	1,914	35	55		56.01
57 CT SCAN	89	3,567	158	293		57
59 CARDIAC CATHETERIZATION	19,956	2,063	57			59
60 LABORATORY	81,843	9,818		981		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	20	1,093		131		65
66 PHYSICAL THERAPY	3,115	10,916		1,492		66
69 ELECTROCARDIOLOGY	10,934	2,058		284		69
70 ELECTROENCEPHALOGRAPHY		1,043		29		70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 OUTPATIENT PHARMACY	233	1,986				73.01
74 RENAL DIALYSIS						74
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	2,913	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	295	2,058	109			90.02
90.03 RIVER FOREST	1,398	10,000				90.03
91 EMERGENCY	37,557	13,754	4,553	952		91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	2,561			1,234		101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	698			56		116
118 SUBTOTALS (SUM OF LINES 1-117)	1,232,148	223,843	160,694	26,587	148,263	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,866	1,032				190

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
 11/25/2013 14:50

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		MAINTEN- ANCE AND REPAIRS MAINT REQS	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6	7	8	9	10	
192	PHYSICIANS' PRIVATE OFFICES						192
192.01	NON-EMPLOYEE CHILD CARE CENTER						192.01
193	NONPAID WORKERS		1,580				193
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	3,507,289	7,180,302	923,841	3,314,506	2,804,075	202
203	UNIT COST MULT-WS B PT I	2.842179	31.707412	5.749070	124.666416	18.912844	203
204	COST TO BE ALLOC PER B PT II	195,248	939,736	31,918	129,048	195,900	204
205	UNIT COST MULT-WS B PT II	0.158222	4.149769	0.198626	4.853801	1.321301	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA (FTES SERVED) 11	NURSING ADMINI-STRATION (FTES SERVED) 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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	62,595					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,378	61,217				13
14 CENTRAL SERVICES & SUPPLY	1,699	1,699	10,389,061			14
15 PHARMACY	2,360	2,360	818,402	4,648,407		15
16 MEDICAL RECORDS & LIBRARY	2,242	2,242	19	2,760,667	5,762	16
17 SOCIAL SERVICE	515	515	56			17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	15,649	15,649	753,639	19,668	920	30
31 INTENSIVE CARE UNIT	4,716	4,716	372,520	11,284	245	31
40 SUBPROVIDER - IPF	1,561	1,561	23,256	177	351	40
43 NURSERY	460	460	104		35	43
44 SKILLED NURSING FACILITY	3,637	3,637	110,737	549		44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,778	3,778	3,509,199	21,051	923	50
51 RECOVERY ROOM	425	425	52,940	454	46	51
52 DELIVERY ROOM & LABOR ROOM	1,639	1,639	198,030	2,789	72	52
53 ANESTHESIOLOGY	99	99	224,906	5,365	94	53
54 RADIOLOGY-DIAGNOSTIC	2,370	2,370	68,859	3,576	163	54
56 RADIOISOTOPE	28	28	52,574	265,286	76	56
56.01 ULTRASOUND	482	482	45,845	536	43	56.01
57 CT SCAN	717	717	102,038	661	149	57
59 CARDIAC CATHETERIZATION	644	644	1,051,023	19,774	173	59
60 LABORATORY	4,523	4,523	1,644,155	486	503	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,668	1,668	176,772	6,578	186	65
66 PHYSICAL THERAPY	2,924	2,924	74,073	212	100	66
69 ELECTROCARDIOLOGY	725	725	34,083	294	127	69
70 ELECTROENCEPHALOGRAPHY	178	178	9,738	25	7	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS					258	71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS					1,009	73
73.01 OUTPATIENT PHARMACY	531	531	88,773	1,342,887		73.01
74 RENAL DIALYSIS						74
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	211	211	5,235		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	638	116,398	24,548		90.02
90.03 RIVER FOREST			54,795	106,266		90.03
91 EMERGENCY	3,679	3,679	759,554	27,588	277	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	36,290	1,186		101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	346	346	5,004	26,500		116
118 SUBTOTALS (SUM OF LINES 1-117)	62,172	60,794	10,389,017	4,648,407	5,762	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	145	145				190

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
 11/25/2013 14:50

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAFETERIA (FTES SERVED) 11	NURSING ADMINI- STRATION (FTES SERVED) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS) 14	PHARMACY (COSTED REQUIS) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	
192	PHYSICIANS' PRIVATE OFFICES						192
192.01	NON-EMPLOYEE CHILD CARE CENTER						192.01
193	NONPAID WORKERS	278	278	44			193
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	795,560	3,144,249	2,023,395	3,729,224	4,921,157	202
203	UNIT COST MULT-WS B PT I	12.709641	51.362350	0.194762	0.802258	854.070982	203
204	COST TO BE ALLOC PER B PT II	116,813	112,386	473,703	160,622	185,505	204
205	UNIT COST MULT-WS B PT II	1.866171	1.835863	0.045596	0.034554	32.194551	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	SOCIAL SERVICE	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)	
	(TIME SPENT) 17	22	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS DEPARTMENT			4
5 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 SERVICES-SALARY & FRINGES APPRVD			21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD		100	22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS	5,530	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 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 CHARGED TO PATIENTS			71
72 IMPL. DEV. CHARGED TO PATIENTS			72
73 DRUGS CHARGED TO PATIENTS			73
73.01 OUTPATIENT PHARMACY			73.01
74 RENAL DIALYSIS			74
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
90.03 RIVER FOREST			90.03
91 EMERGENCY	486	99	91
92 OBSERVATION BEDS (NON-DISTINCT PART)			92
OTHER REIMBURSABLE COST CENTERS			
94 HOME PROGRAM DIALYSIS			94
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	118
NONREIMBURSABLE COST CENTERS			
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			190

PROVIDER CCN: 14-0008 GOTTSLIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 14:50

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	SOCIAL SERVICE (TIME SPENT) 17	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME) 22	
192 PHYSICIANS' PRIVATE OFFICES			192
192.01 NON-EMPLOYEE CHILD CARE CENTER			192.01
193 NONPAID WORKERS			193
200 CROSS FOOT ADJUSTMENTS			200
201 NEGATIVE COST CENTER			201
202 COST TO BE ALLOC PER B PT I	780,062	222,238	202
203 UNIT COST MULT-WS B PT I	89.579927	2,222.380000	203
204 COST TO BE ALLOC PER B PT II	36,817	2,488	204
205 UNIT COST MULT-WS B PT II	4.227951	24.880000	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	24,404,583		24,404,583	6,364	24,410,947	30
31 INTENSIVE CARE UNIT	7,703,470		7,703,470	187,038	7,890,508	31
40 SUBPROVIDER - IPF	2,280,222		2,280,222	28,893	2,309,115	40
43 NURSERY	704,804		704,804		704,804	43
44 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	4,895,850		4,895,850		4,895,850	44
50 OPERATING ROOM	10,491,608		10,491,608	11,067	10,502,675	50
51 RECOVERY ROOM	799,648		799,648		799,648	51
52 DELIVERY ROOM & LABOR ROOM	3,046,402		3,046,402		3,046,402	52
53 ANESTHESIOLOGY	203,759		203,759	229,945	433,704	53
54 RADIOLOGY-DIAGNOSTIC	4,720,831		4,720,831		4,720,831	54
56 RADIOISOTOPE	1,881,783		1,881,783		1,881,783	56
56.01 ULTRASOUND	479,034		479,034		479,034	56.01
57 CT SCAN	1,846,436		1,846,436		1,846,436	57
59 CARDIAC CATHETERIZATION	2,589,795		2,589,795		2,589,795	59
60 LABORATORY	8,775,082		8,775,082		8,775,082	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	2,210,391		2,210,391		2,210,391	65
66 PHYSICAL THERAPY	4,156,893		4,156,893		4,156,893	66
69 ELECTROCARDIOLOGY	1,102,017		1,102,017	7,457	1,109,474	69
70 ELECTROENCEPHALOGRAPHY	235,742		235,742		235,742	70
71 MEDICAL SUPPLIES CHARGED TO	5,978,268		5,978,268		5,978,268	71
72 IMPL. DEV. CHARGED TO PATIE	4,920,788		4,920,788		4,920,788	72
73 DRUGS CHARGED TO PATIENTS	4,577,025		4,577,025		4,577,025	73
73.01 OUTPATIENT PHARMACY	2,990,217		2,990,217		2,990,217	73.01
74 RENAL DIALYSIS						74
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	535,729		535,729		535,729	76.01
76.05 INPATIENT RENAL DIALYSIS	341,989		341,989		341,989	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	6,608		6,608		6,608	90
90.01 OUTPATIENT INFUSION PROCEDU						90.01
90.02 WOUND CARE	1,416,455		1,416,455		1,416,455	90.02
90.03 RIVER FOREST	2,804,653		2,804,653		2,804,653	90.03
91 EMERGENCY	6,852,764		6,852,764		6,852,764	91
92 OBSERVATION BEDS (NON-DISTI OTHER REIMBURSABLE COST CENTERS	1,920,023		1,920,023		1,920,023	92
94 HOME PROGRAM DIALYSIS						94
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	3,339,299		3,339,299		3,339,299	101
116 HOSPICE	579,050		579,050		579,050	116
200 SUBTOTAL (SEE INSTRUCTIONS)	118,791,218		118,791,218	470,764	119,261,982	200
201 LESS OBSERVATION BEDS	1,920,023		1,920,023		1,920,023	201
202 TOTAL (SEE INSTRUCTIONS)	116,871,195		116,871,195		117,341,959	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	71,475,610		71,475,610			30
31 INTENSIVE CARE UNIT	18,053,846		18,053,846			31
40 SUBPROVIDER - IPF	8,033,608		8,033,608			40
43 NURSERY	2,569,371		2,569,371			43
44 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	7,427,961		7,427,961			44
50 OPERATING ROOM	13,160,125	13,183,787	26,343,912	0.398256	0.398256	0.398676 50
51 RECOVERY ROOM	3,781,799	1,208,492	4,990,291	0.160241	0.160241	0.160241 51
52 DELIVERY ROOM & LABOR ROOM	6,037,416	668,397	6,705,813	0.454293	0.454293	0.454293 52
53 ANESTHESIOLOGY	8,058,253	8,528,446	16,586,699	0.012284	0.012284	0.026148 53
54 RADIOLOGY-DIAGNOSTIC	5,045,446	12,175,263	17,220,709	0.274137	0.274137	0.274137 54
56 RADIOISOTOPE	2,625,179	5,180,365	7,805,544	0.241083	0.241083	0.241083 56
56.01 ULTRASOUND	2,828,667	7,361,455	10,190,122	0.047010	0.047010	0.047010 56.01
57 CT SCAN	13,958,736	32,583,521	46,542,257	0.039672	0.039672	0.039672 57
59 CARDIAC CATHETERIZATION	12,022,822	7,338,832	19,361,654	0.133759	0.133759	0.133759 59
60 LABORATORY	37,394,544	34,844,999	72,239,543	0.121472	0.121472	0.121472 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	10,035,466	803,309	10,838,775	0.203934	0.203934	0.203934 65
66 PHYSICAL THERAPY	12,220,470	6,809,990	19,030,460	0.218434	0.218434	0.218434 66
69 ELECTROCARDIOLOGY	10,779,635	12,432,596	23,212,231	0.047476	0.047476	0.047797 69
70 ELECTROENCEPHALOGRAPHY	370,338	1,463,509	1,833,847	0.128551	0.128551	0.128551 70
71 MEDICAL SUPPLIES CHARGED TO	53,801,593	23,467,714	77,269,307	0.077369	0.077369	0.077369 71
72 IMPL. DEV. CHARGED TO PATIE	9,808,038	5,544,144	15,352,182	0.320527	0.320527	0.320527 72
73 DRUGS CHARGED TO PATIENTS	61,194,367	15,140,301	76,334,668	0.059960	0.059960	0.059960 73
73.01 OUTPATIENT PHARMACY		1,658,342	1,658,342	1.803137	1.803137	1.803137 73.01
74 RENAL DIALYSIS						74
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	115	801,191	801,306	0.668570	0.668570	0.668570 76.01
76.05 INPATIENT RENAL DIALYSIS	2,104,803	91,887	2,196,690	0.155684	0.155684	0.155684 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		137,343	137,343	0.048113	0.048113	0.048113 90
90.01 OUTPATIENT INFUSION PROCEDU						90.01
90.02 WOUND CARE	201,542	3,334,048	3,535,590	0.400628	0.400628	0.400628 90.02
90.03 RIVER FOREST	23,120	3,385,712	3,408,832	0.822761	0.822761	0.822761 90.03
91 EMERGENCY	16,484,611	34,636,087	51,120,698	0.134051	0.134051	0.134051 91
92 OBSERVATION BEDS (NON-DISTI	3,334,086	13,250,604	16,584,690	0.115771	0.115771	0.115771 92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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		3,530,105	3,530,105			101
116 HOSPICE	120,035	1,071,342	1,191,377			116
200 SUBTOTAL (SEE INSTRUCTIONS)	392,951,602	250,631,781	643,583,383			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	392,951,602	250,631,781	643,583,383			202

