

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

**WORKSHEET S
PARTS I, II & III**

PART I - COST REPORT STATUS

Provider use only		1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.		Date: 11/30/2015 Time: 12:30
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.	

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by

(Signed) _____
Officer or Administrator of Provider(s)

M
Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII				TITLE XIX	
		TITLE V	PART A	PART B	HIT		
		1	2	3	4	5	
1	HOSPITAL		558,509	223,349	-44,972		1
2	SUBPROVIDER - IPF		13,432				2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY		10,493				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		582,434	223,349	-44,972		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. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL 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	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
0	1	2	3	4	5	6	7	8		
3	Hospital	GOTTLIEB MEMORIAL HOSPITAL	14-0008	16974	1	07 / 01 / 1966	N	P	O	3
4	Subprovider - IPF	GOTTLIEB MEMORIAL PSYCHIATRIC UNIT	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 / 2014	To: 06 / 30 / 2015							20
21	Type of control (see instructions)	2								21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	1	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,907	1,601	21		1,202	164	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							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 is 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 is in effect in the cost reporting period.							37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. 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

		1	2	3	
Teaching Hospitals					
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider 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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**WORKSHEET S-2
PART I**

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)					
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
	1	2	3	4	5
65					65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)					
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
	1	2	3	4	5
67					67

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	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, indicate which program year began during this cost reporting period. (see instructions)	N			71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	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, indicate which program year began during this cost reporting period. (see instructions)				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
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.		N		81

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter 'Y' for yes or 'N' for no.		N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.				86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.		N		87

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**WORKSHEET S-2
PART I**

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	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/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers

		1	2			
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105		
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106		
107	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. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107		
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108		
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Physical	Occupational	Speech	Respiratory	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 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 Pub. 15-1, chapter 22, section 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
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	186,762			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 high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N			125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.				134

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**WORKSHEET S-2
PART I**

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	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: 08201			141
142	Street: 20555 VICTORY PARKWAY	P.O. Box:			142
143	City: LIVONIA	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 Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	N		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, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N			147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N			148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N			149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII		Title V	Title XIX	
		Part A	Part B			
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N	N	N	159
160	HHA	N	N	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. (see instructions)					166
	Name	County	State	ZIP Code	CBSA	FTE/Campus
	0	1	2	3	4	5

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)	0.50			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10 / 01 / 2014	09 / 30 / 2015		170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N		171

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
-----------------------------------------------------	---------------------------------------	------------------------------------------------	--------------------------------------------------------------------------

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

**General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.**

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation					
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3

		Y/N	Type	Date	
Financial Data and Reports					
		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	09/23/2015	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities				
		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	Y		9
10	Was an approved Intern and Resident GME 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

		Y/N	
Bad Debts			
		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

		Y/N	
Bed Complement			
		Y/N	
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data					
		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)	Y	10/19/2015	Y	10/19/2015
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	
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
-----------------------------------------------------	---------------------------------------	------------------------------------------------	--------------------------------------------------------------------------

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

**General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.**

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

Capital Related Cost			
22	Have assets been relifed 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 capitalization 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	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render servcies 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: SILIA	Last name: MIGLIO	Title: CONTROLLER
42	Employer: LOYOLA UNIVERSITY HEALTH SYSTEM		
43	Phone number: 708-216-4135	E-mail Address: SIMIGLIO@LUMC.EDU	

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
-----------------------------------------------------	---------------------------------------	------------------------------------------------	--------------------------------------------------------------------------

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				
						Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	185	67,525			12,014	2,470	24,869	1
2	HMO and other (see instructions)						3,649	2,967		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		185	67,525			12,014	2,470	24,869	7
8	Intensive Care Unit	31	24	8,760			1,531	308	3,480	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						151	526	13
14	Total (see instructions)		209	76,285			13,545	2,929	28,875	14
15	CAH Visits									15
16	Subprovider - IPF	40	12	4,380			3,145	5	3,495	16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44	34	12,410			7,758	101	9,481	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101							13,395	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		255							27
28	Observation Bed Days							506	2,806	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)								277	30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)		2	730				265	342	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
-----------------------------------------------------	---------------------------------------	------------------------------------------------	--------------------------------------------------------------------------

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					2,735	1,405	8,004	1
2	HMO and other (see instructions)					733			2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)	3.98	768.28			2,735	1,405	8,004	14
15	CAH Visits								15
16	Subprovider - IPF		16.58			209		241	16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		37.02						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)	3.98	821.88						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
-----------------------------------------------------	---------------------------------------	------------------------------------------------	--------------------------------------------------------------------------

HOSPITAL WAGE INDEX INFORMATION

**WORKSHEET S-3
PARTS II-III**

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	50,185,869		50,185,869	1,709,522.00	29.36	1
2							2
3							3
4							4
4.01							4.01
5							5
6							6
7	21						7
7.01			286,508	286,508	8,549.00	33.51	7.01
8							8
9	44	2,076,708	10,053	2,086,761	77,400.00	26.96	9
10		3,177,743	1,217	3,178,960	100,357.00	31.68	10
OTHER WAGES & RELATED COSTS							
11		386,981	286,508	673,489	15,204.67	44.29	11
12							12
13		1,621,484		1,621,484	14,146.00	114.62	13
14		4,055,022		4,055,022	53,316.00	76.06	14
15							15
16							16
WAGE-RELATED COSTS							
17		13,353,479		13,353,479			17
18							18
19		1,561,607		1,561,607			19
20							20
21							21
22							22
22.01							22.01
23							23
24							24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26		389,480		389,480	24,888.00	15.65	26
27		4,086,056	-347,910	3,738,146	165,160.00	22.63	27
28		127,067		127,067	3,477.69	36.54	28
29		760,161		760,161	25,303.00	30.04	29
30		1,136,472		1,136,472	52,493.00	21.65	30
31							31
32		972,019		972,019	84,861.00	11.45	32
33							33
34		755,212	-139,588	615,624	44,715.00	13.77	34
35							35
36		140,438	139,774	280,212	20,353.00	13.77	36
37							37
38		1,802,118		1,802,118	39,649.00	45.45	38
39		534,233	42,589	576,822	32,552.00	17.72	39
40		2,039,021		2,039,021	49,346.00	41.32	40
41		1,469,623		1,469,623	50,809.00	28.92	41
42		192,425		192,425	7,073.00	27.21	42
43							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	50,312,936	-286,508	50,026,428	1,704,450.69	29.35	1
2	Excluded area salaries (see instructions)	5,254,451	11,270	5,265,721	177,757.00	29.62	2
3	Subtotal salaries (line 1 minus line 2)	45,058,485	-297,778	44,760,707	1,526,693.69	29.32	3
4	Subtotal other wages & related costs (see instructions)	6,063,487	286,508	6,349,995	82,666.67	76.81	4
5	Subtotal wage-related costs (see instructions)	13,353,479		13,353,479		29.83%	5
6	Total (sum of lines 3 through 5)	64,475,451	-11,270	64,464,181	1,609,360.36	40.06	6
7	Total overhead cost (see instructions)	14,404,325	-305,135	14,099,190	600,679.69	23.47	7

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
-----------------------------------------------------	---------------------------------------	------------------------------------------------	--------------------------------------------------------------------------

HOSPITAL WAGE RELATED COSTS

**WORKSHEET S-3
PART IV**

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	1,441,883	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)	3,372,492	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)	4,443,766	8
9	Prescription Drug Plan	921,314	9
10	Dental, Hearing and Vision Plan	169,976	10
11	Life Insurance (If employee is owner or beneficiary)	97,449	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	-34,823	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	503,491	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	3,089,628	17
18	Medicare Taxes - Employers Portion Only	722,574	18
19	Unemployment Insurance	102,399	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	84,943	23
24	Total Wage Related cost (Sum of lines 1-23)	14,915,092	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	Supporting Exhibit for Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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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	06/30/2018		1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)	07/01/2014	06/30/2015	2
3	Midpoint of Provider's Cost Reporting Period Shown on Line 2, Adjusted to First of Month	1/01/2015		3
4	Date Beginning the 3-Year Averaging Period (subtract 18 months from midpoint shown on Line 3)	7/01/2013		4
5	Date Ending the 3-Year Averaging Period (add 18 months to midpoint shown on Line 3)	7/01/2016		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	7/01/2013		9
10	Ending Date of Averaging Period from Line 5	7/01/2016		10
11	Enter Provider Contributions Made During Averaging Period on Lines 9 & 10	DEPOSIT DATE(S)	CONTRIB-UTION(S)	11
11.01		06/30/2013	6,142,521	11.01
11.02		06/30/2014	3,776,899	11.02
11.03		06/30/2015	198,038	11.03
12	Total Calendar Months Included in Averaging Period (36 unless Step 2 completed)	36		12
13	Total Contributions Made During Averaging Period	10,117,458		13
14	Average Monthly Contribution (Line 13 divided by Line 12)	281,041		14
15	Number of MOnths in Provider Cost Reporting Period on Line 2	12		15
16	Average Pension Contributions (Line 14 times Line 15)	3,372,492		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)	3,372,492		19

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
-----------------------------------------------------	---------------------------------------	------------------------------------------------	--------------------------------------------------------------------------

HOSPITAL CONTRACT LABOR AND BENEFIT COST

**WORKSHEET S-3
PART V**

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost			1
2	Hospital			2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
-----------------------------------------------------	---------------------------------------	------------------------------------------------	--------------------------------------------------------------------------

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA CCN: 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	2,919				2,919	1
2	Unduplicated Census Count (see instructions)						2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)				4
5	Other Administrative Personnel		8.62		8.62
6	Direct Nursing Service		8.55		8.55
7	Nursing Supervisor				7
8	Physical Therapy Service		3.20		3.20
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service		0.12		0.12
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service				12
13	Speech Pathology Supervisor				13
14	Medical Social Service		0.78		0.78
15	Medical Social Service Supervisor				15
16	Home Health Aide		1.40		1.40
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.	1	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).	16974	20

PPS ACTIVITY

		Full Episodes		LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		Without Outliers	With Outliers				
		1	2	3	4	5	
21	Skilled Nursing Visits	4,360	123	145	94	4,722	21
22	Skilled Nursing Visit Charges	903,206	25,239	30,536	19,352	978,333	22
23	Physical Therapy Visits	3,010	6	24	55	3,095	23
24	Physical Therapy Visit Charges	869,906	1,764	7,056	16,116	894,842	24
25	Occupational Therapy Visits	175		1	2	178	25
26	Occupational Therapy Visit Charges	42,552		240	480	43,272	26
27	Speech Pathology Visits	7				7	27
28	Speech Pathology Visit Charges	1,680				1,680	28
29	Medical Social Service Visits	395	3	9	9	416	29
30	Medical Social Service Visit Charges	120,199	913	2,739	2,739	126,590	30
31	Home Health Aide Visits	1,106	32	6	36	1,180	31
32	Home Health Aide Visit Charges	141,236	4,214	766	4,597	150,813	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	9,053	164	185	196	9,598	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	2,078,779	32,130	41,337	43,284	2,195,530	35
36	Total Number of Episodes (standard/non-outlier)	533		71	17	621	36
37	Total Number of Ourlier Episodes		4			4	37
38	Total Non-Routine Medical Supply Charges	35,334	2,042	2,017	692	40,085	38

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

	DESCRIPTION	Outpatient		Training		Home		
		Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list			11
12	Number of patients transplanted during the cost reporting period			12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider			13
14	Epoetin amount from Worksheet A for home dialysis program			14
15	Number of EPO units furnished relating to the renal dialysis department			15
16	Number of EPO units furnished relating to the home dialysis department			16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider			17
18	ARANESP amount from Worksheet A for home dialysis program			18
19	Number of ARANESP units furnished relating to the renal dialysis department			19
20	Number of ARANESP units furnished relating to the home dialysis department			20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable method(s))

21	MCP	INITIAL METHOD	
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Erythropoiesis-Stimulating Agents (ESA) Statistics:		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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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 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

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX	1		1	3
4	RUL	41		41	4
5	RVX				5
6	RVL	9		9	6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC	264		264	12
13	RUB	1,177		1,177	13
14	RUA	303		303	14
15	RVC	581		581	15
16	RVB	3,424		3,424	16
17	RVA	824		824	17
18	RHC	97		97	18
19	RHB	575		575	19
20	RHA	108		108	20
21	RMC	21		21	21
22	RMB	78		78	22
23	RMA	7		7	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2	15		15	31
32	HD1				32
33	HC2	2		2	33
34	HC1	4		4	34
35	HB2				35
36	HB1	29		29	36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2	5		5	41
42	LC1	22		22	42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2	6		6	47
48	CD1	20		20	48
49	CC2	8		8	49
50	CC1	38		38	50
51	CB2				51
52	CB1	27		27	52
53	CA2				53
54	CA1	3		3	54
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	8		8	66
67	BA2				67
68	BA1				68
69	PE2				69

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
70	PE1				70
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1	46		46	74
75	PB2				75
76	PB1	13		13	76
77	PA2				77
78	PA1				78
199	AAA	2		2	199
200	TOTAL	7,758		7,758	200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).		00004	201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related 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)	7,404,404			207

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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HOSPICE IDENTIFICATION DATA

HOSPICE CCN: 14-1561

WORKSHEET S-9
PARTS I & II

PART I - ENROLLMENT DAYS

		Unduplicated Days					Total (sum of cols. 1, 2, & 5)	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other		
		1	2	3	4	5	6	
1	Continuous Home Care							1
2	Routine Home Care	3,550	114			78	3,742	2
3	Inpatient Respite Care							3
4	General Inpatient Care	318	17			34	369	4
5	Total Hospice Days	3,868	131			112	4,111	5

PART II - CENSUS DATA

		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2, & 5)	
		1	2	3	4	5	6	
6	Number of Patients Receiving Hospice Care	116	9			21	146	6
7	Total Number of Unduplicated Continuous Care Hours Billable to Medicare							7
8	Average Length of Stay (line 5/line 6)	33.34	14.56			5.33	28.16	8
9	Unduplicated Census Count							9

NOTE: Parts I & II, columns 1 and 2 also include the days reported in column 3 and 4.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
-----------------------------------------------------	---------------------------------------	------------------------------------------------	--------------------------------------------------------------------------