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
 11/25/2013 14:50

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	1,603,782		1,603,782	47.37	16,770	794,395	30
31 INTENSIVE CARE UNIT	393,314		393,314	88.78	2,279	202,330	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	76,455		76,455	20.71	3,591	74,370	40
41 SUBPROVIDER - IRF							41
42 SUBPROVIDER I							42
43 NURSERY	37,630		37,630	77.43			43
44 SKILLED NURSING FACILITY	324,457		324,457	32.11	7,827	251,325	44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	2,435,638		2,435,638		30,467	1,322,420	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 COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 + COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,336,507	26,343,912	0.050733	7,122,362	361,339	50
51 RECOVERY ROOM	48,635	4,990,291	0.009746	1,690,618	16,477	51
52 DELIVERY ROOM & LABOR ROOM	208,908	6,705,813	0.031153	5,216	162	52
53 ANESTHESIOLOGY	52,955	16,586,699	0.003193	3,182,425	10,161	53
54 RADIOLOGY-DIAGNOSTIC	908,267	17,220,709	0.052743	3,859,995	203,588	54
56 RADIOISOTOPE	62,609	7,805,544	0.008021	920,457	7,383	56
56.01 ULTRASOUND	127,366	10,190,122	0.012499	1,865,231	23,314	56.01
57 CT SCAN	370,516	46,542,257	0.007961	8,090,175	64,406	57
59 CARDIAC CATHETERIZATION	545,050	19,361,654	0.028151	3,789,331	106,673	59
60 LABORATORY	698,018	72,239,543	0.009663	20,631,032	199,358	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	131,906	10,838,775	0.012170	4,486,042	54,595	65
66 PHYSICAL THERAPY	255,181	19,030,460	0.013409	2,838,936	38,067	66
69 ELECTROCARDIOLOGY	130,060	23,212,231	0.005603	6,561,123	36,762	69
70 ELECTROENCEPHALOGRAPHY	20,780	1,833,847	0.011331	215,963	2,447	70
71 MEDICAL SUPPLIES CHARGED TO P	72,767	77,269,307	0.000942	27,387,515	25,799	71
72 IMPL. DEV. CHARGED TO PATIENT	55,089	15,352,182	0.003588			72
73 DRUGS CHARGED TO PATIENTS	74,077	76,334,668	0.000970	29,616,331	28,728	73
73.01 OUTPATIENT PHARMACY	106,747	1,658,342	0.064370			73.01
74 RENAL DIALYSIS						74
76 LITHOTRIPSY						76
76.01 CARDIAC REHABILITATION	81,027	801,306	0.101119			76.01
76.05 INPATIENT RENAL DIALYSIS	3,829	2,196,690	0.001743	558,616	974	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	2,222	137,343	0.016178			90
90.01 OUTPATIENT INFUSION PROCEDURE						90.01
90.02 WOUND CARE	72,144	3,535,590	0.020405			90.02
90.03 RIVER FOREST	298,347	3,408,832	0.087522			90.03
91 EMERGENCY	459,133	51,120,698	0.008981	8,777,990	78,835	91
92 OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS	126,144	16,584,690	0.007606	2,087,757	15,879	92
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)	6,248,284	531,301,505		133,687,115	1,274,947	200

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
 11/25/2013 14:50

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	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 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
 11/25/2013 14:50

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	33,857		16,770		30
31 INTENSIVE CARE UNIT	4,430		2,279		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	3,692		3,591		40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY	486				43
44 SKILLED NURSING FACILITY	10,105		7,827		44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	52,570		30,467		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 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 CHARGED TO P						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 OUTPATIENT PHARMACY						73.01
74 RENAL DIALYSIS						74
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
90.03 RIVER FOREST						90.03
91 EMERGENCY						91
92 OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS						92
94 HOME PROGRAM DIALYSIS						94
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	[XX] 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) 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	26,343,912			7,122,362		4,552,870	50
51 RECOVERY ROOM	4,990,291			1,690,618		1,173,778	51
52 DELIVERY ROOM & LABOR ROOM	6,705,813			5,216			52
53 ANESTHESIOLOGY	16,586,699			3,182,425		2,356,566	53
54 RADIOLOGY-DIAGNOSTIC	17,220,709			3,859,995		3,921,176	54
56 RADIOISOTOPE	7,805,544			920,457		1,057,002	56
56.01 ULTRASOUND	10,190,122			1,865,231		1,744,584	56.01
57 CT SCAN	46,542,257			8,090,175		9,619,547	57
59 CARDIAC CATHETERIZATION	19,361,654			3,789,331		686,563	59
60 LABORATORY	72,239,543			20,631,032		1,267,582	60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	10,838,775			4,486,042		803,309	65
66 PHYSICAL THERAPY	19,030,460			2,838,936		89,799	66
69 ELECTROCARDIOLOGY	23,212,231			6,561,123		4,974,925	69
70 ELECTROENCEPHALOGRAPHY	1,833,847			215,963		139,303	70
71 MEDICAL SUPPLIES CHARGED TO	77,269,307			27,387,515		9,510,624	71
72 IMPL. DEV. CHARGED TO PATIEN	15,352,182						72
73 DRUGS CHARGED TO PATIENTS	76,334,668			29,616,331		5,151,649	73
73.01 OUTPATIENT PHARMACY	1,658,342						73.01
74 RENAL DIALYSIS							74
76 LITHOTRIPSY							76
76.01 CARDIAC REHABILITATION	801,306						76.01
76.05 INPATIENT RENAL DIALYSIS	2,196,690			558,616		12,674	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	137,343						90
90.01 OUTPATIENT INFUSION PROCEDUR							90.01
90.02 WOUND CARE	3,535,590						90.02
90.03 RIVER FOREST	3,408,832						90.03
91 EMERGENCY	51,120,698			8,777,990		6,861,183	91
92 OBSERVATION BEDS (NON-DISTIN	16,584,690			2,087,757		3,247,183	92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)	531,301,505			133,687,115		57,170,317	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 1	RATIO	PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.398256		4,552,870			1,813,208		50
51 RECOVERY ROOM	0.160241		1,173,778			188,087		51
52 DELIVERY ROOM & LABOR ROOM	0.454293							52
53 ANESTHESIOLOGY	0.012284		2,356,566			28,948		53
54 RADIOLOGY-DIAGNOSTIC	0.274137		3,921,176			1,074,939		54
56 RADIOISOTOPE	0.241083		1,057,002			254,825		56
56.01 ULTRASOUND	0.047010		1,744,584			82,013		56.01
57 CT SCAN	0.039672		9,619,547			381,627		57
59 CARDIAC CATHETERIZATION	0.133759		686,563			91,834		59
60 LABORATORY	0.121472		1,267,582			153,976		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65 RESPIRATORY THERAPY	0.203934		803,309			163,822		65
66 PHYSICAL THERAPY	0.218434		89,799			19,615		66
69 ELECTROCARDIOLOGY	0.047476		4,974,925			236,190		69
70 ELECTROENCEPHALOGRAPHY	0.128551		139,303			17,908		70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.077369		9,510,624			735,827		71
72 IMPL. DEV. CHARGED TO PATIENTS	0.320527							72
73 DRUGS CHARGED TO PATIENTS	0.059960		5,151,649			308,893		73
73.01 OUTPATIENT PHARMACY	1.803137							73.01
74 RENAL DIALYSIS								74
76 LITHOTRIPSY								76
76.01 CARDIAC REHABILITATION	0.668570							76.01
76.05 INPATIENT RENAL DIALYSIS	0.155684		12,674			1,973		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	0.048113							90
90.01 OUTPATIENT INFUSION PROCEDURES								90.01
90.02 WOUND CARE	0.400628							90.02
90.03 RIVER FOREST	0.822761							90.03
91 EMERGENCY	0.134051		6,861,183			919,748		91
92 OBSERVATION BEDS (NON-DISTINCT)	0.115771		3,247,183			375,930		92
OTHER REIMBURSABLE COST CENTERS								
94 HOME PROGRAM DIALYSIS								94
200 SUBTOTAL (SEE INSTRUCTIONS)			57,170,317			6,849,363		200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)			57,170,317			6,849,363		202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [XX] TITLE XVIII-PT A [] TITLE XIX	[] HOSPITAL [XX] IPF (14-S008) [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA	
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	1,336,507	26,343,912	0.050733	50
51	RECOVERY ROOM	48,635	4,990,291	0.009746	51
52	DELIVERY ROOM & LABOR ROOM	208,908	6,705,813	0.031153	52
53	ANESTHESIOLOGY	52,955	16,586,699	0.003193	53
54	RADIOLOGY-DIAGNOSTIC	908,267	17,220,709	0.052743	29,424 1,552
56	RADIOISOTOPE	62,609	7,805,544	0.008021	1,198 10
56.01	ULTRASOUND	127,366	10,190,122	0.012499	9,507 119
57	CT SCAN	370,516	46,542,257	0.007961	123,730 985
59	CARDIAC CATHETERIZATION	545,050	19,361,654	0.028151	
60	LABORATORY	698,018	72,239,543	0.009663	518,665 5,012
62.30	BLOOD CLOTTING FOR HEMOPHILIA				
65	RESPIRATORY THERAPY	131,906	10,838,775	0.012170	24,271 295
66	PHYSICAL THERAPY	255,181	19,030,460	0.013409	5,176 69
69	ELECTROCARDIOLOGY	130,060	23,212,231	0.005603	33,821 189
70	ELECTROENCEPHALOGRAPHY	20,780	1,833,847	0.011331	15,152 172
71	MEDICAL SUPPLIES CHARGED TO P	72,767	77,269,307	0.000942	35,825 34
72	IMPL. DEV. CHARGED TO PATIENT	55,089	15,352,182	0.003588	
73	DRUGS CHARGED TO PATIENTS	74,077	76,334,668	0.000970	1,351,394 1,311
73.01	OUTPATIENT PHARMACY	106,747	1,658,342	0.064370	
74	RENAL DIALYSIS				
76	LITHOTRIPSY				
76.01	CARDIAC REHABILITATION	81,027	801,306	0.101119	
76.05	INPATIENT RENAL DIALYSIS	3,829	2,196,690	0.001743	
76.97	CARDIAC REHABILITATION				
76.98	HYPERBARIC OXYGEN THERAPY				
76.99	LITHOTRIPSY				
OUTPATIENT SERVICE COST CENTERS					
90	CLINIC	2,222	137,343	0.016178	
90.01	OUTPATIENT INFUSION PROCEDURE				
90.02	WOUND CARE	72,144	3,535,590	0.020405	
90.03	RIVER FOREST	298,347	3,408,832	0.087522	
91	EMERGENCY	459,133	51,120,698	0.008981	68,790 618
92	OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS		16,584,690	16,584,690	
94	HOME PROGRAM DIALYSIS				
200	TOTAL (SUM OF LINES 50-199)	6,122,140	531,301,505		2,216,953 10,366 200

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 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 CHARGED TO P						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 OUTPATIENT PHARMACY						73.01
74 RENAL DIALYSIS						74
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
90.03 RIVER FOREST						90.03
91 EMERGENCY						91
92 OBSERVATION BEDS (NON-DISTINC						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	[XX] 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	26,343,912						50
51 RECOVERY ROOM	4,990,291						51
52 DELIVERY ROOM & LABOR ROOM	6,705,813						52
53 ANESTHESIOLOGY	16,586,699						53
54 RADIOLOGY-DIAGNOSTIC	17,220,709			29,424			54
56 RADIOISOTOPE	7,805,544			1,198			56
56.01 ULTRASOUND	10,190,122			9,507			56.01
57 CT SCAN	46,542,257			123,730			57
59 CARDIAC CATHETERIZATION	19,361,654						59
60 LABORATORY	72,239,543			518,665			60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	10,838,775			24,271			65
66 PHYSICAL THERAPY	19,030,460			5,176			66
69 ELECTROCARDIOLOGY	23,212,231			33,821			69
70 ELECTROENCEPHALOGRAPHY	1,833,847			15,152			70
71 MEDICAL SUPPLIES CHARGED TO	77,269,307			35,825			71
72 IMPL. DEV. CHARGED TO PATIEN	15,352,182						72
73 DRUGS CHARGED TO PATIENTS	76,334,668			1,351,394			73
73.01 OUTPATIENT PHARMACY	1,658,342						73.01
74 RENAL DIALYSIS							74
76 LITHOTRIPSY							76
76.01 CARDIAC REHABILITATION	801,306						76.01
76.05 INPATIENT RENAL DIALYSIS	2,196,690						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	137,343						90
90.01 OUTPATIENT INFUSION PROCEDUR							90.01
90.02 WOUND CARE	3,535,590						90.02
90.03 RIVER FOREST	3,408,832						90.03
91 EMERGENCY	51,120,698			68,790			91
92 OBSERVATION BEDS (NON-DISTIN	16,584,690						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)	531,301,505			2,216,953			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	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT SUBJECT TO	COST SERVICES	COST SVCS NOT SUBJECT TO	
	CHARGE RATIO FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.398256						50
51 RECOVERY ROOM	0.160241						51
52 DELIVERY ROOM & LABOR ROOM	0.454293						52
53 ANESTHESIOLOGY	0.012284						53
54 RADIOLOGY-DIAGNOSTIC	0.274137						54
56 RADIOISOTOPE	0.241083						56
56.01 ULTRASOUND	0.047010						56.01
57 CT SCAN	0.039672						57
59 CARDIAC CATHETERIZATION	0.133759						59
60 LABORATORY	0.121472						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.203934						65
66 PHYSICAL THERAPY	0.218434						66
69 ELECTROCARDIOLOGY	0.047476						69
70 ELECTROENCEPHALOGRAPHY	0.128551						70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.077369						71
72 IMPL. DEV. CHARGED TO PATIENTS	0.320527						72
73 DRUGS CHARGED TO PATIENTS	0.059960						73
73.01 OUTPATIENT PHARMACY	1.803137						73.01
74 RENAL DIALYSIS							74
76 LITHOTRIPSY							76
76.01 CARDIAC REHABILITATION	0.668570						76.01
76.05 INPATIENT RENAL DIALYSIS	0.155684						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	0.048113						90
90.01 OUTPATIENT INFUSION PROCEDURES							90.01
90.02 WOUND CARE	0.400628						90.02
90.03 RIVER FOREST	0.822761						90.03
91 EMERGENCY	0.134051						91
92 OBSERVATION BEDS (NON-DISTINCT)	0.115771						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
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	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 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 CHARGED TO P						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 OUTPATIENT PHARMACY						73.01
74 RENAL DIALYSIS						74
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
90.03 RIVER FOREST						90.03
91 EMERGENCY						91
92 OBSERVATION BEDS (NON-DISTINC						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	[XX]	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	INPAT PGM	O/P PGM	O/P PGM			
	CHARGES	COST TO	OF COST TO					PASS-THRU	PASS-THRU	PASS-THRU
	(FROM WKST	CHARGES	CHARGES	INPAT	COSTS	CHARGES	COSTS			
	C, PT. I,	(COL. 5 +	(COL. 6 +	PGM	(COL. 8 x		(COL. 9 x			
	COL. 8)	COL. 7)	COL. 7)	CHARGES	COL. 10)	CHARGES	COL. 12)			
	7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS										
50 OPERATING ROOM	26,343,912			22,352			50			
51 RECOVERY ROOM	4,990,291						51			
52 DELIVERY ROOM & LABOR ROOM	6,705,813						52			
53 ANESTHESIOLOGY	16,586,699			45,327			53			
54 RADIOLOGY-DIAGNOSTIC	17,220,709			138,198			54			
56 RADIOISOTOPE	7,805,544						56			
56.01 ULTRASOUND	10,190,122			90,530			56.01			
57 CT SCAN	46,542,257			14,161			57			
59 CARDIAC CATHETERIZATION	19,361,654			6,547			59			
60 LABORATORY	72,239,543			1,282,111			60			
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30			
65 RESPIRATORY THERAPY	10,838,775			390,103			65			
66 PHYSICAL THERAPY	19,030,460			5,927,475			66			
69 ELECTROCARDIOLOGY	23,212,231			76,058			69			
70 ELECTROENCEPHALOGRAPHY	1,833,847			12,274			70			
71 MEDICAL SUPPLIES CHARGED TO	77,269,307			1,704,584			71			
72 IMPL. DEV. CHARGED TO PATIEN	15,352,182						72			
73 DRUGS CHARGED TO PATIENTS	76,334,668			3,797,887			73			
73.01 OUTPATIENT PHARMACY	1,658,342						73.01			
74 RENAL DIALYSIS							74			
76 LITHOTRIPSY							76			
76.01 CARDIAC REHABILITATION	801,306						76.01			
76.05 INPATIENT RENAL DIALYSIS	2,196,690						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	137,343						90			
90.01 OUTPATIENT INFUSION PROCEDUR							90.01			
90.02 WOUND CARE	3,535,590						90.02			
90.03 RIVER FOREST	3,408,832						90.03			
91 EMERGENCY	51,120,698			31,724			91			
92 OBSERVATION BEDS (NON-DISTIN	16,584,690			8,104			92			
OTHER REIMBURSABLE COST CENTERS										
94 HOME PROGRAM DIALYSIS							94			
200 TOTAL (SUM OF LINES 50-199)	531,301,505			13,547,435			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 [] IPF [XX] SNF (14-5526) [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT SUBJECT TO	COST SERVICES	COST SVCS NOT SUBJECT TO	
	CHARGE RATIO FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.398256						50
51 RECOVERY ROOM	0.160241						51
52 DELIVERY ROOM & LABOR ROOM	0.454293						52
53 ANESTHESIOLOGY	0.012284						53
54 RADIOLOGY-DIAGNOSTIC	0.274137						54
56 RADIOISOTOPE	0.241083						56
56.01 ULTRASOUND	0.047010						56.01
57 CT SCAN	0.039672						57
59 CARDIAC CATHETERIZATION	0.133759						59
60 LABORATORY	0.121472						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.203934						65
66 PHYSICAL THERAPY	0.218434						66
69 ELECTROCARDIOLOGY	0.047476						69
70 ELECTROENCEPHALOGRAPHY	0.128551						70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.077369						71
72 IMPL. DEV. CHARGED TO PATIENTS	0.320527						72
73 DRUGS CHARGED TO PATIENTS	0.059960						73
73.01 OUTPATIENT PHARMACY	1.803137						73.01
74 RENAL DIALYSIS							74
76 LITHOTRIPSY							76
76.01 CARDIAC REHABILITATION	0.668570						76.01
76.05 INPATIENT RENAL DIALYSIS	0.155684						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	0.048113						90
90.01 OUTPATIENT INFUSION PROCEDURES							90.01
90.02 WOUND CARE	0.400628						90.02
90.03 RIVER FOREST	0.822761						90.03
91 EMERGENCY	0.134051						91
92 OBSERVATION BEDS (NON-DISTINCT)	0.115771						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