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.220247	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		28,658,472	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		82,410,188	6
7	Medicaid cost (line 1 times line 6)		18,150,597	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 fundng charity care			17
18	Government grants, appropriations of transfers for support of hospital operations			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 (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,658,485	453,932	2,112,417	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	365,276	99,977	465,253	21
22	Partial payment by patients approved for charity care	2,335	29,007	31,342	22
23	Cost of charity care (line 21 minus line 22)	362,941	70,970	433,911	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)			25
26	Total bad debt expense for the entire hospital complex (see instructions)		9,893,892	26
27	Medicare bad debts for the entire hospital complex (see instructions)		627,787	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		9,266,105	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,040,832	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		2,474,743	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,474,743	31

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		8,164,159	8,164,159		8,164,159	120,439	8,284,598	1
2	00200	Cap Rel Costs-Mvble Equip		18,810	18,810		18,810		18,810	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	389,480	11,312,356	11,701,836		11,701,836	-425,493	11,276,343	4
5	00500	Administrative & General	4,086,056	20,082,404	24,168,460	-4,034,176	20,134,284	-6,351,977	13,782,307	5
6	00600	Maintenance & Repairs	760,161	1,757,560	2,517,721		2,517,721		2,517,721	6
7	00700	Operation of Plant	1,136,472	3,058,453	4,194,925		4,194,925	-1,573	4,193,352	7
8	00800	Laundry & Linen Service		690,191	690,191		690,191		690,191	8
9	00900	Housekeeping	972,019	1,294,541	2,266,560		2,266,560		2,266,560	9
10	01000	Dietary	755,212	1,232,010	1,987,222	-523,338	1,463,884	-18,337	1,445,547	10
11	01100	Cafeteria	140,438	2,094	142,532	523,645	666,177	-232,984	433,193	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,802,118	248,355	2,050,473		2,050,473	-669	2,049,804	13
14	01400	Central Services & Supply	534,233	766,539	1,300,772	70,264	1,371,036		1,371,036	14
15	01500	Pharmacy	2,039,021	3,074,345	5,113,366	-1,731,692	3,381,674		3,381,674	15
16	01600	Medical Records & Library	1,469,623	736,784	2,206,407		2,206,407	-722	2,205,685	16
17	01700	Social Service	192,425	30,049	222,474		222,474		222,474	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				286,508	286,508		286,508	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	9,693,447	1,365,277	11,058,724	-39,536	11,019,188	-800,539	10,218,649	30
31	03100	Intensive Care Unit	2,682,603	661,899	3,344,502	865,068	4,209,570	-928,489	3,281,081	31
40	04000	Subprovider - IPF	937,576	44,866	982,442	96,528	1,078,970	-94,608	984,362	40
43	04300	Nursery				623,021	623,021		623,021	43
44	04400	Skilled Nursing Facility	2,076,708	840,765	2,917,473	14,414	2,931,887		2,931,887	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	2,686,968	8,491,780	11,178,748	-5,904,620	5,274,128	-207,967	5,066,161	50
51	05100	Recovery Room	451,717	117,314	569,031	7,827	576,858		576,858	51
52	05200	Delivery Room & Labor Room	1,595,033	224,705	1,819,738	-3,046	1,816,692		1,816,692	52
53	05300	Anesthesiology		230,459	230,459	690,610	921,069	-833,000	88,069	53
54	05400	Radiology-Diagnostic	1,595,530	146,529	1,742,059	-68,847	1,673,212		1,673,212	54
56	05600	Radioisotope	191,227	283,367	474,594	-63,307	411,287		411,287	56
56.01	03630	ULTRASOUND	558,731	46,178	604,909	20,093	625,002		625,002	56.01
57	05700	CT Scan	510,072	151,591	661,663	56,384	818,047		818,047	57
59	05900	Cardiac Catheterization	650,997	1,526,179	2,177,176	-1,135,806	1,041,370		1,041,370	59
60	06000	Laboratory	2,289,603	2,402,866	4,692,469		4,692,469		4,692,469	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	1,011,972	227,531	1,239,503	-125,217	1,114,286		1,114,286	65
66	06600	Physical Therapy	2,011,508	80,199	2,091,707	-43,529	2,048,178		2,048,178	66
69	06900	Electrocardiology	388,487	44,701	433,188	28,836	462,024		462,024	69
70	07000	Electroencephalography	87,271	5,074	92,345	1,109	93,454		93,454	70
71	07100	Medical Supplies Charged to Patients				3,479,795	3,479,795		3,479,795	71
72	07200	Impl. Dev. Charged to Patients				4,843,447	4,843,447		4,843,447	72
73	07300	Drugs Charged to Patients				2,633,957	2,633,957		2,633,957	73
73.01	07301	OUTPATIENT PHARMACY	328,611	1,331,893	1,660,504	-351,578	1,308,926		1,308,926	73.01
74	07400	Renal Dialysis				233,499	233,499		233,499	74
76	03950	LITHOTRIPSY								76
76.01	03951	CARDIAC REHABILITATION	217,523	5,048	222,571	12	222,583		222,583	76.01
76.05	03954	INPATIENT RENAL DIALYSIS								76.05
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic				10,386	10,386		10,386	90
90.01	09001	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	04950	WOUND CARE	367,005	613,454	980,459	-37,141	943,318	-51,150	892,168	90.02
90.03	09003	RIVER FOREST								90.03
91	09100	Emergency	3,235,855	1,442,596	4,678,451	-379,124	4,299,327	-168,457	4,130,870	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
101	10100	Home Health Agency	1,749,144	120,872	1,870,016		1,870,016		1,870,016	101
		SPECIAL PURPOSE COST CENTERS								

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
116	11600	Hospice	299,166	142,830	441,996	-44,446	397,550		397,550	116
118		SUBTOTALS (sum of lines 1-117)	49,994,012	73,016,623	123,010,635		123,010,635	-9,995,526	113,015,109	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	30,572	57,764	88,336		88,336		88,336	190
192	19200	Physicians' Private Offices		9,530	9,530		9,530		9,530	192
192.0	19201	NON-EMPLOYEE CHILD CARE CENTER								192.0
										1
193.0	19301	ADULT DAY CARE	161,285	19,828	181,113		181,113		181,113	193.0
										1
200		TOTAL (sum of lines 118-199)	50,185,869	73,103,745	123,289,614		123,289,614	-9,995,526	113,294,088	200

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DRUGS SOLD TO PTS	A	Drugs Charged to Patients	73		2,371,375	1
2			Central Services & Supply	14		65	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
20							20
21							21
500	Total reclassifications					2,371,440	500
	Code Letter - A						
1	PURCHASED SERVICES	B	Renal Dialysis	74		233,499	1
2							2
500	Total reclassifications					233,499	500
	Code Letter - B						
1	SHARED DIETARY COST	C	Cafeteria	11	139,588	383,750	1
500	Total reclassifications				139,588	383,750	500
	Code Letter - C						
1	RECLASS INTERN AND RESIDENT COST	E	I&R Services-Other Prgm Costs	22		286,508	1
500	Total reclassifications					286,508	500
	Code Letter - E						
1	HOUSE STAF PHYS.	F	Adults & Pediatrics	30		800,539	1
2			Intensive Care Unit	31		928,489	2
3			Subprovider - IPF	40		94,608	3
4			Operating Room	50		207,967	4
5			Anesthesiology	53		833,000	5
6			WOUND CARE	90.02		51,150	6
7			Emergency	91		168,457	7
500	Total reclassifications					3,084,210	500
	Code Letter - F						
1	PT TRANSPORT	H	Cafeteria	11	186	121	1
2			Central Services & Supply	14	42,589	27,610	2
3			Adults & Pediatrics	30	137,904	89,402	3
4			Intensive Care Unit	31	12,115	7,854	4
5			Subprovider - IPF	40	1,217	789	5
6			Nursery	43	344	223	6
7			Skilled Nursing Facility	44	10,053	6,517	7
8			Operating Room	50	458	297	8
9			Recovery Room	51	5,026	3,259	9
10			Delivery Room & Labor Room	52	1,776	1,151	10
11			Radiology-Diagnostic	54	229	149	11
12			Radioisotope	56	7,117	4,614	12
13			ULTRASOUND	56.01	12,201	7,910	13
14			CT Scan	57	36,846	23,887	14
15			Cardiac Catheterization	59	730	473	15
16			Respiratory Therapy	65	286	186	16
17			Physical Therapy	66	43	28	17
18			Electrocardiology	69	17,528	11,363	18
19			Electroencephalography	70	673	436	19
20			OUTPATIENT PHARMACY	73.01	43	28	20
21			CARDIAC REHABILITATION	76.01	14	9	21
22			Clinic	90	6,301	4,085	22
23			WOUND CARE	90.02	3,594	2,330	23
24			Emergency	91	50,637	32,827	24
500	Total reclassifications				347,910	225,548	500
	Code Letter - H						
1	FLOOR STOCK SUPPLIES	I	Medical Supplies Charged to P	71		3,479,795	1

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	Total reclassifications					3,479,795	500
	Code Letter - I						
1	CHEMO INFUSION	J	Drugs Charged to Patients	73	229,790	32,792	1
500	Total reclassifications				229,790	32,792	500
	Code Letter - J						
1	IMPLANTS	L	Impl. Dev. Charged to Patient	72		4,843,447	1
2							2
3							3
4							4
500	Total reclassifications					4,843,447	500
	Code Letter - L						
1	NURSERY	M	Nursery	43	583,743	38,711	1
500	Total reclassifications				583,743	38,711	500
	Code Letter - M						
	GRAND TOTAL (Increases)				1,301,031	14,979,700	

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

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref. 10	
		1	6	7	8	9		
1	DRUGS SOLD TO PTS	A	Administrative & General	5		90,000	1	
2			Pharmacy	15		1,731,692	2	
3			Adults & Pediatrics	30		23,841	3	
4			Intensive Care Unit	31		8,395	4	
5			Subprovider - IPF	40		86	5	
6			Skilled Nursing Facility	44		2,156	6	
7			Operating Room	50		5,867	7	
8			Recovery Room	51		458	8	
9			Delivery Room & Labor Room	52		5,537	9	
10			Anesthesiology	53		9,207	10	
11			Radiology-Diagnostic	54		25	11	
12			Radioisotope	56		75,038	12	
13			ULTRASOUND	56.01		18	13	
14			CT Scan	57		4,349	14	
15			Cardiac Catheterization	59		1,653	15	
16			Physical Therapy	66		1	16	
17			Electrocardiology	69		55	17	
18			OUTPATIENT PHARMACY	73.01		351,649	18	
19			CARDIAC REHABILITATION	76.01		11	19	
20			Emergency	91		16,956	20	
21			Hospice	116		44,446	21	
500	Total reclassifications					2,371,440	500	
	Code letter - A							
1	PURCHASED SERVICES	B	Intensive Care Unit	31		74,995	1	
2			Adults & Pediatrics	30		158,504	2	
500	Total reclassifications					233,499	500	
	Code letter - B							
1	SHARED DIETARY COST	C	Dietary	10	139,588	383,750	1	
500	Total reclassifications				139,588	383,750	500	
	Code letter - C							
1	RECLASS INTERN AND RESIDENT COST	E	Administrative & General	5		286,508	1	
500	Total reclassifications					286,508	500	
	Code letter - E							
1	HOUSE STAF PHYS.	F	Administrative & General	5		3,084,210	1	
2							2	
3							3	
4							4	
5							5	
6							6	
7							7	
500	Total reclassifications					3,084,210	500	
	Code letter - F							
1	PT TRANSPORT	H	Administrative & General	5	347,910	225,548	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	
20							20	
21							21	
22							22	
23							23	
24							24	
500	Total reclassifications				347,910	225,548	500	
	Code letter - H							

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref. 10	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9		
1	FLOOR STOCK SUPPLIES	I	Operating Room	50		1,655,049	1	
2			Anesthesiology	53		133,183	2	
3			Radiology-Diagnostic	54		69,200	3	
4			Cardiac Catheterization	59		746,490	4	
5			Respiratory Therapy	65		125,689	5	
6			Physical Therapy	66		43,599	6	
7			WOUND CARE	90.02		94,215	7	
8			Emergency	91		612,370	8	
500	Total reclassifications					3,479,795	500	
	Code letter - I							
1	CHEMO INFUSION	J	Adults & Pediatrics	30	229,790	32,792	1	
500	Total reclassifications				229,790	32,792	500	
	Code letter - J							
1	IMPLANTS	L	Operating Room	50		4,452,426	1	
2			Delivery Room & Labor Room	52		436	2	
3			Cardiac Catheterization	59		388,866	3	
4			Emergency	91		1,719	4	
500	Total reclassifications					4,843,447	500	
	Code letter - L							
1	NURSERY	M	Adults & Pediatrics	30	583,743	38,711	1	
500	Total reclassifications				583,743	38,711	500	
	Code letter - M							
	GRAND TOTAL (Decreases)				1,301,031	14,979,700		

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

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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RECONCILIATION OF CAPITAL COST CENTERS

**WORKSHEET A-7
PARTS I, II & III**

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	12,500,000					12,500,000		1
2	Land Improvements	987,143					987,143		2
3	Buildings and Fixtures	48,961,294	1,818,804		1,818,804		50,780,098		3
4	Building Improvements								4
5	Fixed Equipment	8,588,567				169,422	8,419,145		5
6	Movable Equipment	26,980,543	1,996,879		1,996,879		28,977,422		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	98,017,547	3,815,683		3,815,683	169,422	101,663,808		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	98,017,547	3,815,683		3,815,683	169,422	101,663,808		10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	8,164,159						8,164,159	1	
2	Cap Rel Costs-Mvble Equip	18,810						18,810	2	
3	Total (sum of lines 1-2)	8,182,969						8,182,969	3	

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi				0.000000					1
2	Cap Rel Costs-Mvble Equip				0.000000					2
3	Total (sum of lines 1-2)				0.000000					3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	8,284,598						8,284,598	1	
2	Cap Rel Costs-Mvble Equip	18,810						18,810	2	
3	Total (sum of lines 1-2)	8,303,408						8,303,408	3	