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 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	1,603,782		1,603,782	47.37	3,503	165,937	30
31 INTENSIVE CARE UNIT	393,314		393,314	88.78	608	53,978	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	76,455		76,455	20.71			40
41 SUBPROVIDER - IRF							41
42 SUBPROVIDER I							42
43 NURSERY	37,630		37,630	77.43			43
44 SKILLED NURSING FACILITY	324,457		324,457	32.11	267	8,573	44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	2,435,638		2,435,638		4,378	228,488	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 COST	TOTAL CHARGES	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	CAPITAL
	(FROM WKST B, PT. II, COL. 26) 1	(FROM WKST C, PT. I, COL. 8) 2	(COL.1 ÷ COL.2) 3		(COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	1,336,507	26,343,912	0.050733		50
51 RECOVERY ROOM	48,635	4,990,291	0.009746		51
52 DELIVERY ROOM & LABOR ROOM	208,908	6,705,813	0.031153		52
53 ANESTHESIOLOGY	52,955	16,586,699	0.003193		53
54 RADIOLOGY-DIAGNOSTIC	908,267	17,220,709	0.052743		54
56 RADIOISOTOPE	62,609	7,805,544	0.008021		56
56.01 ULTRASOUND	127,366	10,190,122	0.012499		56.01
57 CT SCAN	370,516	46,542,257	0.007961		57
59 CARDIAC CATHETERIZATION	545,050	19,361,654	0.028151		59
60 LABORATORY	698,018	72,239,543	0.009663		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
65 RESPIRATORY THERAPY	131,906	10,838,775	0.012170		65
66 PHYSICAL THERAPY	255,181	19,030,460	0.013409		66
69 ELECTROCARDIOLOGY	130,060	23,212,231	0.005603		69
70 ELECTROENCEPHALOGRAPHY	20,780	1,833,847	0.011331		70
71 MEDICAL SUPPLIES CHARGED TO P	72,767	77,269,307	0.000942		71
72 IMPL. DEV. CHARGED TO PATIENT	55,089	15,352,182	0.003588		72
73 DRUGS CHARGED TO PATIENTS	74,077	76,334,668	0.000970		73
73.01 OUTPATIENT PHARMACY	106,747	1,658,342	0.064370		73.01
74 RENAL DIALYSIS					74
76 LITHOTRIPSY					76
76.01 CARDIAC REHABILITATION	81,027	801,306	0.101119		76.01
76.05 INPATIENT RENAL DIALYSIS	3,829	2,196,690	0.001743		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	2,222	137,343	0.016178		90
90.01 OUTPATIENT INFUSION PROCEDURE					90.01
90.02 WOUND CARE	72,144	3,535,590	0.020405		90.02
90.03 RIVER FOREST	298,347	3,408,832	0.087522		90.03
91 EMERGENCY	459,133	51,120,698	0.008981		91
92 OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS	126,144	16,584,690	0.007606		92
94 HOME PROGRAM DIALYSIS					94
200 TOTAL (SUM OF LINES 50-199)	6,248,284	531,301,505			200

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 14:50

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 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
 11/25/2013 14:50

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	33,857		3,503		30
31 INTENSIVE CARE UNIT	4,430		608		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	3,692				40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY	486				43
44 SKILLED NURSING FACILITY	10,105		267		44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	52,570		4,378		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 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 CHARGED TO P						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 OUTPATIENT PHARMACY						73.01
74 RENAL DIALYSIS						74
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
90.03 RIVER FOREST						90.03
91 EMERGENCY						91
92 OBSERVATION BEDS (NON-DISTINC						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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 [XX] 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	26,343,912						50
51 RECOVERY ROOM	4,990,291						51
52 DELIVERY ROOM & LABOR ROOM	6,705,813						52
53 ANESTHESIOLOGY	16,586,699						53
54 RADIOLOGY-DIAGNOSTIC	17,220,709						54
56 RADIOISOTOPE	7,805,544						56
56.01 ULTRASOUND	10,190,122						56.01
57 CT SCAN	46,542,257						57
59 CARDIAC CATHETERIZATION	19,361,654						59
60 LABORATORY	72,239,543						60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	10,838,775						65
66 PHYSICAL THERAPY	19,030,460						66
69 ELECTROCARDIOLOGY	23,212,231						69
70 ELECTROENCEPHALOGRAPHY	1,833,847						70
71 MEDICAL SUPPLIES CHARGED TO	77,269,307						71
72 IMPL. DEV. CHARGED TO PATIEN	15,352,182						72
73 DRUGS CHARGED TO PATIENTS	76,334,668						73
73.01 OUTPATIENT PHARMACY	1,658,342						73.01
74 RENAL DIALYSIS							74
76 LITHOTRIPSY							76
76.01 CARDIAC REHABILITATION	801,306						76.01
76.05 INPATIENT RENAL DIALYSIS	2,196,690						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	137,343						90
90.01 OUTPATIENT INFUSION PROCEDUR							90.01
90.02 WOUND CARE	3,535,590						90.02
90.03 RIVER FOREST	3,408,832						90.03
91 EMERGENCY	51,120,698						91
92 OBSERVATION BEDS (NON-DISTIN	16,584,690						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)	531,301,505						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 [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT SUBJECT TO	COST SERVICES	COST SVCS NOT SUBJECT TO	
	CHARGE RATIO FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.398256						50
51 RECOVERY ROOM	0.160241						51
52 DELIVERY ROOM & LABOR ROOM	0.454293						52
53 ANESTHESIOLOGY	0.012284						53
54 RADIOLOGY-DIAGNOSTIC	0.274137						54
56 RADIOISOTOPE	0.241083						56
56.01 ULTRASOUND	0.047010						56.01
57 CT SCAN	0.039672						57
59 CARDIAC CATHETERIZATION	0.133759						59
60 LABORATORY	0.121472						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.203934						65
66 PHYSICAL THERAPY	0.218434						66
69 ELECTROCARDIOLOGY	0.047476						69
70 ELECTROENCEPHALOGRAPHY	0.128551						70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.077369						71
72 IMPL. DEV. CHARGED TO PATIENTS	0.320527						72
73 DRUGS CHARGED TO PATIENTS	0.059960						73
73.01 OUTPATIENT PHARMACY	1.803137						73.01
74 RENAL DIALYSIS							74
76 LITHOTRIPSY							76
76.01 CARDIAC REHABILITATION	0.668570						76.01
76.05 INPATIENT RENAL DIALYSIS	0.155684						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	0.048113						90
90.01 OUTPATIENT INFUSION PROCEDURES							90.01
90.02 WOUND CARE	0.400628						90.02
90.03 RIVER FOREST	0.822761						90.03
91 EMERGENCY	0.134051						91
92 OBSERVATION BEDS (NON-DISTINCT)	0.115771						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

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)	33,857	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	33,857	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	31,194	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)	16,770	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)	24,410,947	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	24,410,947	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)	24,410,947	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) 721.00 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 12,091,170 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) 12,091,170 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	7,890,508	4,430	1,781.15	2,279	4,059,241	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)					15,174,115	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					31,324,526	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 996,725 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 1,274,947 51
 52 TOTAL PROGRAM EXCLUDABLE COST 2,271,672 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 29,052,854 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 THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 2,663 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 721.00 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 1,920,023 89

COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	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	
90 CAPITAL-RELATED COST	1,603,782	24,410,947	0.065699	1,920,023	126,144	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)	3,692	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,692	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,692	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)	3,591	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)	2,309,115	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	2,309,115	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)	2,309,115	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)	625.44 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	2,245,955 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)	2,245,955 41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	179,383 48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	2,425,338 49
PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	74,370 50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	10,366 51
52	TOTAL PROGRAM EXCLUDABLE COST	84,736 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	2,340,602 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 THE MARKET BASKET	59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)	61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)	62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	63
PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)	67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)	68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)	69

WORKSHEET D-1
 PART I

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)	10,105	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	10,105	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	10,105	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)	7,827	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)	4,895,850	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	4,895,850	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)	4,895,850	37

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 14:50

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)	4,895,850	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	484.50	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	3,792,182	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)	3,792,182	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)	3,792,182	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	1,953,079	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	5,745,261	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)	33,857	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	33,857	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	31,194	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)	3,503	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)	486	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)	24,404,583	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	24,404,583	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)	24,404,583	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) 720.81 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 2,524,997 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) 2,524,997 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)	704,804	486	1,450.21		42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	7,703,470	4,430	1,738.93	608	1,057,269 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)					3,582,266 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 219,915 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 219,915 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 THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 2,663 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

	COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	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	5
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 TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)		
			3	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		39,693,614			30
31 INTENSIVE CARE UNIT		9,648,785			31
40 SUBPROVIDER - IPF					40
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.398676	7,122,362	2,839,515		50
51 RECOVERY ROOM	0.160241	1,690,618	270,906		51
52 DELIVERY ROOM & LABOR ROOM	0.454293	5,216	2,370		52
53 ANESTHESIOLOGY	0.026148	3,182,425	83,214		53
54 RADIOLOGY-DIAGNOSTIC	0.274137	3,859,995	1,058,167		54
56 RADIOISOTOPE	0.241083	920,457	221,907		56
56.01 ULTRASOUND	0.047010	1,865,231	87,685		56.01
57 CT SCAN	0.039672	8,090,175	320,953		57
59 CARDIAC CATHETERIZATION	0.133759	3,789,331	506,857		59
60 LABORATORY	0.121472	20,631,032	2,506,093		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.203934	4,486,042	914,856		65
66 PHYSICAL THERAPY	0.218434	2,838,936	620,120		66
69 ELECTROCARDIOLOGY	0.047797	6,561,123	313,602		69
70 ELECTROENCEPHALOGRAPHY	0.128551	215,963	27,762		70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.077369	27,387,515	2,118,945		71
72 IMPL. DEV. CHARGED TO PATIENTS	0.320527				72
73 DRUGS CHARGED TO PATIENTS	0.059960	29,616,331	1,775,795		73
73.01 OUTPATIENT PHARMACY	1.803137				73.01
74 RENAL DIALYSIS					74
76 LITHOTRIPSY					76
76.01 CARDIAC REHABILITATION	0.668570				76.01
76.05 INPATIENT RENAL DIALYSIS	0.155684	558,616	86,968		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	0.048113				90
90.01 OUTPATIENT INFUSION PROCEDURES					90.01
90.02 WOUND CARE	0.400628				90.02
90.03 RIVER FOREST	0.822761				90.03
91 EMERGENCY	0.134051	8,777,990	1,176,698		91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.115771	2,087,757	241,702		92
94 HOME PROGRAM DIALYSIS					94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		133,687,115	15,174,115		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		133,687,115			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		7,811,661		40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.398676			50
51 RECOVERY ROOM	0.160241			51
52 DELIVERY ROOM & LABOR ROOM	0.454293			52
53 ANESTHESIOLOGY	0.026148			53
54 RADIOLOGY-DIAGNOSTIC	0.274137	29,424	8,066	54
56 RADIOISOTOPE	0.241083	1,198	289	56
56.01 ULTRASOUND	0.047010	9,507	447	56.01
57 CT SCAN	0.039672	123,730	4,909	57
59 CARDIAC CATHETERIZATION	0.133759			59
60 LABORATORY	0.121472	518,665	63,003	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.203934	24,271	4,950	65
66 PHYSICAL THERAPY	0.218434	5,176	1,131	66
69 ELECTROCARDIOLOGY	0.047797	33,821	1,617	69
70 ELECTROENCEPHALOGRAPHY	0.128551	15,152	1,948	70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.077369	35,825	2,772	71
72 IMPL. DEV. CHARGED TO PATIENTS	0.320527			72
73 DRUGS CHARGED TO PATIENTS	0.059960	1,351,394	81,030	73
73.01 OUTPATIENT PHARMACY	1.803137			73.01
74 RENAL DIALYSIS				74
76 LITHOTRIPSY				76
76.01 CARDIAC REHABILITATION	0.668570			76.01
76.05 INPATIENT RENAL DIALYSIS	0.155684			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	0.048113			90
90.01 OUTPATIENT INFUSION PROCEDURES				90.01
90.02 WOUND CARE	0.400628			90.02
90.03 RIVER FOREST	0.822761			90.03
91 EMERGENCY	0.134051	68,790	9,221	91
92 OBSERVATION BEDS (NON-DISTINCT	0.115771			92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		2,216,953	179,383	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		2,216,953		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	0.398256	22,352	8,902	50
51 RECOVERY ROOM	0.160241			51
52 DELIVERY ROOM & LABOR ROOM	0.454293			52
53 ANESTHESIOLOGY	0.012284	45,327	557	53
54 RADIOLOGY-DIAGNOSTIC	0.274137	138,198	37,885	54
56 RADIOISOTOPE	0.241083			56
56.01 ULTRASOUND	0.047010	90,530	4,256	56.01
57 CT SCAN	0.039672	14,161	562	57
59 CARDIAC CATHETERIZATION	0.133759	6,547	876	59
60 LABORATORY	0.121472	1,282,111	155,741	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.203934	390,103	79,555	65
66 PHYSICAL THERAPY	0.218434	5,927,475	1,294,762	66
69 ELECTROCARDIOLOGY	0.047476	76,058	3,611	69
70 ELECTROENCEPHALOGRAPHY	0.128551	12,274	1,578	70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.077369	1,704,584	131,882	71
72 IMPL. DEV. CHARGED TO PATIENTS	0.320527			72
73 DRUGS CHARGED TO PATIENTS	0.059960	3,797,887	227,721	73
73.01 OUTPATIENT PHARMACY	1.803137			73.01
74 RENAL DIALYSIS				74
76 LITHOTRIPSY				76
76.01 CARDIAC REHABILITATION	0.668570			76.01
76.05 INPATIENT RENAL DIALYSIS	0.155684			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	0.048113			90
90.01 OUTPATIENT INFUSION PROCEDURES				90.01
90.02 WOUND CARE	0.400628			90.02
90.03 RIVER FOREST	0.822761			90.03
91 EMERGENCY	0.134051	31,724	4,253	91
92 OBSERVATION BEDS (NON-DISTINCT	0.115771	8,104	938	92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		13,547,435	1,953,079	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		13,547,435		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	0.398256		50
51 RECOVERY ROOM	0.160241		51
52 DELIVERY ROOM & LABOR ROOM	0.454293		52
53 ANESTHESIOLOGY	0.012284		53
54 RADIOLOGY-DIAGNOSTIC	0.274137		54
56 RADIOISOTOPE	0.241083		56
56.01 ULTRASOUND	0.047010		56.01
57 CT SCAN	0.039672		57
59 CARDIAC CATHETERIZATION	0.133759		59
60 LABORATORY	0.121472		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY	0.203934		65
66 PHYSICAL THERAPY	0.218434		66
69 ELECTROCARDIOLOGY	0.047476		69
70 ELECTROENCEPHALOGRAPHY	0.128551		70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.077369		71
72 IMPL. DEV. CHARGED TO PATIENTS	0.320527		72
73 DRUGS CHARGED TO PATIENTS	0.059960		73
73.01 OUTPATIENT PHARMACY	1.803137		73.01
74 RENAL DIALYSIS			74
76 LITHOTRIPSY			76
76.01 CARDIAC REHABILITATION	0.668570		76.01
76.05 INPATIENT RENAL DIALYSIS	0.155684		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	0.048113		90
90.01 OUTPATIENT INFUSION PROCEDURES			90.01
90.02 WOUND CARE	0.400628		90.02
90.03 RIVER FOREST	0.822761		90.03
91 EMERGENCY	0.134051		91
92 OBSERVATION BEDS (NON-DISTINCT)	0.115771		92
OTHER REIMBURSABLE COST CENTERS			
94 HOME PROGRAM DIALYSIS			94
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	26,603,339	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	236,429	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS	3,655,836	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	201.70	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	2.99	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	1.97	13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	1.97	14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	1.97	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	1.97	18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)	0.009767	19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)	0.008315	20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)	0.008315	21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	137,225	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)	1.02	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)	137,225	29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0463	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (SEE INSTRUCTIONS)	0.1502	31
32	SUM OF LINES 30 AND 31	0.1965	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0552	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	1,468,504	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)	28,445,497	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)	28,445,497	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	2,233,457	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)	90,090	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)	30,769,044	59
60	PRIMARY PAYER PAYMENTS	9,142	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	30,759,902	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	2,667,980	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	184,601	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	365,839	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	256,087	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	337,882	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	28,163,408	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
70.93	HVBP PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	22,970	70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (SEE INSTRUCTIONS)	-28,073	70.94
71	AMOUNT DUE PROVIDER (SEE INSTRUCTIONS)	28,158,305	71
71.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	140,792	71.01
72	INTERIM PAYMENTS	27,386,963	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS LINES 71.01, 72 AND 73)	630,550	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	334,463	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

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	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		27,374,413		6,173,612	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 05/08/2013	12,550	05/08/2013	1,014	3.01
	.02				3.02
	.03				3.03
	.04				3.04
	.05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE		NONE	3.50
	.51				3.51
	.52				3.52
	.53				3.53
	.54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
	.99				3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		12,550		1,014	
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		27,386,963		6,174,626	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	771,342		189,337	6.01
	TO .02				6.02
	PROVIDER .03				6.03
	PROVIDER .04				6.04
	TO .05				6.05
	PROGRAM .06				6.06
	.07				6.07
	.08				6.08
	.09				6.09
	PROVIDER .50	NONE		NONE	6.50
	TO .51				6.51
	PROGRAM .52				6.52
	.53				6.53
	.54				6.54
	.55				6.55
	.56				6.56
	.57				6.57
	.58				6.58
	.59				6.59
	.99				6.99
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		28,158,305		6,363,963	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

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 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		2,979,462		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		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)		2,979,462		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		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	22,338		6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		3,001,800		7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR DATE:	8

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

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		2,979,462		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)		2,979,462		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	17,734		6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		2,997,196		7
8 NAME OF CONTRACTOR: _____		CONTRACTOR NUMBER: _____	NPR DATE: _____	8

PROVIDER CCN: 14-0008 GOTTLIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 14:50

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-0008) [] CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	8,106	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	19,049	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	2,579	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	35,624	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	643,583,383	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	25,707,629	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)	2,144,721	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	42,894	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)	2,101,827	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	2,071,700	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	30,127	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)	3,132,350	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
4.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii) (F)(1) OR (2) (SEE INSTRUCTIONS)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		8
9	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	10.115068	9
10	TEACHING ADJUSTMENT FACTOR $\{(1 + (\text{LINE 8}/\text{LINE 9})) \text{ RAISED TO THE POWER OF } .5150 - 1\}$		10
11	TEACHING ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1, 2, 3 AND 11)	3,132,350	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)	3,132,350	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (LINE 16 LESS LINE 17)	3,132,350	18
19	DEDUCTIBLES	112,068	19
20	SUBTOTAL (LINE 18 MINUS LINE 19)	3,020,282	20
21	COINSURANCE	27,071	21
22	SUBTOTAL (LINE 20 MINUS LINE 21)	2,993,211	22
23	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	12,270	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	8,589	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	11,199	25
26	SUBTOTAL (SUM OF LINES 22 AND 24)	3,001,800	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49) (FOR FREESTANDING IPF ONLY)		27
28	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	3,001,800	31
31.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	15,009	31.01
32	INTERIM PAYMENTS	2,979,462	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 31.01, 32 AND 33)	7,329	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

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

PROSPECTIVE PAYMENT AMOUNT			
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	3,132,350	1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
4	SUBTOTAL (SUM OF LINES 1-3)	3,132,350	4
COMPUTATION OF NET COST OF COVERED SERVICES			
5	MEDICAL AND OTHER SERVICES		5
6	DEDUCTIBLES	112,068	6
7	COINSURANCE	27,071	7
8	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	3,985	8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	3,985	9
10	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	3,985	10
11	UTILIZATION REVIEW		11
12	SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS)	2,997,196	12
13	INPATIENT PRIMARY PAYER PAYMENTS		13
14	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		14
15	SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	2,997,196	15
15.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	14,986	15.01
16	INTERIM PAYMENTS	2,979,462	16
17	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		17
18	BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS 15.01, 16 AND 17)	2,748	18
19	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

	INPATIENT	OUTPATIENT
	TITLE V OR	TITLE V OR
	TITLE XIX	TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1 INPATIENT HOSPITAL SNF/NF SERVICES	3,582,266	1
2 MEDICAL AND OTHER SERVICES		2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)	3,582,266	4
5 INPATIENT PRIMARY PAYER PAYMENTS		5
6 OUTPATIENT PRIMARY PAYER PAYMENTS		6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	3,582,266	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	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))	3,582,266	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) (FOR CAH, SEE INSTRUCTIONS)		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 42 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 ADJUSTED CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 AND 4.02 PLUS APPLICABLE SUBSCRIPTS)		1.31 5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)		2.99 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	2.22	0.76 2.98 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	0.97	0.33 1.30 9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		10
11	TOTAL WEIGHTED FTE COUNT	0.97	0.33 11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)	1.87	1.00 12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)	0.91	1.00 13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)	1.25	0.78 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	1.25	0.78 17
18	PER RESIDENT AMOUNT	82,024.68	82,024.68 18
19	APPROVED AMOUNT FOR RESIDENT COSTS	102,531	63,979 166,510 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 UNWEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		1.68 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)		166,510 25
COMPUTATION OF PROGRAM PATIENT LOAD			
		INPATIENT PART A	MANAGED CARE
26	INPATIENT DAYS	22,640	2,579 26
27	TOTAL INPATIENT DAYS (SEE INSTRUCTIONS)	39,316	39,316 27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.575847	0.065597 28
29	PROGRAM DIRECT GME AMOUNT	95,884	10,923 29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE		1,543 30
31	NET PROGRAM DIRECT GME AMOUNT		105,264 31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM 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)		40,674,396 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)		11,410 40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)		40,662,986 41
PART B REASONABLE COST			
42	REASONABLE COST (SEE INSTRUCTIONS)		6,849,363 42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		317 43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)		6,849,046 44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)		47,512,032 45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)		0.855846 46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)		0.144154 47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B			
48	TOTAL PROGRAM GME PAYMENT (LINE 31)		105,264 48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)		90,090 49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)		15,174 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