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

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.
				COST CENTER	LINE#	
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2	2
3	Investment income-other (chapter 2)					3
4	Trade, quantity, and time discounts (chapter 8)					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	-116,150	Administrative & General	5	7
8	Television and radio service (chapter 21)	A	-1,573	Operation of Plant	7	8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-3,084,210			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-2,813,812			12
13	Laundry and linen service					13
14	Cafeteria - employees and guests	B	-226,869	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	-722	Medical Records & Library	16	18
19	Nursing school (tuition,fees,books,etc.)					19
20	Vending machines	B	-6,115	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 overpayments					22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65	23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66	24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114	25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1	26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19	28
29	Physicians' assistant					29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67	30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68	31
32	CAH HIT Adj for Depreciation					32
33						33
34						34
35						35
35.04	VOLUNTEER SALARIES (632.186)	A	-192,504	Administrative & General	5	35.04
35.07	MISC INCOME A&G	B	-2,680,780	Administrative & General	5	35.07
35.15	WEST TOWNS (958.729)	A	-152,591	Administrative & General	5	35.15
35.19	EMPLOYEE DAY CARE REVENUE	B	-452,483	Employee Benefits Department	4	35.19
36						36
37	DIETARY	B	-18,337	Dietary	10	37
38	AHA LOBBYING FEES	A	-32,216	Administrative & General	5	38
39						39
40						40
41	ADVERTISING	A	-216,106	Administrative & General	5	41
42	MISC NURSING DEVELOPMENT	B	-669	Nursing Administration	13	42
43						43
44						44
44.06	EMPLOYEE HEALTH CENTER	B	-389	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 worksheet A, column 6, line 200)		-9,995,526			50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
 (2) Basis for adjustment (see instructions)
 A. Costs - if cost, including applicable overhead, can be determined
 B. Amount Received - if cost cannot be determined
 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
-----------------------------------------------------	---------------------------------------	------------------------------------------------	--------------------------------------------------------------------------

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

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

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

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
1	2	3	4	5	6	7	
1	1	Cap Rel Costs-Bldg & Fixt	INTERCOMPANY LOAN AND CAP	477,983	357,544	120,439	9
2	5	Administrative & General	ADMIN OTHER OPERATING EXP	3,922,658	978,628	2,944,030	2
3	1	Cap Rel Costs-Bldg & Fixt	TIS CAPITAL EXPENSE	7,753	7,753		9
3.01	5	Administrative & General	TIS OPERATING EXPENSE	567,340		567,340	3.01
3.02	5	Administrative & General	MALP INSURANCE	186,762	5,064,135	-4,877,373	3.02
3.03	5	Administrative & General	WORK COMP INSURANCE	503,491	1,525,337	-1,021,846	3.03
3.04	5	Administrative & General	PROPERTY INSURANCE	72,667	101,257	-28,590	3.04
3.05	5	Administrative & General	INTEGRATED RISK INSURANCE	71,331	530,013	-458,682	3.05
3.06	5	Administrative & General	PENSION	370,362	456,871	-86,509	3.06
3.07	4	Employee Benefits Department	EMP HEALTH STOP LOSS	343,871	316,492	27,379	3.07
4							4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			6,524,218	9,338,030	-2,813,812	5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

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

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
			Name	Percentage of Ownership	Type of Business
1	2	3	4	5	6
B			TRINITY HEALTH	100.00	HEALTHCARE SYSTEM

(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:

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics AGGREGATE	800,539	800,539						1
2	31	Intensive Care Unit AGGREGATE	928,489	928,489						2
3	40	Subprovider - IPF AGGREGATE	94,608	94,608						3
4	50	Operating Room AGGREGATE	207,967	207,967						4
5	53	Anesthesiology AGGREGATE	833,000	833,000						5
6	90.02	WOUND CARE AGGREGATE	51,150	51,150						6
7	91	Emergency AGGREGATE	168,457	168,457						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
20										20
200		TOTAL	3,084,210	3,084,210						200

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics	AGGREGATE						800,539	1
2	31	Intensive Care Unit	AGGREGATE						928,489	2
3	40	Subprovider - IPF	AGGREGATE						94,608	3
4	50	Operating Room	AGGREGATE						207,967	4
5	53	Anesthesiology	AGGREGATE						833,000	5
6	90.02	WOUND CARE	AGGREGATE						51,150	6
7	91	Emergency	AGGREGATE						168,457	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
20										20
200		TOTAL							3,084,210	200

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	8,284,598	8,284,598					1
2	Cap Rel Costs-Mvble Equip	18,810		18,810				2
4	Employee Benefits Department	11,276,343	17,095	128	11,293,566			4
5	Administrative & General	13,782,307	753,289	2,839	847,793	15,386,228	15,386,228	5
6	Maintenance & Repairs	2,517,721	42,366	1,284	172,401	2,733,772	429,612	6
7	Operation of Plant	4,193,352	1,017,119	2,145	257,746	5,470,362	859,667	7
8	Laundry & Linen Service	690,191	40,672			730,863	114,855	8
9	Housekeeping	2,266,560	37,847	35	220,449	2,524,891	396,787	9
10	Dietary	1,445,547	217,897	103	139,620	1,803,167	283,368	10
11	Cafeteria	433,193	192,150	52	63,551	688,946	108,268	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,049,804	61,572	1,703	408,711	2,521,790	396,299	13
14	Central Services & Supply	1,371,036	237,995	614	130,820	1,740,465	273,514	14
15	Pharmacy	3,381,674	81,552	15	462,440	3,925,681	616,921	15
16	Medical Records & Library	2,205,685	83,127		333,303	2,622,115	412,065	16
17	Social Service	222,474	48,491		43,641	314,606	49,440	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	286,508				286,508	45,025	22
23	Paramed Ed Prgm (specify)							23
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	10,218,649	1,797,224	589	2,045,190	14,061,652	2,209,797	30
31	Intensive Care Unit	3,281,081	327,038	415	611,149	4,219,683	663,123	31
40	Subprovider - IPF	984,362		7	212,914	1,197,283	188,153	40
43	Nursery	623,021	38,472		132,468	793,961	124,771	43
44	Skilled Nursing Facility	2,931,887	357,304	19	473,267	3,762,477	591,273	44
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	5,066,161	756,024	2,405	609,495	6,434,085	1,011,116	50
51	Recovery Room	576,858	45,102		103,587	725,547	114,020	51
52	Delivery Room & Labor Room	1,816,692	168,752	407	362,148	2,347,999	368,988	52
53	Anesthesiology	88,069	13,884	205		102,158	16,054	53
54	Radiology-Diagnostic	1,673,212	295,821	2,106	361,910	2,333,049	366,639	54
56	Radioisotope	411,287	56,548		44,983	512,818	80,589	56
56.01	ULTRASOUND	625,002	56,905	829	129,485	812,221	127,641	56.01
57	CT Scan	818,047	106,050	148	146,718	1,070,963	168,302	57
59	Cardiac Catheterization	1,041,370	61,335	425	147,808	1,250,938	196,585	59
60	Laboratory	4,692,469	291,897	1,027	519,271	5,504,664	865,058	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,114,286	32,496	327	229,575	1,376,684	216,346	65
66	Physical Therapy	2,048,178	324,541	37	456,210	2,828,966	444,572	66
69	Electrocardiology	462,024	61,186	312		92,082	96,742	69
70	Electroencephalography	93,454	31,009		19,945	144,408	22,694	70
71	Medical Supplies Charged to Patients	3,479,795				3,479,795	546,850	71
72	Impl. Dev. Charged to Patients	4,843,447				4,843,447	761,148	72
73	Drugs Charged to Patients	2,633,957			52,115	2,686,072	422,116	73
73.01	OUTPATIENT PHARMACY	1,308,926	59,045	13	74,537	1,442,521	226,692	73.01
74	Renal Dialysis	233,499				233,499	36,694	74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	222,583	107,298	14	49,336	379,231	59,596	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	10,386	2,735		1,429	14,550	2,287	90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	892,168	61,186	14	84,050	1,037,418	163,030	90.02
90.03	RIVER FOREST							90.03
91	Emergency	4,130,870	401,574	593	745,360	5,278,397	829,500	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	1,870,016			396,697	2,266,713	356,214	101
SPECIAL PURPOSE COST CENTERS								
116	Hospice	397,550			67,849	465,399	73,137	116
118	SUBTOTALS (sum of lines 1-117)	113,015,109	8,284,598	18,810	11,250,053	112,971,596	15,335,548	118
NONREIMBURSABLE COST CENTERS								

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINI- STRATIVE & GENERAL	
		0	1	2	4	4A	5	
190	Gift, Flower, Coffee Shop & Canteen	88,336			6,934	95,270	14,972	190
192	Physicians' Private Offices	9,530				9,530	1,498	192
192.0 1	NON-EMPLOYEE CHILD CARE CENTER							192.0 1
193.0 1	ADULT DAY CARE	181,113			36,579	217,692	34,210	193.0 1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	113,294,088	8,284,598	18,810	11,293,566	113,294,088	15,386,228	202

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	MAINTEN- ANCE AND REPAIRS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
	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	3,163,384						6
7	Operation of Plant	1,085,573	7,415,602					7
8	Laundry & Linen Service		46,726	892,444				8
9	Housekeeping	352,605	43,481	71,533	3,389,297			9
10	Dietary	182,816	250,334		91,530	2,611,215		10
11	Cafeteria	63	220,754		80,185		1,098,216	11
12	Maintenance of Personnel							12
13	Nursing Administration	104,361	70,738		7,011		34,426	13
14	Central Services & Supply	32,132	273,424		51,502		25,359	14
15	Pharmacy	7,842	93,692		40,793		42,843	15
16	Medical Records & Library	3,736	95,502		23,839		44,125	16
17	Social Service	1,134	55,709				6,141	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	18,071	2,064,767		1,329,613	1,574,741	258,825	30
31	Intensive Care Unit	15,063	375,723		142,777	218,652	53,590	31
40	Subprovider - IPF	1,431				218,215	29,947	40
43	Nursery		44,199		31,232			43
44	Skilled Nursing Facility	1,317	410,494	50	285,554	599,607	66,865	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	367,272	868,568	816,236	335,016		70,243	50
51	Recovery Room	5,431	51,816		32,380		8,959	51
52	Delivery Room & Labor Room	3,940	193,873		65,397		36,214	52
53	Anesthesiology	9	15,951		4,717		48,406	53
54	Radiology-Diagnostic	587,370	339,858		85,029			54
56	Radioisotope	1,639	64,966		33,782		3,793	56
56.01	ULTRASOUND	35,158	65,376		7,011		11,162	56.01
57	CT Scan	2,954	121,837	739	37,351		14,793	57
59	Cardiac Catheterization	1,208	70,465				12,390	59
60	Laboratory	109,891	335,349	335	125,057		76,763	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	390	37,333		16,700		27,562	65
66	Physical Therapy	9,734	372,853		190,199		52,235	66
69	Electrocardiology	2,581	70,294		36,204		11,776	69
70	Electroencephalography		35,625		3,697		2,800	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	2,423	67,835				8,019	73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	1,690	123,271		46,912		4,552	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		3,142					90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	341	70,294				10,223	90.02
90.03	RIVER FOREST							90.03
91	Emergency	213,153	461,353	3,551	121,360		81,062	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	6,446			157,310		40,946	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	1,134			7,139		7,315	116
118	SUBTOTALS (sum of lines 1-117)	3,158,908	7,415,602	892,444	3,389,297	2,611,215	1,091,334	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	4,376					1,174	190
192	Physicians' Private Offices							192

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	MAINTEN- ANCE AND REPAIRS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
192.0 1	NON-EMPLOYEE CHILD CARE CENTER							192.0 1
193.0 1	ADULT DAY CARE	100					5,708	193.0 1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,163,384	7,415,602	892,444	3,389,297	2,611,215	1,098,216	202

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NURSING ADMINISTRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	I/R-OTHER PROGRAM COSTS 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	3,134,625						13
14	Central Services & Supply	74,724	2,471,120					14
15	Pharmacy	126,243	69,487	4,923,502				15
16	Medical Records & Library	130,022	1		3,331,405			16
17	Social Service	18,096	57			445,183		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						331,533	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	762,675	224,026	214,423	531,915	282,713	3,315	30
31	Intensive Care Unit	157,910	143,117	72,304	141,651	29,191		31
40	Subprovider - IPF	88,242	5,283	3,141	202,937	108,433		40
43	Nursery				20,236			43
44	Skilled Nursing Facility	197,028	34,743	16,177				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	206,981	656,939	80,766	533,649			50
51	Recovery Room	26,398	15,556	3,673	26,596			51
52	Delivery Room & Labor Room	106,710	49,131	37,245	41,628			52
53	Anesthesiology	142,635	58,727	103,717	54,348			53
54	Radiology-Diagnostic		22,194	21,269	94,241			54
56	Radioisotope	11,177	49,013	699,865	43,941			56
56.01	ULTRASOUND	32,891	12,398	6,673	24,861			56.01
57	CT Scan	43,589	26,845	175,536	86,147			57
59	Cardiac Catheterization	36,510	306,836	59,086	100,023			59
60	Laboratory	226,194	436,750		290,819			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	81,217	49,408	3,646	107,539			65
66	Physical Therapy	153,918	12,393	1,258	57,817			66
69	Electrocardiology	34,701	12,124	370	73,427			69
70	Electroencephalography	8,249	997		4,047			70
71	Medical Supplies Charged to Patients				149,167			71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients				583,372			73
73.01	OUTPATIENT PHARMACY	23,631	14,714	2,828,258				73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	13,412	811	74	1,735			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				1,156			90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	30,124	28,444	97,757				90.02
90.03	RIVER FOREST							90.03
91	Emergency	238,861	225,384	197,021	160,153	24,846	328,218	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	120,655	11,274	2,274				101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	21,555	4,455	298,969				116
118	SUBTOTALS (sum of lines 1-117)	3,114,348	2,471,107	4,923,502	3,331,405	445,183	331,533	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	3,459	3					190
192	Physicians' Private Offices							192

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NURSING ADMINI- STRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	I/R-OTHER PROGRAM COSTS 22	
192.0 1	NON-EMPLOYEE CHILD CARE CENTER							192.0 1
193.0 1	ADULT DAY CARE	16,818	10					193.0 1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,134,625	2,471,120	4,923,502	3,331,405	445,183	331,533	202

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		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 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	23,536,533	-3,315	23,533,218		30
31	Intensive Care Unit	6,232,784		6,232,784		31
40	Subprovider - IPF	2,043,065		2,043,065		40
43	Nursery	1,014,399		1,014,399		43
44	Skilled Nursing Facility	5,965,585		5,965,585		44
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	11,380,871		11,380,871		50
51	Recovery Room	1,010,376		1,010,376		51
52	Delivery Room & Labor Room	3,251,125		3,251,125		52
53	Anesthesiology	546,722		546,722		53
54	Radiology-Diagnostic	3,849,649		3,849,649		54
56	Radioisotope	1,501,583		1,501,583		56
56.01	ULTRASOUND	1,135,392		1,135,392		56.01
57	CT Scan	1,749,056		1,749,056		57
59	Cardiac Catheterization	2,034,041		2,034,041		59
60	Laboratory	7,970,880		7,970,880		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	1,916,825		1,916,825		65
66	Physical Therapy	4,123,945		4,123,945		66
69	Electrocardiology	953,823		953,823		69
70	Electroencephalography	222,517		222,517		70
71	Medical Supplies Charged to Patients	4,175,812		4,175,812		71
72	Impl. Dev. Charged to Patients	5,604,595		5,604,595		72
73	Drugs Charged to Patients	3,691,560		3,691,560		73
73.01	OUTPATIENT PHARMACY	4,614,093		4,614,093		73.01
74	Renal Dialysis	270,193		270,193		74
76	LITHOTRIPSY					76
76.01	CARDIAC REHABILITATION	631,284		631,284		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	21,135		21,135		90
90.01	OUTPATIENT INFUSION PROCEDURES					90.01
90.02	WOUND CARE	1,437,631		1,437,631		90.02
90.03	RIVER FOREST					90.03
91	Emergency	8,162,859	-328,218	7,834,641		91
92	Observation Beds (Non-Distinct Part)					92
	OTHER REIMBURSABLE COST CENTERS					
99.10	CORF					99.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					99.40
101	Home Health Agency	2,961,832		2,961,832		101
	SPECIAL PURPOSE COST CENTERS					
116	Hospice	879,103		879,103		116
118	SUBTOTALS (sum of lines 1-117)	112,889,268	-331,533	112,557,735		118
	NONREIMBURSABLE COST CENTERS					
190	Gift, Flower, Coffee Shop & Canteen	119,254		119,254		190
192	Physicians' Private Offices	11,028		11,028		192

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		24	25	26			
192.0 1	NON-EMPLOYEE CHILD CARE CENTER						192.0 1
193.0 1	ADULT DAY CARE	274,538		274,538			193.0 1
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	113,294,088	-331,533	112,962,555			202

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINI- STRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		17,095	128	17,223	17,223		4
5	Administrative & General		753,289	2,839	756,128	1,293	757,421	5
6	Maintenance & Repairs		42,366	1,284	43,650	263	21,148	6
7	Operation of Plant		1,017,119	2,145	1,019,264	393	42,319	7
8	Laundry & Linen Service		40,672		40,672		5,654	8
9	Housekeeping		37,847	35	37,882	336	19,533	9
10	Dietary		217,897	103	218,000	213	13,949	10
11	Cafeteria		192,150	52	192,202	97	5,330	11
12	Maintenance of Personnel							12
13	Nursing Administration		61,572	1,703	63,275	624	19,509	13
14	Central Services & Supply		237,995	614	238,609	200	13,464	14
15	Pharmacy		81,552	15	81,567	706	30,369	15
16	Medical Records & Library		83,127		83,127	508	20,285	16
17	Social Service		48,491		48,491	67	2,434	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						2,216	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,797,224	589	1,797,813	3,114	108,789	30
31	Intensive Care Unit		327,038	415	327,453	932	32,643	31
40	Subprovider - IPF			7	7	325	9,262	40
43	Nursery		38,472		38,472	202	6,142	43
44	Skilled Nursing Facility		357,304	19	357,323	722	29,107	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		756,024	2,405	758,429	930	49,774	50
51	Recovery Room		45,102		45,102	158	5,613	51
52	Delivery Room & Labor Room		168,752	407	169,159	552	18,164	52
53	Anesthesiology		13,884	205	14,089		790	53
54	Radiology-Diagnostic		295,821	2,106	297,927	552	18,048	54
56	Radioisotope		56,548		56,548	69	3,967	56
56.01	ULTRASOUND		56,905	829	57,734	198	6,283	56.01
57	CT Scan		106,050	148	106,198	224	8,285	57
59	Cardiac Catheterization		61,335	425	61,760	225	9,677	59
60	Laboratory		291,897	1,027	292,924	792	42,584	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		32,496	327	32,823	350	10,650	65
66	Physical Therapy		324,541	37	324,578	696	21,885	66
69	Electrocardiology		61,186	312	61,498	140	4,762	69
70	Electroencephalography		31,009		31,009	30	1,117	70
71	Medical Supplies Charged to Patients						26,920	71
72	Impl. Dev. Charged to Patients						37,469	72
73	Drugs Charged to Patients					80	20,779	73
73.01	OUTPATIENT PHARMACY		59,045	13	59,058	114	11,159	73.01
74	Renal Dialysis						1,806	74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION		107,298	14	107,312	75	2,934	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		2,735		2,735	2	113	90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE		61,186	14	61,200	128	8,025	90.02
90.03	RIVER FOREST							90.03
91	Emergency		401,574	593	402,167	1,137	40,834	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency					605	17,535	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice					104	3,600	116
118	SUBTOTALS (sum of lines 1-117)		8,284,598	18,810	8,303,408	17,156	754,926	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					11	737	190
192	Physicians' Private Offices						74	192

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	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	ADMINI- STRATIVE & GENERAL 5	
192.0 1	NON-EMPLOYEE CHILD CARE CENTER							192.0 1
193.0 1	ADULT DAY CARE					56	1,684	193.0 1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		8,284,598	18,810	8,303,408	17,223	757,421	202

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	MAINTEN- ANCE AND REPAIRS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
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	65,061						6
7	Operation of Plant	22,327	1,084,303					7
8	Laundry & Linen Service		6,832	53,158				8
9	Housekeeping	7,252	6,358	4,261	75,622			9
10	Dietary	3,760	36,604		2,042	274,568		10
11	Cafeteria	1	32,278		1,789		231,697	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,146	10,343		156		7,263	13
14	Central Services & Supply	661	39,980		1,149		5,350	14
15	Pharmacy	161	13,699		910		9,039	15
16	Medical Records & Library	77	13,964		532		9,309	16
17	Social Service	23	8,146				1,296	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	372	301,910		29,668	165,584	54,607	30
31	Intensive Care Unit	310	54,938		3,186	22,991	11,306	31
40	Subprovider - IPF	29				22,945	6,318	40
43	Nursery		6,463		697			43
44	Skilled Nursing Facility	27	60,022	3	6,371	63,048	14,107	44
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	7,554	127,001	48,618	7,475		14,819	50
51	Recovery Room	112	7,576		722		1,890	51
52	Delivery Room & Labor Room	81	28,348		1,459		7,640	52
53	Anesthesiology		2,332		105		10,212	53
54	Radiology-Diagnostic	12,080	49,694		1,897			54
56	Radioisotope	34	9,499		754		800	56
56.01	ULTRASOUND	723	9,559		156		2,355	56.01
57	CT Scan	61	17,815	44	833		3,121	57
59	Cardiac Catheterization	25	10,303				2,614	59
60	Laboratory	2,260	49,035	20	2,790		16,195	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	8	5,459		373		5,815	65
66	Physical Therapy	200	54,518		4,244		11,020	66
69	Electrocardiology	53	10,278		808		2,485	69
70	Electroencephalography		5,209		82		591	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	50	9,919				1,692	73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	35	18,025		1,047		960	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		459					90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	7	10,278				2,157	90.02
90.03	RIVER FOREST							90.03
91	Emergency	4,384	67,459	212	2,708		17,102	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	133			3,510		8,639	101
SPECIAL PURPOSE COST CENTERS								
116	Hospice	23			159		1,543	116
118	SUBTOTALS (sum of lines 1-117)	64,969	1,084,303	53,158	75,622	274,568	230,245	118
NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop & Canteen	90					248	190
192	Physicians' Private Offices							192

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	MAINTEN- ANCE AND REPAIRS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
192.0 1	NON-EMPLOYEE CHILD CARE CENTER							192.0 1
193.0 1	ADULT DAY CARE	2					1,204	193.0 1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	65,061	1,084,303	53,158	75,622	274,568	231,697	202

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	NURSING ADMINI- STRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	I/R-OTHER PROGRAM COSTS 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	103,316						13
14	Central Services & Supply	2,463	301,876					14
15	Pharmacy	4,161	8,489	149,101				15
16	Medical Records & Library	4,285			132,087			16
17	Social Service	596	7			61,060		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						2,216	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	25,139	27,368	6,493	21,090	38,776		30
31	Intensive Care Unit	5,205	17,483	2,190	5,616	4,004		31
40	Subprovider - IPF	2,908	645	95	8,046	14,872		40
43	Nursery				802			43
44	Skilled Nursing Facility	6,494	4,244	490				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,822	80,255	2,446	21,159			50
51	Recovery Room	870	1,900	111	1,054			51
52	Delivery Room & Labor Room	3,517	6,002	1,128	1,651			52
53	Anesthesiology	4,701	7,174	3,141	2,155			53
54	Radiology-Diagnostic		2,711	644	3,737			54
56	Radioisotope	368	5,987	21,194	1,742			56
56.01	ULTRASOUND	1,084	1,515	202	986			56.01
57	CT Scan	1,437	3,279	5,316	3,416			57
59	Cardiac Catheterization	1,203	37,484	1,789	3,966			59
60	Laboratory	7,455	53,354		11,531			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,677	6,036	110	4,264			65
66	Physical Therapy	5,073	1,514	38	2,292			66
69	Electrocardiology	1,144	1,481	11	2,911			69
70	Electroencephalography	272	122		160			70
71	Medical Supplies Charged to Patients				5,914			71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients				23,130			73
73.01	OUTPATIENT PHARMACY	779	1,797	85,652				73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	442	99	2	69			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				46			90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	993	3,475	2,960				90.02
90.03	RIVER FOREST							90.03
91	Emergency	7,873	27,533	5,966	6,350	3,408		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	3,977	1,377	69				101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	710	544	9,054				116
118	SUBTOTALS (sum of lines 1-117)	102,648	301,875	149,101	132,087	61,060		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	114						190
192	Physicians' Private Offices							192

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	NURSING ADMINI- STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I/R-OTHER PROGRAM COSTS	
		13	14	15	16	17	22	
192.0 1	NON-EMPLOYEE CHILD CARE CENTER							192.0 1
193.0 1	ADULT DAY CARE	554	1					193.0 1
200	Cross Foot Adjustments						2,216	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	103,316	301,876	149,101	132,087	61,060	2,216	202

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		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 Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	2,580,723		2,580,723			30
31	Intensive Care Unit	488,257		488,257			31
40	Subprovider - IPF	65,452		65,452			40
43	Nursery	52,778		52,778			43
44	Skilled Nursing Facility	541,958		541,958			44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,125,282		1,125,282			50
51	Recovery Room	65,108		65,108			51
52	Delivery Room & Labor Room	237,701		237,701			52
53	Anesthesiology	44,699		44,699			53
54	Radiology-Diagnostic	387,290		387,290			54
56	Radioisotope	100,962		100,962			56
56.01	ULTRASOUND	80,795		80,795			56.01
57	CT Scan	150,029		150,029			57
59	Cardiac Catheterization	129,046		129,046			59
60	Laboratory	478,940		478,940			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	68,565		68,565			65
66	Physical Therapy	426,058		426,058			66
69	Electrocardiology	85,571		85,571			69
70	Electroencephalography	38,592		38,592			70
71	Medical Supplies Charged to Patients	32,834		32,834			71
72	Impl. Dev. Charged to Patients	37,469		37,469			72
73	Drugs Charged to Patients	43,989		43,989			73
73.01	OUTPATIENT PHARMACY	170,220		170,220			73.01
74	Renal Dialysis	1,806		1,806			74
76	LITHOTRIPSY						76
76.01	CARDIAC REHABILITATION	131,000		131,000			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	3,355		3,355			90
90.01	OUTPATIENT INFUSION PROCEDURES						90.01
90.02	WOUND CARE	89,223		89,223			90.02
90.03	RIVER FOREST						90.03
91	Emergency	587,133		587,133			91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	Home Health Agency	35,845		35,845			101
	SPECIAL PURPOSE COST CENTERS						
116	Hospice	15,737		15,737			116
118	SUBTOTALS (sum of lines 1-117)	8,296,417		8,296,417			118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	1,200		1,200			190
192	Physicians' Private Offices	74		74			192

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		24	25	26			
192.0 1	NON-EMPLOYEE CHILD CARE CENTER						192.0 1
193.0 1	ADULT DAY CARE	3,501		3,501			193.0 1
200	Cross Foot Adjustments	2,216		2,216			200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	8,303,408		8,303,408			202