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 42 CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		3.01	
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))		4	
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		4.01	
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		4.02	
5	FTE ADJUSTED CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 AND 4.02 PLUS APPLICABLE SUBSCRIPTS)		5	
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)		6	
7	ENTER THE LESSER OF LINE 5 OR LINE 6		7	
		PRIMARY CARE 1	OTHER 2	TOTAL 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	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)			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 UNWEIGHTED 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 PART A	MANAGED CARE	
26	INPATIENT DAYS	4,111		26
27	TOTAL INPATIENT DAYS (SEE INSTRUCTIONS)	39,316		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.104563		28
29	PROGRAM DIRECT GME AMOUNT			29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE			30
31	NET PROGRAM DIRECT GME AMOUNT			31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM 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	3,637,966			1
2 TEMPORARY INVESTMENTS	1,499,591			2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	31,253,374			4
5 OTHER RECEIVABLES	5,246,705			5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-5,492,361			6
7 INVENTORY	2,939,000			7
8 PREPAID EXPENSES	154,452			8
9 OTHER CURRENT ASSETS	163,113			9
10 DUE FROM OTHER FUNDS	33,332,189			10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	72,734,029			11
FIXED ASSETS				
12 LAND	12,500,000			12
13 LAND IMPROVEMENTS	987,143			13
14 ACCUMULATED DEPRECIATION	-92,015			14
15 BUILDINGS	45,145,680			15
16 ACCUMULATED DEPRECIATION	-6,296,901			16
17 LEASEHOLD IMPROVEMENTS	377,031			17
18 ACCUMULATED AMORTIZATION	-30,376			18
19 FIXED EQUIPMENT	7,954,675			19
20 ACCUMULATED DEPRECIATION	-453,751			20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT	19,439,704			23
24 ACCUMULATED DEPRECIATION	-7,116,245			24
25 MINOR EQUIPMENT DEPRECIABLE	5,241,815			25
26 ACCUMULATED DEPRECIATION	-497,843			26
27 HIT DESIGNATED ASSETS				27
28 ACCUMULATED DEPRECIATION				28
29 MINOR EQUIPMENT-NONDEPRECIABLE	1,156,687			29
30 TOTAL FIXED ASSETS (SUM OF LINES 12-29)	78,315,604			30
OTHER ASSETS				
31 INVESTMENTS	101,500			31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS	5,201,733			34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	5,303,233			35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	156,352,866			36
LIABILITIES AND FUND BALANCES				
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	20,937,206			37
38 SALARIES, WAGES & FEES PAYABLE	5,613,020			38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)				40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS				43
44 OTHER CURRENT LIABILITIES	11,874,943			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	38,425,169			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE				46
47 NOTES PAYABLE				47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES	33,944,733			49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	33,944,733			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	72,369,902			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	83,982,964			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)	83,982,964			59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	156,352,866			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	1	3	5	7	
	2	4	6	8	
1 FUND BALANCES AT BEGINNING OF PERIOD	45,761,585				1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)	38,221,379				2
3 TOTAL (SUM OF LINE 1 AND LINE 2)	83,982,964				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)	83,982,964				11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)					12
13					13
14					14
15					15
16					16
17					17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)					18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)	83,982,964				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	74,044,981		74,044,981	2
3 SUBPROVIDER IPF	8,033,608		8,033,608	3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY	7,427,961		7,427,961	7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	89,506,550		89,506,550	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	18,053,846		18,053,846	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)	18,053,846		18,053,846	17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	107,560,396		107,560,396	18
19 ANCILLARY SERVICES	285,271,168		285,271,168	19
20 OUTPATIENT SERVICES		246,030,632	246,030,632	20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY		3,532,363	3,532,363	23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE		1,071,342	1,071,342	27
28 OTHER (SPECIFY)				28
29 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	392,831,564	250,634,337	643,465,901	29

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		122,927,411	29
30 ADD (SPECIFY)			30
31 BAD DEBTS			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		122,927,411	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	643,465,901	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	482,317,111	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	161,148,790	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	122,927,411	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	38,221,379	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		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)	38,221,379	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)	38,221,379	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	455,336		43,050		108,332	606,718 5
HHA REIMBURSABLE SERVICES						
6 SKILLED NURSING CARE	843,201					843,201 6
7 PHYSICAL THERAPY	348,999					348,999 7
8 OCCUPATIONAL THERAPY	48,836					48,836 8
9 SPEECH PATHOLOGY						9
10 MEDICAL SOCIAL SERVICES	55,201					55,201 10
11 HOME HEALTH AIDE	50,929					50,929 11
12 SUPPLIES (SEE INSTRUCTIONS)					30,605	30,605 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)	1,802,502		43,050		138,937	1,984,489 24

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		606,718		606,718	5
6		843,201		843,201	6
7		348,999		348,999	7
8		48,836		48,836	8
9					9
10		55,201		55,201	10
11		50,929		50,929	11
12		30,605		30,605	12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24		1,984,489		1,984,489	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	606,718					606,718	606,718		5
HHA REIMBURSABLE SERVICES									
6 SKILLED NURSING CARE	843,201					843,201	371,314	1,214,515	6
7 PHYSICAL THERAPY	348,999					348,999	153,686	502,685	7
8 OCCUPATIONAL THERAPY	48,836					48,836	21,506	70,342	8
9 SPEECH PATHOLOGY									9
10 MEDICAL SOCIAL SERVICES	55,201					55,201	24,308	79,509	10
11 HOME HEALTH AIDE	50,929					50,929	22,427	73,356	11
12 SUPPLIES (SEE INSTRUCTIONS)	30,605					30,605	13,477	44,082	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)	1,984,489					1,984,489		1,984,489	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					-606,718	1,377,771	5
6 SKILLED NURSING CARE						843,201	6
7 PHYSICAL THERAPY						348,999	7
8 OCCUPATIONAL THERAPY						48,836	8
9 SPEECH PATHOLOGY							9
10 MEDICAL SOCIAL SERVICES						55,201	10
11 HOME HEALTH AIDE						50,929	11
12 SUPPLIES (SEE INSTRUCTIONS)						30,605	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)					-606,718	1,377,771	24
25 COST TO BE ALLOC (PER W/S H)						606,718	25
26 UNIT COST MULTIPLIER						0.440362	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	527,998		527,998			1
2 SKILLED NURSING CARE	1,723,996		1,723,996	323,788	2,047,784	2
3 PHYSICAL THERAPY	713,556		713,556	134,015	847,571	3
4 OCCUPATIONAL THERAPY	99,849		99,849	18,753	118,602	4
5 SPEECH PATHOLOGY						5
6 MEDICAL SOCIAL SERVICES	112,862		112,862	21,197	134,059	6
7 HOME HEALTH AIDE	104,128		104,128	19,557	123,685	7
8 SUPPLIES	56,910		56,910	10,688	67,598	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)	3,339,299		3,339,299	527,998	3,339,299	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.				0.187813		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 DEPARTMENT 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		452,976		190,471	2,561	1
2 SKILLED NURSING CARE				843,213		1,524,756		2
3 PHYSICAL THERAPY				348,999		631,091		3
4 OCCUPATIONAL THERAPY				48,836		88,310		4
5 SPEECH PATHOLOGY								5
6 MEDICAL SOCIAL SERVICES				55,201		99,819		6
7 HOME HEALTH AIDE				50,929		92,094		7
8 SUPPLIES						44,082		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		1,800,154		2,670,623	2,561	20
21 TOTAL COST TO BE ALLOCATED		23,809		662,325		348,970	7,279	21
22 UNIT COST MULTIPLIER							2.842249	22
22 UNIT COST MULTIPLIER		1.345978		0.367927		0.130670		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 (FTES SERVED) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS) 14	PHARMACY (COSTED REQUIS) 15	
1 ADMINISTRATIVE AND GENERAL		1,234		2,350		2,350		1,186	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							36,290		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	36,290	1,186	20
21 TOTAL COST TO BE ALLOCATED		153,838		29,868		120,702	7,068	951	21
22 UNIT COST MULTIPLIER							0.194764		22
22 UNIT COST MULTIPLIER		124.666126		12.709787		51.362553		0.801855	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	2,047,784		2,047,784	6,947	294.77	1
2	PHYSICAL THERAPY	3	847,571	174,045	1,021,616	9,483	107.73	2
3	OCCUPATIONAL THERAPY	4	118,602		118,602	1,631	72.72	3
4	SPEECH PATHOLOGY	5				6		4
5	MEDICAL SOCIAL SERVICES	6	134,059		134,059	1,215	110.34	5
6	HOME HEALTH AIDE	7	123,685		123,685	2,449	50.50	6
7	TOTAL (SUM OF LINES 1-6)		3,271,701	174,045	3,445,746	21,731		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	67,598	5,483	73,081			15
16	COST OF DRUGS	9		145	145			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 A		PART B		PART A		PART B		
PATIENT SERVICES	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
1 SKILLED NURSING CARE	3,989	2,418	1,175,838	712,754	1,888,592	1			
2 PHYSICAL THERAPY	2,828	1,112	304,660	119,796	424,456	2			
3 OCCUPATIONAL THERAPY	360	191	26,179	13,890	40,069	3			
4 SPEECH PATHOLOGY		4				4			
5 MEDICAL SOCIAL SERVICES	361	172	39,833	18,978	58,811	5			
6 HOME HEALTH AIDE	660	799	33,330	40,350	73,680	6			
7 TOTAL (SUM OF LINES 1-6)	8,198	4,696	1,579,840	905,768	2,485,608	7			

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS			
		PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	TOTAL
8 SKILLED NURSING CARE	1	2	3	4	8
9 PHYSICAL THERAPY	16974	3,989	2,418		9
10 OCCUPATIONAL THERAPY	16974	2,828	1,112		10
11 SPEECH PATHOLOGY	16974	360	191		11
12 MEDICAL SOCIAL SERVICES	16974		4		12
13 HOME HEALTH AIDE	16974	361	172		13
14 TOTAL (SUM OF LINES 8-13)	16974	660	799		14
		8,198	4,696		

SUPPLIES AND DRUGS COST COMPUTATIONS	PROGRAM COVERED CHARGES				COST OF SERVICES			
	PART A		PART B		PART A		PART B	
OTHER PATIENT SERVICES	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR
15 COST OF MEDICAL SUPPLIES								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	66	0.218434	796,786	174,045	COL 2, LINE 2
2 OCCUPATIONAL THERAPY	67		113,005		COL 2, LINE 3
3 SPEECH PATHOLOGY	68		780		COL 2, LINE 4
4 MEDICAL SUPPLIES CHARGED TO PA	71	0.077369	70,866	5,483	COL 2, LINE 15
5 DRUGS CHARGED TO PATIENTS	73	0.059960	2,423	145	COL 2, LINE 16
5.01 OUTPATIENT PHARMACY	73.01	1.803137			COL 2, LINE 16