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	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	MAINTEN-ANCE AND REPAIRS MAINT REQ	
		1	2	4	5A	5	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	278,654						1
2	Cap Rel Costs-Mvble Equip		2,943,156					2
4	Employee Benefits Department	575	20,106	49,796,389				4
5	Administrative & General	25,337	443,528	3,738,146	-15,386,228	97,907,860		5
6	Maintenance & Repairs	1,425	200,910	760,161		2,733,772	1,364,218	6
7	Operation of Plant	34,211	335,706	1,136,472		5,470,362	468,156	7
8	Laundry & Linen Service	1,368				730,863		8
9	Housekeeping	1,273	5,409	972,019		2,524,891	152,062	9
10	Dietary	7,329	16,100	615,624		1,803,167	78,840	10
11	Cafeteria	6,463	8,171	280,212		688,946	27	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,071	266,537	1,802,118		2,521,790	45,006	13
14	Central Services & Supply	8,005	96,127	576,822		1,740,465	13,857	14
15	Pharmacy	2,743	2,390	2,039,021		3,925,681	3,382	15
16	Medical Records & Library	2,796		1,469,623		2,622,115	1,611	16
17	Social Service	1,631		192,425		314,606	489	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					286,508		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	60,450	92,236	9,017,818		14,061,652	7,793	30
31	Intensive Care Unit	11,000	64,886	2,694,718		4,219,683	6,496	31
40	Subprovider - IPF		1,119	938,793		1,197,283	617	40
43	Nursery	1,294		584,087		793,961		43
44	Skilled Nursing Facility	12,018	2,980	2,086,761		3,762,477	568	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	25,429	376,355	2,687,426		6,434,085	158,387	50
51	Recovery Room	1,517		456,743		725,547	2,342	51
52	Delivery Room & Labor Room	5,676	63,666	1,596,809		2,347,999	1,699	52
53	Anesthesiology	467	32,117			102,158	4	53
54	Radiology-Diagnostic	9,950	329,598	1,595,759		2,333,049	253,305	54
56	Radioisotope	1,902		198,344		512,818	707	56
56.01	ULTRASOUND	1,914	129,703	570,932		812,221	15,162	56.01
57	CT Scan	3,567	23,221	646,918		1,070,963	1,274	57
59	Cardiac Catheterization	2,063	66,564	651,727		1,250,938	521	59
60	Laboratory	9,818	160,678	2,289,603		5,504,664	47,391	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,093	51,166	1,012,258		1,376,684	168	65
66	Physical Therapy	10,916	5,862	2,011,551		2,828,966	4,198	66
69	Electrocardiology	2,058	48,855	406,015		615,604	1,113	69
70	Electroencephalography	1,043		87,944		144,408		70
71	Medical Supplies Charged to Patients					3,479,795		71
72	Impl. Dev. Charged to Patients					4,843,447		72
73	Drugs Charged to Patients			229,790		2,686,072		73
73.01	OUTPATIENT PHARMACY	1,986	1,971	328,654		1,442,521	1,045	73.01
74	Renal Dialysis					233,499		74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	3,609	2,238	217,537		379,231	729	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		6,301		14,550		90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	2,058	2,237	370,599		1,037,418	147	90.02
90.03	RIVER FOREST							90.03
91	Emergency	13,507	92,720	3,286,492		5,278,397	91,923	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency			1,749,144		2,266,713	2,780	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice			299,166		465,399	489	116
118	SUBTOTALS (sum of lines 1-117)	278,654	2,943,156	49,604,532	-15,386,228	97,585,368	1,362,288	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			30,572		95,270	1,887	190

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	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	MAINTEN-ANCE AND REPAIRS MAINT REQ	
		1	2	4	5A	5	6	
192	Physicians' Private Offices					9,530		192
192.0	NON-EMPLOYEE CHILD CARE CENTER							192.0
1								1
193.0	ADULT DAY CARE			161,285		217,692	43	193.0
1								1
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	8,284,598	18,810	11,293,566		15,386,228	3,163,384	202
203	Unit Cost Multiplier (Wkst. B, Part I)	29.730770	0.006391	0.226795		0.157150	2.318826	203
204	Cost to be allocated (Per Wkst. B, Part II)			17,223		757,421	65,061	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000346		0.007736	0.047691	205

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	NURSING ADMINISTRATION (FTES SERVED)	
		7	8	9	10	11	13	
	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	217,106						7
8	Laundry & Linen Service	1,368	143,749					8
9	Housekeeping	1,273	11,522	26,587				9
10	Dietary	7,329		718	125,538			10
11	Cafeteria	6,463		629		60,803		11
12	Maintenance of Personnel							12
13	Nursing Administration	2,071		55		1,906	58,897	13
14	Central Services & Supply	8,005		404		1,404	1,404	14
15	Pharmacy	2,743		320		2,372	2,372	15
16	Medical Records & Library	2,796		187		2,443	2,443	16
17	Social Service	1,631				340	340	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	60,450		10,430	75,708	14,330	14,330	30
31	Intensive Care Unit	11,000		1,120	10,512	2,967	2,967	31
40	Subprovider - IPF				10,491	1,658	1,658	40
43	Nursery	1,294		245				43
44	Skilled Nursing Facility	12,018	8	2,240	28,827	3,702	3,702	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	25,429	131,474	2,628		3,889	3,889	50
51	Recovery Room	1,517		254		496	496	51
52	Delivery Room & Labor Room	5,676		513		2,005	2,005	52
53	Anesthesiology	467		37		2,680	2,680	53
54	Radiology-Diagnostic	9,950		667				54
56	Radioisotope	1,902		265		210	210	56
56.01	ULTRASOUND	1,914		55		618	618	56.01
57	CT Scan	3,567	119	293		819	819	57
59	Cardiac Catheterization	2,063				686	686	59
60	Laboratory	9,818	54	981		4,250	4,250	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,093		131		1,526	1,526	65
66	Physical Therapy	10,916		1,492		2,892	2,892	66
69	Electrocardiology	2,058		284		652	652	69
70	Electroencephalography	1,043		29		155	155	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	1,986				444	444	73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	3,609		368		252	252	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	2,058				566	566	90.02
90.03	RIVER FOREST							90.03
91	Emergency	13,507	572	952		4,488	4,488	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency			1,234		2,267	2,267	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice			56		405	405	116
118	SUBTOTALS (sum of lines 1-117)	217,106	143,749	26,587	125,538	60,422	58,516	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					65	65	190

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	NURSING ADMINI- STRATION (FTES SERVED)	
		7	8	9	10	11	13	
192	Physicians' Private Offices							192
192.0 1	NON-EMPLOYEE CHILD CARE CENTER							192.0 1
193.0 1	ADULT DAY CARE					316	316	193.0 1
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	7,415,602	892,444	3,389,297	2,611,215	1,098,216	3,134,625	202
203	Unit Cost Multiplier (Wkst. B, Part I)	34.156596	6.208349	127.479482	20.800196	18.061872	53.222151	203
204	Cost to be allocated (Per Wkst. B, Part II)	1,084,303	53,158	75,622	274,568	231,697	103,316	204
205	Unit Cost Multiplier (Wkst. B, Part II)	4.994348	0.369797	2.844322	2.187131	3.810618	1.754181	205

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)		
	14	15	16	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	8,800,579					14
15	Pharmacy	247,468	731,949				15
16	Medical Records & Library	4		5,762			16
17	Social Service	204			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	797,840	31,877	920	5,530	1	30
31	Intensive Care Unit	509,691	10,749	245	571		31
40	Subprovider - IPF	18,814	467	351	2,121		40
43	Nursery			35			43
44	Skilled Nursing Facility	123,733	2,405				44
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,339,619	12,007	923			50
51	Recovery Room	55,400	546	46			51
52	Delivery Room & Labor Room	174,975	5,537	72			52
53	Anesthesiology	209,147	15,419	94			53
54	Radiology-Diagnostic	79,040	3,162	163			54
56	Radioisotope	174,552	104,045	76			56
56.01	ULTRASOUND	44,155	992	43			56.01
57	CT Scan	95,605	26,096	149			57
59	Cardiac Catheterization	1,092,755	8,784	173			59
60	Laboratory	1,555,428		503			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	175,959	542	186			65
66	Physical Therapy	44,137	187	100			66
69	Electrocardiology	43,178	55	127			69
70	Electroencephalography	3,550		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	52,402	420,461				73.01
74	Renal Dialysis						74
76	LITHOTRIPSY						76
76.01	CARDIAC REHABILITATION	2,887	11	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	101,299	14,533				90.02
90.03	RIVER FOREST						90.03
91	Emergency	802,675	29,290	277	486	99	91
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	Home Health Agency	40,150	338				101
SPECIAL PURPOSE COST CENTERS							
116	Hospice	15,866	44,446				116
118	SUBTOTALS (sum of lines 1-117)	8,800,533	731,949	5,762	8,708	100	118

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)		
		14	15	16	17	22		
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	12						190
192	Physicians' Private Offices							192
192.0 1	NON-EMPLOYEE CHILD CARE CENTER							192.0 1
193.0 1	ADULT DAY CARE	34						193.0 1
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,471,120	4,923,502	3,331,405	445,183	331,533		202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.280791	6.726564	578.168171	51.123450	3,315.330000		203
204	Cost to be allocated (Per Wkst. B, Part II)	301,876	149,101	132,087	61,060	2,216		204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.034302	0.203704	22.923811	7.011943	22.160000		205

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		PART	LINE NO.		
	1	2	3	4	

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	23,533,218		23,533,218		23,533,218	30
31	Intensive Care Unit	6,232,784		6,232,784		6,232,784	31
40	Subprovider - IPF	2,043,065		2,043,065		2,043,065	40
43	Nursery	1,014,399		1,014,399		1,014,399	43
44	Skilled Nursing Facility	5,965,585		5,965,585		5,965,585	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	11,380,871		11,380,871		11,380,871	50
51	Recovery Room	1,010,376		1,010,376		1,010,376	51
52	Delivery Room & Labor Room	3,251,125		3,251,125		3,251,125	52
53	Anesthesiology	546,722		546,722		546,722	53
54	Radiology-Diagnostic	3,849,649		3,849,649		3,849,649	54
56	Radioisotope	1,501,583		1,501,583		1,501,583	56
56.01	ULTRASOUND	1,135,392		1,135,392		1,135,392	56.01
57	CT Scan	1,749,056		1,749,056		1,749,056	57
59	Cardiac Catheterization	2,034,041		2,034,041		2,034,041	59
60	Laboratory	7,970,880		7,970,880		7,970,880	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,916,825		1,916,825		1,916,825	65
66	Physical Therapy	4,123,945		4,123,945		4,123,945	66
69	Electrocardiology	953,823		953,823		953,823	69
70	Electroencephalography	222,517		222,517		222,517	70
71	Medical Supplies Charged to Patients	4,175,812		4,175,812		4,175,812	71
72	Impl. Dev. Charged to Patients	5,604,595		5,604,595		5,604,595	72
73	Drugs Charged to Patients	3,691,560		3,691,560		3,691,560	73
73.01	OUTPATIENT PHARMACY	4,614,093		4,614,093		4,614,093	73.01
74	Renal Dialysis	270,193		270,193		270,193	74
76	LITHOTRIPSY						76
76.01	CARDIAC REHABILITATION	631,284		631,284		631,284	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	21,135		21,135		21,135	90
90.01	OUTPATIENT INFUSION PROCEDURES						90.01
90.02	WOUND CARE	1,437,631		1,437,631		1,437,631	90.02
90.03	RIVER FOREST						90.03
91	Emergency	7,834,641		7,834,641		7,834,641	91
92	Observation Beds (Non-Distinct Part)	2,386,054		2,386,054		2,386,054	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	Home Health Agency	2,961,832		2,961,832		2,961,832	101
116	Hospice	879,103		879,103		879,103	116
200	Subtotal (sum of lines 30 thru 199)	114,943,789		114,943,789		114,943,789	200
201	Less Observation Beds	2,386,054		2,386,054		2,386,054	201
202	Total (line 200 minus line 201)	112,557,735		112,557,735		112,557,735	202

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COMPUTATION OF RATIO OF COST TO CHARGES

**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8				
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	60,890,013		60,890,013				30
31	Intensive Care Unit	13,057,814		13,057,814				31
40	Subprovider - IPF	7,547,040		7,547,040				40
43	Nursery	3,007,653		3,007,653				43
44	Skilled Nursing Facility	7,375,164		7,375,164				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	11,720,511	18,950,785	30,671,296	0.371059	0.371059	0.371059	50
51	Recovery Room	5,049,618	7,019,545	12,069,163	0.083715	0.083715	0.083715	51
52	Delivery Room & Labor Room	6,147,506	478,683	6,626,189	0.490648	0.490648	0.490648	52
53	Anesthesiology	11,483,414	17,368,210	28,851,624	0.018949	0.018949	0.018949	53
54	Radiology-Diagnostic	4,852,217	14,306,115	19,158,332	0.200939	0.200939	0.200939	54
56	Radioisotope	1,781,029	4,272,546	6,053,575	0.248049	0.248049	0.248049	56
56.01	ULTRASOUND	2,592,870	8,194,552	10,787,422	0.105251	0.105251	0.105251	56.01
57	CT Scan	15,637,845	39,246,788	54,884,633	0.031868	0.031868	0.031868	57
59	Cardiac Catheterization	7,232,851	5,913,513	13,146,364	0.154723	0.154723	0.154723	59
60	Laboratory	31,228,120	30,770,635	61,998,755	0.128565	0.128565	0.128565	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	7,711,215	1,691,569	9,402,784	0.203857	0.203857	0.203857	65
66	Physical Therapy	10,474,351	4,559,883	15,034,234	0.274304	0.274304	0.274304	66
69	Electrocardiology	8,495,727	8,957,726	17,453,453	0.054650	0.054650	0.054650	69
70	Electroencephalography	310,456	1,631,112	1,941,568	0.114607	0.114607	0.114607	70
71	Medical Supplies Charged to Patients	5,352,894	3,789,588	9,142,482	0.456748	0.456748	0.456748	71
72	Impl. Dev. Charged to Patients	8,606,837	4,003,512	12,610,349	0.444444	0.444444	0.444444	72
73	Drugs Charged to Patients	20,540,419	6,446,113	26,986,532	0.136793	0.136793	0.136793	73
73.01	OUTPATIENT PHARMACY		1,494,726	1,494,726	3.086916	3.086916	3.086916	73.01
74	Renal Dialysis	2,076,787	129,513	2,206,300	0.122464	0.122464	0.122464	74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	1,071	883,667	884,738	0.713526	0.713526	0.713526	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		100,133	100,133	0.211069	0.211069	0.211069	90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	13,769	2,736,853	2,750,622	0.522657	0.522657	0.522657	90.02
90.03	RIVER FOREST							90.03
91	Emergency	17,792,286	41,053,169	58,845,455	0.133139	0.133139	0.133139	91
92	Observation Beds (Non-Distinct Part)	3,641,766	7,800,500	11,442,266	0.208530	0.208530	0.208530	92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency		3,129,001	3,129,001				101
116	Hospice		1,502,457	1,502,457				116
200	Subtotal (sum of lines 30 thru 199)	274,621,243	236,430,894	511,052,137				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	274,621,243	236,430,894	511,052,137				202