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	2,630,424			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)	2,630,424			6
8 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 1)	2,630,424			7
9 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 1 EXCEEDS LINE 6)				8
PRIMARY PAYER PAYMENTS	2,268			9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	1,348,064	704,401	11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	2,172	11,578	12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	18,092	17,660	13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES	5,531	16,981	14
15 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	1,693	3,190	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)	1,373,284	753,810	22
23 EXCESS REASONABLE COST (FROM LINE 8)			23
24 SUBTOTAL (LINE 22 MINUS LINE 23)	1,373,284	753,810	24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26 NET COST (LINE 24 MINUS LINE 25)	1,373,284	753,810	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)	1,373,284	753,810	29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	1,373,284	753,810	31
31.01 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	5,316	3,086	31.01
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)	1,367,968	750,724	32
33 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 31.01, 32 AND 33)			34
35 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2			35

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

COMPONENT NO: -

WORKSHEET I-1

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [] HOME PROGRAM DIALYSIS

	TOTAL COSTS	BASIS	STATISTICS	FTEs PER 2080 HOURS
	1	2	3	4
1 REGISTERED NURSES		HOURS OF SERVICE		1
2 LICENSED PRACTICAL NURSES		HOURS OF SERVICE		2
3 NURSES AIDES		HOURS OF SERVICE		3
4 TECHNICIANS		HOURS OF SERVICE		4
5 SOCIAL WORKERS		HOURS OF SERVICE		5
6 DIETICIANS		HOURS OF SERVICE		6
7 PHYSICIANS		ACCUMULATED COST		7
8 NON-PATIENT CARE SALARY		ACCUMULATED COST		8
9 SUBTOTAL (SUM OF LINES 1-8)				9
10 EMPLOYEE BENEFITS		SALARY		10
11 CAPITAL RELATED COSTS-BLDGS. & FIXTURES		SQUARE FEET		11
12 CAPITAL RELATED COSTS-MOVABLE EQUIPMENT		PERCENTAGE OF TIME		12
13 MACHINES COSTS & REPAIRS		PERCENTAGE OF TIME		13
14 SUPPLIES		REQUISITIONS		14
15 DRUGS		REQUISITIONS		15
16 OTHER		ACCUMULATED COST		16
17 SUBTOTAL (SUM OF LINES 9-16)				17
18 CAPITAL RELATED COSTS-BLDGS. & FIXTURES		SQUARE FEET		18
19 CAPITAL RELATED COSTS-MOVABLE EQUIPMENT		PERCENTAGE OF TIME		19
20 EMPLOYEE BENEFITS DEPARTMENT		SALARY		20
21 ADMINISTRATIVE AND GENERAL		ACCUMULATED COST		21
22 MAINT./REPAIRS-OPERATION-HOUSEKEEPING		SQUARE FEET		22
23 MEDICAL EDUCATION PROGRAM COSTS				23
24 CENTRAL SERVICES & SUPPLIES		REQUISITIONS		24
25 PHARMACY		REQUISITIONS		25
26 OTHER ALLOCATED COSTS		ACCUMULATED COST		26
27 SUBTOTAL (SUM OF LINES 17-26)				27
28 LABORATORY		CHARGES		28
29 RESPIRATORY THERAPY		CHARGES		29
30 LITHOTRIPSY		CHARGES		30
30.01 CARDIAC REHABILITATION		CHARGES		30.01
30.05 INPATIENT RENAL DIALYSIS		CHARGES		30.05
30.97 CARDIAC REHABILITATION		CHARGES		30.97
30.98 HYPERBARIC OXYGEN THERAPY		CHARGES		30.98
30.99 LITHOTRIPSY		CHARGES		30.99
31 TOTAL COSTS (SUM OF LINES 27-30)				31

PROVIDER CCN: 14-0008 GOTTSLIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 14:50

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODILITIES

COMPONENT NO: -

WORKSHEET I-2

CHECK APPLICABLE BOX:

RENAL DIALYSIS DEPARTMENT

HOME PROGRAM DIALYSIS

	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE	SALARY	EMPLOYEE	
	BUILDING	EQUIPMENT	RNs	OTHER	BENEFITS	DRUGS
	1	2	3	4	5	6
1	TOTAL RENAL DEPT COSTS					1
	MAINTENANCE					
2	HEMODIALYSIS					2
3	INTERMITTENT PERITONEAL					3
	TRAINING					
4	HEMODIALYSIS					4
5	INTERMITTENT PERITONEAL					5
6	CAPD					6
7	CCPD					7
	HOME					
8	HEMODIALYSIS					8
9	INTERMITTENT PERITONEAL					9
10	CAPD					10
11	CCPD					11
	OTHER BILLABLE SERVICES					
12	INPATIENT DIALYSIS					12
13	METHOD II HOME PATIENT					13
14	EPO (INCL IN RENAL DEPT)					14
15	ARANESP (INCL IN RENAL DEPT)					15
16	OTHER					16
17	TOTAL (SUM OF LINES 2-16)					17
18	MEDICAL EDUC PGM COSTS					18
19	TOTAL RENAL COSTS (LINES 17+18)					19

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODILITIES

COMPONENT NO: -

WORKSHEET I-2
 (CONTINUED)

CHECK APPLICABLE BOX: RENAL DIALYSIS DEPARTMENT HOME PROGRAM DIALYSIS

	MEDICAL SUPPLIES 7	ROUTINE ANCILLARY SERVICES 8	SUBTOTAL (SUM OF COLS.1-8) 9	OVERHEAD 10	TOTAL (COL.9 + COL.10) 11	
1						1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION -
 STATISTICAL BASIS

COMPONENT NO: -

WORKSHEET I-3

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [] HOME PROGRAM DIALYSIS

	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE RNs (HOURS)	SALARY OTHER (HOURS)	EMPLOYEE BENEFITS DEPARTMENT (SALARY)	
	BUILDING (SQUARE FEET) 1	EQUIPMENT (% OF TIME) 2				
1	TOTAL RENAL DEPT COSTS MAINTENANCE					1
2	HEMODIALYSIS					2
3	INTERMITTENT PERITONEAL TRAINING					3
4	HEMODIALYSIS					4
5	INTERMITTENT PERITONEAL					5
6	CAPD					6
7	CCPD					7
8	HOME HEMODIALYSIS					8
9	INTERMITTENT PERITONEAL					9
10	CAPD					10
11	CCPD					11
	OTHER BILLABLE SERVICES					
12	INPT DIAL TRTMNTS					
13	METHOD II HOME PATIENT					13
14	EPO					14
15	ARANESP					15
16	OTHER					16
17	TOTAL STATISTICAL BASIS					17
18	UNIT COST MULTIPLIER (LINE 1 ÷ LINE 17)					18

PROVIDER CCN: 14-0008 GOTTSLIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 14:50

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION -
STATISTICAL BASIS

COMPONENT NO: -

WORKSHEET I-3
(CONTINUED)

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [] HOME PROGRAM DIALYSIS

	DRUGS (REQUIST.)	MEDICAL SUPPLIES (REQUIST.)	ROUTINE ANCILLARY SERVICES (CHARGES)	SUBTOTAL	OVERHEAD (ACCUM. COST)	
	6	7	8	9	10	
1						1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						13
13						14
14						15
15						16
16						17
17						18
18						

(LINE 1 ÷ LINE 17)

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

COMPONENT NO: -

WORKSHEET I-4
 (CONTINUED)

CHECK APPLICABLE BOX: RENAL DIALYSIS DEPARTMENT HOME PROGRAM DIALYSIS

	TOTAL PROGRAM PAYMENT	TOTAL PROGRAM PAYMENT	TOTAL PROGRAM PAYMENT	AVERAGE PAYMENT RATE (COL. 6 ÷ COL. 4)	AVERAGE PAYMENT RATE (COL. 6.01 ÷ COL. 4.01)	AVERAGE PAYMENT RATE (COL. 6.02 ÷ COL. 4.02)	
1 MAINTENANCE - HEMODIALYSIS							1
2 MAINTENANCE - PERITONEAL DIALYSIS							2
3 TRAINING - HEMODIALYSIS							3
4 TRAINING - PERITONEAL DIALYSIS							4
5 TRAINING - CAPD							5
6 TRAINING - CCPD							6
7 HOME PROGRAM - HEMODIALYSIS							7
8 HOME PROGRAM - PERITONEAL DIALYSIS							8
9 HOME PROGRAM - CAPD							9
10 HOME PROGRAM - CCPD							10
11 TOTALS (SUM OF LINES 1-8, COLS. 1 & 4) (SUM OF LINES 1-10, COLS. 2, 5 & 6)	6	6.01	6.02	7	7.01	7.02	11
12 TOTAL TREATMENTS (SUM OF LINES 1-8 PLUS (SUM OF LINES 9 AND 10 TIMES 3))							12

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

COMPONENT NO: -

WORKSHEET I-5

DESCRIPTION

1	TOTAL EXPENSES RELATED TO CARE OF PROGRAM BENEFICIARIES (SEE INSTRUCTIONS)			1
2	TOTAL PAYMENT DUE (FROM I-4, COL. 6, LINE 11)(SEE INSTRUCTIONS)	1	2	2
2.01	TOTAL PAYMENT DUE (FROM I-4, COL. 6.01, LINE 11)(SEE INSTRUCTIONS)			2.01
2.02	TOTAL PAYMENT DUE (FROM I-4, COL. 6.02, LINE 11)(SEE INSTRUCTIONS)			2.02
2.03	TOTAL PAYMENT DUE (SEE INSTRUCTIONS)			2.03
2.04	OUTLIER PAYMENTS			2.04
3	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3
3.01	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.01
3.02	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.02
3.03	TOTAL DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.03
4	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4
4.01	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.01
4.02	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.02
4.03	TOTAL COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.03
5	BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE, NET OF BAD DEBT RECOVERIES			5
5.01	TRANSITION PERIOD 1 (75-25%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2011 BUT BEFORE 1/1/2012			5.01
5.02	TRANSITION PERIOD 2 (50-50%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2012 BUT BEFORE 1/1/2013			5.02
5.03	TRANSITION PERIOD 3 (25-75%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2013 BUT BEFORE 1/1/2014			5.03
5.04	100% PPS BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2014			5.04
5.05	TOTAL BAD DEBTS (SUM OF LINE 5 THROUGH LINE 5.04)			5.05
6	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)			6
7	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			7
8	NET DEDUCTIBLES AND COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			8
9	PROGRAM PAYMENT (SEE INSTRUCTIONS)			9
10	UNRECOVERED FROM MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			10
11	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) (TRANSFER TO WKST E, PART B, LINE 33)			11

PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE RATE PERCENTAGE

12	TOTAL ALLOWABLE EXPENSES (SEE INSTRUCTIONS)			12
13	TOTAL COMPOSITE COSTS (FROM WKST I-4, COL. 2, LINE 11)			13
14	FACILITY SPECIFIC COMPOSITE COST PERCENTAGE (LINE 13 DIVIDED BY LINE 12)			14