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	2,580,723		2,580,723	27,675	93.25	12,014	1,120,306	30
31	Intensive Care Unit	488,257		488,257	3,480	140.30	1,531	214,799	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	65,452		65,452	3,495	18.73	3,145	58,906	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	52,778		52,778	526	100.34			43
44	Skilled Nursing Facility	541,958		541,958	9,481	57.16	7,758	443,447	44
45	Nursing Facility								45
200	Total (lines 30-199)	3,729,168		3,729,168	44,657		24,448	1,837,458	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0008

**WORKSHEET D
PART II**

Check Title V Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,125,282	30,671,296	0.036688	5,862,614	215,088	50
51	Recovery Room	65,108	12,069,163	0.005395	2,069,411	11,164	51
52	Delivery Room & Labor Room	237,701	6,626,189	0.035873	13,837	496	52
53	Anesthesiology	44,699	28,851,624	0.001549	4,442,730	6,882	53
54	Radiology-Diagnostic	387,290	19,158,332	0.020215	3,289,162	66,490	54
56	Radioisotope	100,962	6,053,575	0.016678	218,469	3,644	56
56.01	ULTRASOUND	80,795	10,787,422	0.007490	1,219,460	9,134	56.01
57	CT Scan	150,029	54,884,633	0.002734	7,183,691	19,640	57
59	Cardiac Catheterization	129,046	13,146,364	0.009816	1,995,223	19,585	59
60	Laboratory	478,940	61,998,755	0.007725	14,682,655	113,424	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	68,565	9,402,784	0.007292	2,982,956	21,752	65
66	Physical Therapy	426,058	15,034,234	0.028339	2,665,799	75,546	66
69	Electrocardiology	85,571	17,453,453	0.004903	4,417,376	21,658	69
70	Electroencephalography	38,592	1,941,568	0.019877	161,321	3,207	70
71	Medical Supplies Charged to Pat	32,834	9,142,482	0.003591	2,493,167	8,953	71
72	Impl. Dev. Charged to Patients	37,469	12,610,349	0.002971	3,713,095	11,032	72
73	Drugs Charged to Patients	43,989	26,986,532	0.001630	8,358,668	13,625	73
73.01	OUTPATIENT PHARMACY	170,220	1,494,726	0.113880			73.01
74	Renal Dialysis	1,806	2,206,300	0.000819	1,435,414	1,176	74
76	LITHOTRIPSY						76
76.01	CARDIAC REHABILITATION	131,000	884,738	0.148066			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	3,355	100,133	0.033505			90
90.01	OUTPATIENT INFUSION PROCEDURES						90.01
90.02	WOUND CARE	89,223	2,750,622	0.032437	3,601	117	90.02
90.03	RIVER FOREST						90.03
91	Emergency	587,133	58,845,455	0.009978	7,752,458	77,354	91
92	Observation Beds (Non-Distinct)	261,662	11,442,266	0.022868	1,771,704	40,515	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	4,777,329	414,542,995		76,732,811	740,482	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics General Routine Care)					30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check [] Title V [XX] PPS
Applicable [XX] Title XVIII, Part A [] TEFRA
Boxes: [] Title XIX [] Other

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
6		7		8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	27,675		12,014		30
31	Intensive Care Unit	3,480		1,531		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	3,495		3,145		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	526				43
44	Skilled Nursing Facility	9,481		7,758		44
45	Nursing Facility					45
200	Total (lines 30-199)	44,657		24,448		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0008

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1	2	3	4	5	6	
		Non Physician Anesth- etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
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 Pat							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							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0008

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	30,671,296			5,862,614		5,525,862		50
51	Recovery Room	12,069,163			2,069,411		2,584,384		51
52	Delivery Room & Labor Room	6,626,189			13,837				52
53	Anesthesiology	28,851,624			4,442,730		4,544,752		53
54	Radiology-Diagnostic	19,158,332			3,289,162		4,449,683		54
56	Radioisotope	6,053,575			218,469		375,319		56
56.01	ULTRASOUND	10,787,422			1,219,460		1,619,555		56.01
57	CT Scan	54,884,633			7,183,691		11,188,521		57
59	Cardiac Catheterization	13,146,364			1,995,223		241,870		59
60	Laboratory	61,998,755			14,682,655		4,188,917		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,402,784			2,982,956		966,914		65
66	Physical Therapy	15,034,234			2,665,799		89,858		66
69	Electrocardiology	17,453,453			4,417,376		4,180,833		69
70	Electroencephalography	1,941,568			161,321		84,411		70
71	Medical Supplies Charged to Pat	9,142,482			2,493,167		973,211		71
72	Impl. Dev. Charged to Patients	12,610,349			3,713,095		1,398,016		72
73	Drugs Charged to Patients	26,986,532			8,358,668		2,499,561		73
73.01	OUTPATIENT PHARMACY	1,494,726							73.01
74	Renal Dialysis	2,206,300			1,435,414		126,740		74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	884,738							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	100,133							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	2,750,622			3,601		2,328,346		90.02
90.03	RIVER FOREST								90.03
91	Emergency	58,845,455			7,752,458		5,097,522		91
92	Observation Beds (Non-Distinct)	11,442,266			1,771,704		2,064,102		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	414,542,995			76,732,811		54,528,377		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0008

WORKSHEET D
PART V

Check [] Title V - O/P [XX] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [XX] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
 Boxes: [] Title XIX - O/P [] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.371059	5,525,862			2,050,421			50
51	Recovery Room	0.083715	2,584,384			216,352			51
52	Delivery Room & Labor Room	0.490648							52
53	Anesthesiology	0.018949	4,544,752			86,119			53
54	Radiology-Diagnostic	0.200939	4,449,683			894,115			54
56	Radioisotope	0.248049	375,319			93,098			56
56.01	ULTRASOUND	0.105251	1,619,555			170,460			56.01
57	CT Scan	0.031868	11,188,521			356,556			57
59	Cardiac Catheterization	0.154723	241,870			37,423			59
60	Laboratory	0.128565	4,188,917			538,548			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.203857	966,914			197,112			65
66	Physical Therapy	0.274304	89,858			24,648			66
69	Electrocardiology	0.054650	4,180,833			228,483			69
70	Electroencephalography	0.114607	84,411			9,674			70
71	Medical Supplies Charged to Pat	0.456748	973,211			444,512			71
72	Impl. Dev. Charged to Patients	0.444444	1,398,016			621,340			72
73	Drugs Charged to Patients	0.136793	2,499,561		35,349	341,922		4,835	73
73.01	OUTPATIENT PHARMACY	3.086916							73.01
74	Renal Dialysis	0.122464	126,740			15,521			74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	0.713526							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	0.211069							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	0.522657	2,328,346			1,216,926			90.02
90.03	RIVER FOREST								90.03
91	Emergency	0.133139	5,097,522			678,679			91
92	Observation Beds (Non-Distinct)	0.208530	2,064,102			430,427			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		54,528,377		35,349	8,652,336		4,835	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		54,528,377		35,349	8,652,336		4,835	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S008

**WORKSHEET D
PART II**

Check Title V Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,125,282	30,671,296	0.036688			50
51	Recovery Room	65,108	12,069,163	0.005395			51
52	Delivery Room & Labor Room	237,701	6,626,189	0.035873			52
53	Anesthesiology	44,699	28,851,624	0.001549			53
54	Radiology-Diagnostic	387,290	19,158,332	0.020215	32,546	658	54
56	Radioisotope	100,962	6,053,575	0.016678			56
56.01	ULTRASOUND	80,795	10,787,422	0.007490	20,507	154	56.01
57	CT Scan	150,029	54,884,633	0.002734	135,298	370	57
59	Cardiac Catheterization	129,046	13,146,364	0.009816			59
60	Laboratory	478,940	61,998,755	0.007725	430,949	3,329	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	68,565	9,402,784	0.007292	57,333	418	65
66	Physical Therapy	426,058	15,034,234	0.028339	121,533	3,444	66
69	Electrocardiology	85,571	17,453,453	0.004903	21,487	105	69
70	Electroencephalography	38,592	1,941,568	0.019877	19,634	390	70
71	Medical Supplies Charged to Pat	32,834	9,142,482	0.003591	6,636	24	71
72	Impl. Dev. Charged to Patients	37,469	12,610,349	0.002971			72
73	Drugs Charged to Patients	43,989	26,986,532	0.001630	494,749	806	73
73.01	OUTPATIENT PHARMACY	170,220	1,494,726	0.113880			73.01
74	Renal Dialysis	1,806	2,206,300	0.000819			74
76	LITHOTRIPSY						76
76.01	CARDIAC REHABILITATION	131,000	884,738	0.148066			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	3,355	100,133	0.033505			90
90.01	OUTPATIENT INFUSION PROCEDURES						90.01
90.02	WOUND CARE	89,223	2,750,622	0.032437			90.02
90.03	RIVER FOREST						90.03
91	Emergency	587,133	58,845,455	0.009978	95,553	953	91
92	Observation Beds (Non-Distinct		11,442,266				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	4,515,667	414,542,995		1,436,225	10,651	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-S008

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1	2	3	4	5	6	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
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 Pat							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							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-S008

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	30,671,296							50
51	Recovery Room	12,069,163							51
52	Delivery Room & Labor Room	6,626,189							52
53	Anesthesiology	28,851,624							53
54	Radiology-Diagnostic	19,158,332			32,546				54
56	Radioisotope	6,053,575							56
56.01	ULTRASOUND	10,787,422			20,507				56.01
57	CT Scan	54,884,633			135,298				57
59	Cardiac Catheterization	13,146,364							59
60	Laboratory	61,998,755			430,949				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,402,784			57,333				65
66	Physical Therapy	15,034,234			121,533				66
69	Electrocardiology	17,453,453			21,487				69
70	Electroencephalography	1,941,568			19,634				70
71	Medical Supplies Charged to Pat	9,142,482			6,636				71
72	Impl. Dev. Charged to Patients	12,610,349							72
73	Drugs Charged to Patients	26,986,532			494,749				73
73.01	OUTPATIENT PHARMACY	1,494,726							73.01
74	Renal Dialysis	2,206,300							74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	884,738							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	100,133							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	2,750,622							90.02
90.03	RIVER FOREST								90.03
91	Emergency	58,845,455			95,553				91
92	Observation Beds (Non-Distinct)	11,442,266							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	414,542,995			1,436,225				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S008

WORKSHEET D
PART V

Check [] Title V - O/P [] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [XX] Title XVIII, Part B [XX] IPF [] SNF [] Swing Bed NF
 Boxes: [] Title XIX - O/P [] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.371059							50
51	Recovery Room	0.083715							51
52	Delivery Room & Labor Room	0.490648							52
53	Anesthesiology	0.018949							53
54	Radiology-Diagnostic	0.200939							54
56	Radioisotope	0.248049							56
56.01	ULTRASOUND	0.105251							56.01
57	CT Scan	0.031868							57
59	Cardiac Catheterization	0.154723							59
60	Laboratory	0.128565							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.203857							65
66	Physical Therapy	0.274304							66
69	Electrocardiology	0.054650							69
70	Electroencephalography	0.114607							70
71	Medical Supplies Charged to Pat	0.456748							71
72	Impl. Dev. Charged to Patients	0.444444							72
73	Drugs Charged to Patients	0.136793							73
73.01	OUTPATIENT PHARMACY	3.086916							73.01
74	Renal Dialysis	0.122464							74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	0.713526							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	0.211069							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	0.522657							90.02
90.03	RIVER FOREST								90.03
91	Emergency	0.133139							91
92	Observation Beds (Non-Distinct)	0.208530							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-5526

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1	2	3	4	5	6	
		Non Physician Anesth- etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
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 Pat							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							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-5526

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	30,671,296			110,156				50
51	Recovery Room	12,069,163							51
52	Delivery Room & Labor Room	6,626,189							52
53	Anesthesiology	28,851,624			75,668				53
54	Radiology-Diagnostic	19,158,332			189,616				54
56	Radioisotope	6,053,575			11,477				56
56.01	ULTRASOUND	10,787,422			107,920				56.01
57	CT Scan	54,884,633			36,910				57
59	Cardiac Catheterization	13,146,364							59
60	Laboratory	61,998,755			1,086,689				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,402,784			623,713				65
66	Physical Therapy	15,034,234			4,811,067				66
69	Electrocardiology	17,453,453			85,836				69
70	Electroencephalography	1,941,568			11,000				70
71	Medical Supplies Charged to Pat	9,142,482			338,166				71
72	Impl. Dev. Charged to Patients	12,610,349							72
73	Drugs Charged to Patients	26,986,532			1,637,492				73
73.01	OUTPATIENT PHARMACY	1,494,726							73.01
74	Renal Dialysis	2,206,300							74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	884,738							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	100,133							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	2,750,622							90.02
90.03	RIVER FOREST								90.03
91	Emergency	58,845,455			27,354				91
92	Observation Beds (Non-Distinct	11,442,266							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	414,542,995			9,153,064				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-5526

WORKSHEET D
PART V

Check [] Title V - O/P [] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [XX] Title XVIII, Part B [] IPF [XX] SNF [] Swing Bed NF
 Boxes: [] Title XIX - O/P [] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.371059						50
51	Recovery Room	0.083715						51
52	Delivery Room & Labor Room	0.490648						52
53	Anesthesiology	0.018949						53
54	Radiology-Diagnostic	0.200939						54
56	Radioisotope	0.248049						56
56.01	ULTRASOUND	0.105251						56.01
57	CT Scan	0.031868						57
59	Cardiac Catheterization	0.154723						59
60	Laboratory	0.128565						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.203857						65
66	Physical Therapy	0.274304						66
69	Electrocardiology	0.054650						69
70	Electroencephalography	0.114607						70
71	Medical Supplies Charged to Pat	0.456748						71
72	Impl. Dev. Charged to Patients	0.444444						72
73	Drugs Charged to Patients	0.136793						73
73.01	OUTPATIENT PHARMACY	3.086916						73.01
74	Renal Dialysis	0.122464						74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	0.713526						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	0.211069						90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	0.522657						90.02
90.03	RIVER FOREST							90.03
91	Emergency	0.133139						91
92	Observation Beds (Non-Distinct)	0.208530						92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

Check Title V
 Applicable Title XVIII, Part A
 Boxes: Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	2,580,723		2,580,723	27,675	93.25	2,470	230,328	30
31	Intensive Care Unit	488,257		488,257	3,480	140.30	308	43,212	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	65,452		65,452	3,495	18.73	5	94	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	52,778		52,778	526	100.34	151	15,151	43
44	Skilled Nursing Facility	541,958		541,958	9,481	57.16	101	5,773	44
45	Nursing Facility								45
200	Total (lines 30-199)	3,729,168		3,729,168	44,657		3,035	294,558	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0008

**WORKSHEET D
PART II**

Check [] Title V [XX] Hospital [] SUB (Other)
 Applicable [] Title XVIII, Part A [] IPF
 Boxes: [XX] Title XIX [] IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,125,282	30,671,296	0.036688			50
51	Recovery Room	65,108	12,069,163	0.005395			51
52	Delivery Room & Labor Room	237,701	6,626,189	0.035873			52
53	Anesthesiology	44,699	28,851,624	0.001549			53
54	Radiology-Diagnostic	387,290	19,158,332	0.020215			54
56	Radioisotope	100,962	6,053,575	0.016678			56
56.01	ULTRASOUND	80,795	10,787,422	0.007490			56.01
57	CT Scan	150,029	54,884,633	0.002734			57
59	Cardiac Catheterization	129,046	13,146,364	0.009816			59
60	Laboratory	478,940	61,998,755	0.007725			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	68,565	9,402,784	0.007292			65
66	Physical Therapy	426,058	15,034,234	0.028339			66
69	Electrocardiology	85,571	17,453,453	0.004903			69
70	Electroencephalography	38,592	1,941,568	0.019877			70
71	Medical Supplies Charged to Pat	32,834	9,142,482	0.003591			71
72	Impl. Dev. Charged to Patients	37,469	12,610,349	0.002971			72
73	Drugs Charged to Patients	43,989	26,986,532	0.001630			73
73.01	OUTPATIENT PHARMACY	170,220	1,494,726	0.113880			73.01
74	Renal Dialysis	1,806	2,206,300	0.000819			74
76	LITHOTRIPSY						76
76.01	CARDIAC REHABILITATION	131,000	884,738	0.148066			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	3,355	100,133	0.033505			90
90.01	OUTPATIENT INFUSION PROCEDURES						90.01
90.02	WOUND CARE	89,223	2,750,622	0.032437			90.02
90.03	RIVER FOREST						90.03
91	Emergency	587,133	58,845,455	0.009978			91
92	Observation Beds (Non-Distinct	261,662	11,442,266	0.022868			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	4,777,329	414,542,995				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics General Routine Care)					30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
6		7		8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	27,675		2,470		30
31	Intensive Care Unit	3,480		308		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	3,495		5		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	526		151		43
44	Skilled Nursing Facility	9,481		101		44
45	Nursing Facility					45
200	Total (lines 30-199)	44,657		3,035		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0008

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1	2	3	4	5	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 HEMOPHILIACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
69	Electrocardiology						69
70	Electroencephalography						70
71	Medical Supplies Charged to Pat						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)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)						200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0008

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	30,671,296							50
51	Recovery Room	12,069,163							51
52	Delivery Room & Labor Room	6,626,189							52
53	Anesthesiology	28,851,624							53
54	Radiology-Diagnostic	19,158,332							54
56	Radioisotope	6,053,575							56
56.01	ULTRASOUND	10,787,422							56.01
57	CT Scan	54,884,633							57
59	Cardiac Catheterization	13,146,364							59
60	Laboratory	61,998,755							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,402,784							65
66	Physical Therapy	15,034,234							66
69	Electrocardiology	17,453,453							69
70	Electroencephalography	1,941,568							70
71	Medical Supplies Charged to Pat	9,142,482							71
72	Impl. Dev. Charged to Patients	12,610,349							72
73	Drugs Charged to Patients	26,986,532							73
73.01	OUTPATIENT PHARMACY	1,494,726							73.01
74	Renal Dialysis	2,206,300							74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	884,738							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	100,133							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	2,750,622							90.02
90.03	RIVER FOREST								90.03
91	Emergency	58,845,455							91
92	Observation Beds (Non-Distinct)	11,442,266							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	414,542,995							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0008

WORKSHEET D
PART V

Check [] Title V - O/P [XX] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
 Boxes: [XX] Title XIX - O/P [] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.371059							50
51	Recovery Room	0.083715							51
52	Delivery Room & Labor Room	0.490648							52
53	Anesthesiology	0.018949							53
54	Radiology-Diagnostic	0.200939							54
56	Radioisotope	0.248049							56
56.01	ULTRASOUND	0.105251							56.01
57	CT Scan	0.031868							57
59	Cardiac Catheterization	0.154723							59
60	Laboratory	0.128565							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.203857							65
66	Physical Therapy	0.274304							66
69	Electrocardiology	0.054650							69
70	Electroencephalography	0.114607							70
71	Medical Supplies Charged to Pat	0.456748							71
72	Impl. Dev. Charged to Patients	0.444444							72
73	Drugs Charged to Patients	0.136793							73
73.01	OUTPATIENT PHARMACY	3.086916							73.01
74	Renal Dialysis	0.122464							74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	0.713526							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	0.211069							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	0.522657							90.02
90.03	RIVER FOREST								90.03
91	Emergency	0.133139							91
92	Observation Beds (Non-Distinct)	0.208530							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0008

WORKSHEET D-1
PART I

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	27,675	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	27,675	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	24,869	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	12,014	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 XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	23,533,218	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 (line 21 minus line 26)	23,533,218	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	23,533,218	37

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0008

WORKSHEET D-1
PART II

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						850.34	38
39	Program general inpatient routine service cost (line 9 x line 38)						10,215,985	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)							40
41	Total Program general inpatient routine service cost (line 39 + line 40)						10,215,985	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)							42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	6,232,784	3,480	1,791.03	1,531	2,742,067		43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						12,819,295	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						25,777,347	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						1,335,105	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						740,482	51
52	Total Program excludable cost (sum of lines 50 and 51)						2,075,587	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						23,701,760	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0008

WORKSHEET D-1
PARTS III & IV

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
Applicable Title XVIII, Part A IPF SNF TEFRA
Boxes: Title XIX - I/P IRF NF Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					2,806	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					850.34	88
89	Observation bed cost (line 87 x line 88) (see instructions)					2,386,054	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	2,580,723	23,533,218	0.109663	2,386,054	261,662	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S008

WORKSHEET D-1
PART I

Check [] Title V - I/P [] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] IPF [] SNF [] TEFRA
 Boxes: [] Title XIX - I/P [] IRF [] NF [] Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,495	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,495	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	3,495	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,145	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 XIX only)		15
16	Nursery days (title V or 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)	2,043,065	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 (line 21 minus line 26)	2,043,065	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,043,065	37

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S008

**WORKSHEET D-1
PART II**

Check [] Title V - I/P [] Hospital [] SUB (Other) [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] IPF [] TEFRA
 Boxes: [] Title XIX - I/P [] IRF [] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	584.57	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,838,473	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	1,838,473	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	200,295	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,038,768	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	58,906	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	10,651	51
52	Total Program excludable cost (sum of lines 50 and 51)	69,557	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,969,211	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-5526

WORKSHEET D-1
PART I

Check [] Title V - I/P [] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [XX] SNF [] TEFRA
 Boxes: [] Title XIX - I/P [] IRF [] NF [] Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,481	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,481	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	9,481	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	7,758	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 XIX only)		15
16	Nursery days (title V or 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)	5,965,585	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 (line 21 minus line 26)	5,965,585	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,965,585	37

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-5526

WORKSHEET D-1
PARTS III & IV

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART III - SNF, NF, AND ICF/IID ONLY

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	5,965,585	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	629.21	71
72	Program routine service cost (line 9 x line 71)	4,881,411	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)	4,881,411	74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26)		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)	4,881,411	83
84	Program inpatient ancillary services (see instructions)	2,070,392	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	6,951,803	86

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0008

WORKSHEET D-1
PART I

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [] ICF/IID [] PPS
 Applicable [] Title XVIII, Part A [] IPF [] SNF [] TEFRA
 Boxes: [XX] Title XIX - I/P [] IRF [] NF [XX] Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	27,675	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	27,675	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	24,869	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,470	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 XIX only)	526	15
16	Nursery days (title V or XIX only)	151	16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	23,533,218	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 (line 21 minus line 26)	23,533,218	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	23,533,218	37

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0008

WORKSHEET D-1
PART II

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						850.34	38
39	Program general inpatient routine service cost (line 9 x line 38)						2,100,340	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)						2,100,340	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
42	Nursery (Titles V and XIX only)	1,014,399	526	1,928.52	151	291,207		42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	6,232,784	3,480	1,791.03	308	551,637		43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47
								1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)							48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						2,943,184	49
								PASS THROUGH COST ADJUSTMENTS
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						288,691	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 (sum of lines 50 and 51)						288,691	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)							53
								TARGET AMOUNT AND LIMIT COMPUTATION
54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63
								PROGRAM INPATIENT ROUTINE SWING BED COST
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0008

WORKSHEET D-1
PARTS III & IV

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
Applicable Title XVIII, Part A IPF SNF TEFRA
Boxes: Title XIX - I/P IRF NF Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					2,806	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0008

WORKSHEET D-3

Check [] Title V [XX] Hospital [] SUB (Other) [] Swing Bed SNF [XX] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [] SNF [] Swing Bed NF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] ICF/IID [] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		31,971,404		30
31	Intensive Care Unit		6,236,715		31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.371059	5,862,614	2,175,376	50
51	Recovery Room	0.083715	2,069,411	173,241	51
52	Delivery Room & Labor Room	0.490648	13,837	6,789	52
53	Anesthesiology	0.018949	4,442,730	84,185	53
54	Radiology-Diagnostic	0.200939	3,289,162	660,921	54
56	Radioisotope	0.248049	218,469	54,191	56
56.01	ULTRASOUND	0.105251	1,219,460	128,349	56.01
57	CT Scan	0.031868	7,183,691	228,930	57
59	Cardiac Catheterization	0.154723	1,995,223	308,707	59
60	Laboratory	0.128565	14,682,655	1,887,676	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.203857	2,982,956	608,096	65
66	Physical Therapy	0.274304	2,665,799	731,239	66
69	Electrocardiology	0.054650	4,417,376	241,410	69
70	Electroencephalography	0.114607	161,321	18,489	70
71	Medical Supplies Charged to Patients	0.456748	2,493,167	1,138,749	71
72	Impl. Dev. Charged to Patients	0.444444	3,713,095	1,650,263	72
73	Drugs Charged to Patients	0.136793	8,358,668	1,143,407	73
73.01	OUTPATIENT PHARMACY	3.086916			73.01
74	Renal Dialysis	0.122464	1,435,414	175,787	74
76	LITHOTRIPSY				76
76.01	CARDIAC REHABILITATION	0.713526			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	0.211069			90
90.01	OUTPATIENT INFUSION PROCEDURES				90.01
90.02	WOUND CARE	0.522657	3,601	1,882	90.02
90.03	RIVER FOREST				90.03
91	Emergency	0.133139	7,752,458	1,032,155	91
92	Observation Beds (Non-Distinct Part)	0.208530	1,771,704	369,453	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		76,732,811	12,819,295	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		76,732,811		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S008

WORKSHEET D-3

Check [] Title V [] Hospital [] SUB (Other) [] Swing Bed SNF [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] IPF [] SNF [] Swing Bed NF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] ICF/IID [] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF		6,793,200		40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.371059			50
51	Recovery Room	0.083715			51
52	Delivery Room & Labor Room	0.490648			52
53	Anesthesiology	0.018949			53
54	Radiology-Diagnostic	0.200939	32,546	6,540	54
56	Radioisotope	0.248049			56
56.01	ULTRASOUND	0.105251	20,507	2,158	56.01
57	CT Scan	0.031868	135,298	4,312	57
59	Cardiac Catheterization	0.154723			59
60	Laboratory	0.128565	430,949	55,405	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.203857	57,333	11,688	65
66	Physical Therapy	0.274304	121,533	33,337	66
69	Electrocardiology	0.054650	21,487	1,174	69
70	Electroencephalography	0.114607	19,634	2,250	70
71	Medical Supplies Charged to Patients	0.456748	6,636	3,031	71
72	Impl. Dev. Charged to Patients	0.444444			72
73	Drugs Charged to Patients	0.136793	494,749	67,678	73
73.01	OUTPATIENT PHARMACY	3.086916			73.01
74	Renal Dialysis	0.122464			74
76	LITHOTRIPSY				76
76.01	CARDIAC REHABILITATION	0.713526			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	0.211069			90
90.01	OUTPATIENT INFUSION PROCEDURES				90.01
90.02	WOUND CARE	0.522657			90.02
90.03	RIVER FOREST				90.03
91	Emergency	0.133139	95,553	12,722	91
92	Observation Beds (Non-Distinct Part)	0.208530			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,436,225	200,295	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,436,225		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-5526