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE NO.: 14-1561

WORKSHEET K

	SALARIES (FROM WKST K-1)	EMPLOYEE BENEFITS (FROM WKST K-2)	TRANS- PORTATION (SEE INSTR.)	CONTRACTED SERVICES (FROM WKST K-3)	OTHER	TOTAL (COLS. 1-5)
	1	2	3	4	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	106,798				81,567	188,365 6
7 INPATIENT - GENERAL CARE						7
8 INPATIENT - RESPITE CARE						8
9 VISITING SERVICES						9
10 PHYSICIAN SERVICES						10
11 NURSING CARE	121,842					121,842 11
12 NURSING CARE-CONTINUOUS HOME CARE						12
13 PHYSICAL THERAPY						13
14 OCCUPATIONAL THERAPY						14
15 SPEECH/LANGUAGE PATHOLOGY						15
16 MEDICAL SOCIAL SERVICES	15,984					15,984 16
17 SPIRITUAL COUNSELING	5,848					5,848 17
18 DIETARY COUNSELING						18
19 COUNSELING - OTHER	18,843					18,843 19
20 HOME HEALTH AIDE AND HOMEMAKER	15,210					15,210 20
21 HH AIDE & HOMEMAKER-CONT. HOME CARE						21
22 OTHER						22
23 OTHER HOSPICE SERVICE COSTS						23
24 DRUGS, BIOLOGICAL & INFUSION THERAPY						24
25 ANALGESICS						25
26 SEDATIVES/HYPNOTICS						26
27 OTHER - SPECIFY						27
28 DURABLE MEDICAL EQUIPMENT/OXYGEN						28
29 PATIENT TRANSPORTATION						29
30 IMAGING SERVICES						30
31 LABS AND DIAGNOSTICS						31
32 MEDICAL SUPPLIES						32
33 OUTPATIENT SERVICES (INCLUDING E/R DEPT.)						33
34 RADIATION THERAPY						34
35 CHEMOTHERAPY						35
36 OTHER						36
37 HOSPICE NONREIMBURSABLE SERVICE						37
38 BEREAVEMENT PROGRAM COSTS						38
39 VOLUNTEER PROGRAM COSTS						39
40 FUNDRAISING						40
41 OTHER PROGRAM COSTS						41
42 TOTAL (SUM OF LINES 1-38)	284,525				81,567	366,092 42

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		188,365		188,365	6
7					7
8					8
9					9
10		121,842		121,842	10
11					11
12					12
13					13
14					14
15		15,984		15,984	15
16		5,848		5,848	16
17					17
18		18,843		18,843	18
19		15,210		15,210	19
20					20
21					21
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
35					35
36					36
37					37
38					38
39		366,092		366,092	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									1
2									2
3									3
4									4
5									5
6	234			94,247				12,317	106,798
7									7
8									8
9									9
10					121,842				121,842
11									11
12									12
13									13
14									14
15								15,984	15,984
16								5,848	5,848
17									17
18								18,843	18,843
19							15,210		15,210
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									35
36									36
37									37
38									38
39	234			94,247	121,842		15,210	52,992	284,525

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								6
8	INPATIENT CARE SERVICE								
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)								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	188,365						188,365	188,365	6
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	121,842						121,842	129,135	12
14	NURSING CARE-CONTINUOUS HOME									13
15	PHYSICAL THERAPY									14
16	OCCUPATIONAL THERAPY									15
17	SPEECH/LANGUAGE PATHOLOGY									16
18	MEDICAL SOCIAL SERVICES	15,984						15,984	16,941	17
19	SPIRITUAL COUNSELING	5,848						5,848	6,198	18
20	DIETARY COUNSELING									19
21	COUNSELING - OTHER	18,843						18,843	19,971	20
22	HH AIDE AND HOMEMAKER	15,210						15,210	16,120	21
23	HH AIDE & HMKR-CONT. HOME CA									22
24	OTHER									23
25	OTHER HOSPICE SERVICE COSTS									24
26	DRUGS, BIOL. & INFUS. THER.									25
27	ANALGESICS									26
28	SEDATIVES / HYPNOTICS									27
29	OTHER - SPECIFY									28
30	DURABLE MED. EQUIP./OXYGEN									29
31	PATIENT TRANSPORTATION									30
32	IMAGING SERVICES									31
33	LABS AND DIAGNOSTICS									32
34	MEDICAL SUPPLIES									33
35	OUTPAT.SERV.(INCL.E/R DEPT.)									34
36	RADIATION THERAPY									35
37	CHEMOTHERAPY									36
38	OTHER									37
39	HOSPICE NONREIMBURSABLE SERV.									38
40	BEREAVEMENT PROGRAM COSTS									39
41	VOLUNTEER PROGRAM COSTS									40
42	FUNDRAISING									41
43	OTHER PROGRAM COSTS									42
44	TOTAL (SUM OF LINES 1-38)	366,092						366,092		366,092 39

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	51,385		51,385			1
2 INPATIENT - GENERAL CARE						2
3 INPATIENT - RESPITE CARE						3
4 PHYSICIAN SERVICES						4
5 NURSING CARE	360,288		360,288	35,085	395,373	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	47,873		47,873	4,662	52,535	10
11 SPIRITUAL COUNSELING	17,515		17,515	1,706	19,221	11
12 DIETARY COUNSELING						12
13 COUNSELING - OTHER	56,435		56,435	5,496	61,931	13
14 HOME HLTH AIDE & HOME MAKERS	45,554		45,554	4,436	49,990	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)	579,050		579,050		579,050	34
35 UNIT COST MULTIPLIER				0.097382		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 DEPARTMENT 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								1
2 INPATIENT - GENERAL CARE								2
3 INPATIENT - RESPITE CARE								3
4 PHYSICIAN SERVICES								4
5 NURSING CARE				179,166		316,896	698	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				25,589		42,340		10
11 SPIRITUAL COUNSELING				9,362		15,491		11
12 DIETARY COUNSELING								12
13 COUNSELING - OTHER				30,166		49,913		13
14 HOME HLTH AIDE & HOMEMAKERS				24,350		40,289		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)				268,633		464,929	698	34
35 TOTAL COST TO BE ALLOCATED				98,837		60,752	1,984	35
36 UNIT COST MULTIPLIER				0.367926		0.130669	2.842407	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 (FTES SERVED) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS) 14	PHARMACY (COSTED REQUIS) 15	
1 ADMINISTRATIVE AND GENERAL		56		346		346	5,004	26,500	1
2 INPATIENT - GENERAL CARE									2
3 INPATIENT - RESPITE CARE									3
4 PHYSICIAN SERVICES									4
5 NURSING CARE									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	5,004	26,500	34
35 TOTAL COST TO BE ALLOCATED		6,981		4,398		17,771	975	21,260	35
36 UNIT COST MULTIPLIER		124.660714		12.710983		51.361272	0.194844	0.802264	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	0.218434		1
2	OCCUPATIONAL THERAPY	67			2
3	SPEECH/LANGUAGE PATHOLOGY	68			3
4	DRUGS, BIOLOGICALS AND INFUSION	73	0.059960		4
4.01	OUTPATIENT PHARMACY	73.01	1.803137		4.01
5	DURABLE MEDICAL EQUIPMENT/OXYGEN	96			5
6	LABS AND DIAGNOSTICS	60	0.121472		6
7	MEDICAL SUPPLIES	71	0.077369		7
8	OUTPATIENT SERVICES (INCL. E/R DEPT)	93			8
9	RADIATION THERAPY	55			9
10	LITHOTRIPSY	76			10
10.01	CARDIAC REHABILITATION	76.01	0.668570		10.01
10.05	INPATIENT RENAL DIALYSIS	76.05	0.155684		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)				11

PROVIDER CCN: 14-0008 GOTTlieb MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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11/25/2013 14:50

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)				579,050	1
2 TOTAL UNDUPLICATED DAYS (WKST S-9, COL. 6, LINE 5)				3,811	2
3 AVERAGE COST PER DIEM (LINE 1 DIVIDED BY LINE 2)				151.94	3
4 UNDUPLICATED MEDICARE DAYS (WKST S-9, COL. 1, LINE 5)	3,811				4
5 AGGREGATE MEDICARE COST (LINE 3 TIMES LINE 4)	579,043				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	2,124,434	1
2	CAPITAL DRG OUTLIER PAYMENTS	10,662	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	97.60	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	1.97	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	0.0057	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	12,109	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	0.0463	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (SEE INSTRUCTIONS)	0.1502	8
9	SUM OF LINES 7 AND 8	0.1965	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0406	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	86,252	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	2,233,457	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	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	2A	24	25	26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS DEPARTMENT					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SERVICES-SALARY & FRINGES					21
22 I&R SERVICES-OTHER PRGM COSTS					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 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 CHARGED TO PA					71
72 IMPL. DEV. CHARGED TO PATIENTS					72
73 DRUGS CHARGED TO PATIENTS					73
73.01 OUTPATIENT PHARMACY					73.01
74 RENAL DIALYSIS					74
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
90.03 RIVER FOREST					90.03
91 EMERGENCY					91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS					92
94 HOME PROGRAM DIALYSIS					94
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

PROVIDER CCN: 14-0008 GOTTIEB MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
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VERSION: 2013.11
11/25/2013 14:50

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) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
192.01 NON-EMPLOYEE CHILD CARE CENTER						192.01
193 NONPAID WORKERS						193
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

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

EXHIBIT 3

STEP 1: Determine the 3-Year Averaging Period		
1	Wage index fiscal year ending date	1
2	Provider's cost reporting period used for wage index year on Line 1 (FYB in Col 1, FYE in Col 2)	2
3	Midpoint of provider's cost reporting period shown on Line 2, adjusted to first of month	3
4	Date beginning the 3-year averaging period (subtract 18 months from midpoint shown on Line 3)	4
5	Date ending the 3-year averaging period (add 18 months to midpoint shown on Line 3)	5
STEP 2 (OPTIONAL): Adjust Averaging Period for a New Plan (SEE INSTRUCTIONS)		
6	Effective date of pension plan	6
7	First day of the provider cost reporting period containing the pension plan effective date	7
8	Starting date of the adjusted averaging period (date on Line 7, adjusted to first of month)	8
If this date occurs after the period shown on line 2, stop here and see instructions.		
STEP 3: Average Pension Contributions During the Averaging Period		
9	Beginning date of averaging period from Line 4 or Line 8, as applicable	9
10	Ending date of averaging period from Line 5	10
11	Enter provider contributions made during averaging period on Lines 9 & 10	11
11.01		11.01
12	Total calendar months included in averaging period (36 unless Step 2 completed)	12
13	Total contributions made during averaging period	13
14	Average monthly contribution (Line 13 divided by Line 12)	14
15	Number of months in provider cost reporting period on Line 2	15
16	Average pension contributions (Line 14 times Line 15)	16
STEP 4: Total Pension Cost for Wage Index		
17	Annual prefunding installment (SEE INSTRUCTIONS)	17
18	Reportable prefunding installment ((Line 17 times Line 15) divided by 12)	18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	19