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/IID Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.371059	110,156	40,874	50
51	Recovery Room	0.083715			51
52	Delivery Room & Labor Room	0.490648			52
53	Anesthesiology	0.018949	75,668	1,434	53
54	Radiology-Diagnostic	0.200939	189,616	38,101	54
56	Radioisotope	0.248049	11,477	2,847	56
56.01	ULTRASOUND	0.105251	107,920	11,359	56.01
57	CT Scan	0.031868	36,910	1,176	57
59	Cardiac Catheterization	0.154723			59
60	Laboratory	0.128565	1,086,689	139,710	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.203857	623,713	127,148	65
66	Physical Therapy	0.274304	4,811,067	1,319,695	66
69	Electrocardiology	0.054650	85,836	4,691	69
70	Electroencephalography	0.114607	11,000	1,261	70
71	Medical Supplies Charged to Patients	0.456748	338,166	154,457	71
72	Impl. Dev. Charged to Patients	0.444444			72
73	Drugs Charged to Patients	0.136793	1,637,492	223,997	73
73.01	OUTPATIENT PHARMACY	3.086916			73.01
74	Renal Dialysis	0.122464			74
76	LITHOTRIPSY				76
76.01	CARDIAC REHABILITATION	0.713526			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	0.211069			90
90.01	OUTPATIENT INFUSION PROCEDURES				90.01
90.02	WOUND CARE	0.522657			90.02
90.03	RIVER FOREST				90.03
91	Emergency	0.133139	27,354	3,642	91
92	Observation Beds (Non-Distinct Part)	0.208530			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		9,153,064	2,070,392	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		9,153,064		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0008

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/IID Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
43	Nursery				43
ANCILLARY SERVICE COST CENTERS					
50	Operating Room	0.371059			50
51	Recovery Room	0.083715			51
52	Delivery Room & Labor Room	0.490648			52
53	Anesthesiology	0.018949			53
54	Radiology-Diagnostic	0.200939			54
56	Radioisotope	0.248049			56
56.01	ULTRASOUND	0.105251			56.01
57	CT Scan	0.031868			57
59	Cardiac Catheterization	0.154723			59
60	Laboratory	0.128565			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.203857			65
66	Physical Therapy	0.274304			66
69	Electrocardiology	0.054650			69
70	Electroencephalography	0.114607			70
71	Medical Supplies Charged to Patients	0.456748			71
72	Impl. Dev. Charged to Patients	0.444444			72
73	Drugs Charged to Patients	0.136793			73
73.01	OUTPATIENT PHARMACY	3.086916			73.01
74	Renal Dialysis	0.122464			74
76	LITHOTRIPSY				76
76.01	CARDIAC REHABILITATION	0.713526			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	0.211069			90
90.01	OUTPATIENT INFUSION PROCEDURES				90.01
90.02	WOUND CARE	0.522657			90.02
90.03	RIVER FOREST				90.03
91	Emergency	0.133139			91
92	Observation Beds (Non-Distinct Part)	0.208530			92
OTHER REIMBURSABLE COST CENTERS					
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,552,186			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	17,099,413			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	13,333			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments	5,664,497			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	203.31			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)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 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 line 8 plus lines (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	3.98			10
11	FTE count for residents in dental 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)	0.009690			19
20	Prior year resident to bed ratio (see instructions)	0.009336			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.009336			21
22	IME payment adjustment (see instructions)	144,157			22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)	2.01			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 factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)	144,157			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0425			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1999			31
32	Sum of lines 30 and 31	0.2424			32
33	Allowable disproportionate share percentage (see instructions)	0.0921			33
34	Disproportionate share adjustment (see instructions)	521,553			34
		Prior to October 1	On or after October 1		
	Uncompensated Care Adjustment				
35	Total uncompensated care amount (see instructions)				35
35.01	Factor 3 (see instructions)				35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,528,186	1,354,937		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	385,187	1,013,418		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,398,605			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, 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
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
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 41.01 divided by 7 days)				44

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46
47	Subtotal (see instructions)	24,729,247			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 (see instructions)	24,729,247			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,915,091			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)	58,716			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 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	26,703,054			59
60	Primary payer payments	5,946			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	26,697,108			61
62	Deductibles billed to program beneficiaries	2,415,240			62
63	Coinsurance billed to program beneficiaries	99,341			63
64	Allowable bad debts (see instructions)	585,894			64
65	Adjusted reimbursable bad debts (see instructions)	380,831			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	395,729			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	24,563,358			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	-41,763			70.93
70.94	HRR adjustment amount (see instructions)	-29,025			70.94
71	Amount due provider (see instructions)	24,492,570			71
71.01	Sequestration adjustment (see instructions)	489,851			71.01
72	Interim payments	23,444,210			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	558,509			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	675,370			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. 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

HSP Bonus Payment Amount

Prior to 10/1 On or After 10/1

100	HSP bonus amount (see instructions)				100
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HVBP Adjustment for HSP Bonus Payment

Prior to 10/1 On or After 10/1

101	HVBP adjustment factor (see instructions)	0.000000000	0.000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

HRR Adjustment for HSP Bonus Payment

Prior to 10/1 On or After 10/1

103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0008

**WORKSHEET E
PART B**

Check applicable box: Hospital IPF IRF SUB (Other) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	4,835			1
2	Medical and other services reimbursed under OPPS (see instructions)	8,652,336			2
3	PPS payments	9,239,655			3
4	Outlier payment (see instructions)	1,560			4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	4,835			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	35,349			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	35,349			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	35,349			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	30,514			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	4,835			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	9,241,215			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	1,938,341			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	7,307,709			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	13,958			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	7,321,667			30
31	Primary payer payments	6,454			31
32	Subtotal (line 30 minus line 31)	7,315,213			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	342,371			34
35	Adjusted reimbursable bad debts (see instructions)	222,541			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	240,212			36
37	Subtotal (see instructions)	7,537,754			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	7,537,754			40
40.01	Sequestration adjustment (see instructions)	150,755			40.01
41	Interim payments	7,163,650			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	223,349			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	22,254			44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S008

WORKSHEET E
PART B

Check applicable box: [] Hospital [XX] IPF [] IRF [] SUB (Other) [] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-5526

WORKSHEET E
PART B

Check applicable box: Hospital IPF IRF SUB (Other) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0008

WORKSHEET E-1
PART I

Check Hospital SUB (Other)
Applicable IPF SNF
Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	Total interim payments paid to provider		23,288,382		7,162,272	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	02/27/2015	155,828	02/27/2015	1,378	3.01
						3.02
	Program					3.03
	to					3.04
	Provider					3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
	Provider					3.52
	to					3.53
	Program					3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99	155,828		1,378	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		23,444,210		7,163,650	4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					5.01
						5.02
	Program					5.03
	to					5.04
	Provider					5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
	Provider					5.52
	to					5.53
	Program					5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	558,509		223,349	6.01
		.02				6.02
7	Total Medicare program liability (see instructions)		24,002,719		7,386,999	7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	8

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

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-S008

WORKSHEET E-1
PART I

Check Hospital SUB (Other)
Applicable IPF SNF
Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		2,666,471		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
	Provider	.52			3.52
	to	.53			3.53
	Program	.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,666,471		4
	TO BE COMPLETED BY CONTRACTOR				
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	13,432		6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		2,679,903		7
8	Name of Contractor		Contractor Number	NPR Date (Month/Day/Year)	8

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

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-5526

WORKSHEET E-1
PART I

Check [] Hospital [] SUB (Other)
Applicable [] IPF [XX] SNF
Boxes: [] IRF [] Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		3,277,002		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
	Provider	.52			3.52
	to	.53			3.53
	Program	.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,277,002		4
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	10,493		6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		3,287,495		7
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)	
					8

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

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

**WORKSHEET E-1
PART II**

Check applicable box: Hospital CAH

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 (Wkst. S-3, Pt. I, col. 15, line 14)	8,004	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	13,545	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	3,649	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	28,349	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	511,052,137	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	2,112,417	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	1,026,470	8
9	Sequestration adjustment amount (see instructions)	20,529	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	1,005,941	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	1,050,913	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-44,972	32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S008

**WORKSHEET E-3
PART II**

Check Hospital
Applicable Subprovider IPF
Box:

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	2,870,180	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 42 CFR §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)	9,575,342	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)	2,870,180	12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	2,870,180	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	2,870,180	18
19	Deductibles	131,052	19
20	Subtotal (line 18 minus line 19)	2,739,128	20
21	Coinsurance	18,240	21
22	Subtotal (line 20 minus line 21)	2,720,888	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	21,088	23
24	Adjusted reimbursable bad debts (see instructions)	13,707	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	10,880	25
26	Subtotal (sum of lines 22 and 24)	2,734,595	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
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	2,734,595	31
31.01	Sequestration adjustment (see instructions)	54,692	31.01
32	Interim payments	2,666,471	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	13,432	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E-3
PART VI**

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

PROSPECTIVE PAYMENT AMOUNT (see instructions)			
1	Resource Utilization Group (RUGS) payment	3,698,241	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	3,698,241	4
COMPUTATION OF NET COST OF COVERED SERVICES			
5	Medical and other services. Do not use this line. (see instructions)		5
6	Deductibles		6
7	Coinsurance	354,362	7
8	Allowable bad debts (see instructions)	16,461	8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	71	9
10	Adjusted reimbursable bad debts (see instructions)	10,708	10
11	Utilization review		11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)	3,354,587	12
13	Inpatient primary payer payments		13
14	Other adjustments (specify) (see instructions)		14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		14.50
15	Subtotal (see instructions)	3,354,587	15
15.01	Sequestration adjustment (see instructions)	67,092	15.01
16	Interim payments	3,277,002	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 16 and 17)	10,493	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0008

WORKSHEET E-3
PART VII

Check [] Title V [XX] Hospital [] NF [] PPS
Applicable [XX] Title XIX [] SUB (Other) [] ICF/IID [] TEFRA
Boxes: [] SNF [XX] Other

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	2,943,184	1
2	Medical and other services		2
3	Organ acquisition (certified transplant centers only)		3
4	Subtotal (sum of lines 1, 2 and 3)	2,943,184	4
5	Inpatient primary payer payments		5
6	Outpatient primary payer payments		6
7	Subtotal (line 4 less sum of lines 5 and 6)	2,943,184	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	Routine service charges		8
9	Ancillary service charges		9
10	Organ acquisition charges, net of revenue		10
11	Incentive from target amount computation		11
12	Total reasonable charges (sum of lines 8-11)		12
CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a charge basis		13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	15
16	Total customary charges (see instructions)		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	2,943,184	18
19	Interns and residents (see instructions)		19
20	Cost of physicians' services in a teaching hospital (see instructions)		20
21	Cost of covered services (lesser of line 4 or line 16)		21
PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments		22
23	Outlier payments		23
24	Program capital payments		24
25	Capital exception payments (see instructions)		25
26	Routine and ancillary service other pass through costs		26
27	Subtotal (sum of lines 22 through 26)		27
28	Customary charges (Titles V or XIX PPS covered services only)		28
29	Titles V or XIX (sum of lines 21 and 27)		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	2,943,184	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 line 41)		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		43

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

Check [] Title V
Applicable [XX] Title XVIII
Box: [] Title XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT					
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) (see instructions)			2	
3	Amount of reduction to Direct GME cap under §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 §5503 increase to the direct GME FTE cal (see instructions for cost reporting periods straddling 7/1/2011)			4.01	
4.02	ACA §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 teh current year from your records (see instructions)		3.98	6	
7	Enter the lesser of line 5 or line 6		1.31	7	
		Primary Care 1	Other 2	Total 3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	2.85	1.00	3.85	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	0.94	0.33	1.27	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
11	Total weighted FTE count	0.94	0.33		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.99	0.32		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.97	0.33		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.97	0.33		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
17	Adjusted rolling average FTE count	0.97	0.33		17
18	Per resident amount	90,765.63	90,765.63		18
19	Approved amount for resident costs	88,043	29,953	117,996	19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)			2.67	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)			117,996	25
		Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	16,690	3,649		26
27	Total inpatient days (see instructions)	32,186	32,186		27
28	Ratio of inpatient days to total inpatient days	0.518548	0.113372		28
29	Program direct GME amount	61,187	13,377		29
30	Reduction for direct GME payments for Medicare Advantage		1,890		30
31	Net Program direct GME amount			72,674	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, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			2,206,300	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)			36,395,767	37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)			5,946	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			36,389,821	41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)			8,657,171	42
43	Primary payer payments (see instructions)			6,454	43
44	Total Part B reasonable cost (line 42 minus line 43)			8,650,717	44
45	Total reasonable cost (sum of lines 41 and 44)			45,040,538	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.807935	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.192065	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			72,674	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			58,716	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			13,958	50

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

Check Title V
 Applicable Title XVIII
 Box: Title XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
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) (see instructions)			2
3	Amount of reduction to Direct GME cap under §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 §5503 increase to the direct GME FTE cal (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA §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 teh 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	0.00	0.00	0.00 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	0.00	0.00	0.00 9
10	Weighted dental and podiatric resident FTE count for the current year		0.00	
11	Total weighted FTE count	0.00	0.00	
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00	
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00	
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00	
15	Adjustment for residents in initial years of new programs	0.00	0.00	
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00	
17	Adjusted rolling average FTE count	0.00	0.00	
18	Per resident amount	0.00	0.00	
19	Approved amount for resident costs			
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)			
21	Direct GME FTE unweighted resident count over cap (see instructions)			
22	Allowable additional direct GME FTE resident count (see instructions)			
23	Enter the locality adjustment national average per resident amount (see instructions)			
24	Multiply line 22 times line 23			
25	Total direct GME amount (sum of lines 19 and 24)			
		Inpatient Part A	Managed Care	
26	Inpatient days (see instructions)	3,048	2,967	26
27	Total inpatient days (see instructions)	32,186	32,186	27
28	Ratio of inpatient days to total inpatient days	0.094700	0.092183	28
29	Program direct GME amount			29
30	Reduction for direct GME payments for Medicare Advantage			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, Pt. I, sum of col. 20 and 23, lines 74 and 94)			32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. 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, Pt. III, col 1, line 69)			38
39	Cost of physicians' services in a teaching hospital (see instructions)			39
40	Primary payer payments (see instructions)			40
41	Total Part A reasonable cost (sum of lines 37 through 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

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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BALANCE SHEET

WORKSHEET G

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

Assets (Omit Cents)		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund
		1	2	3	4
CURRENT ASSETS					
1	Cash on hand and in banks	4,482,026			1
2	Temporary investments	15,133,519			2
3	Notes receivable				3
4	Accounts receivable	18,673,155			4
5	Other receivables	48,332,247			5
6	Allowances for uncollectible notes and accounts receivable	-1,264,480			6
7	Inventory	3,176,000			7
8	Prepaid expenses	548,199			8
9	Other current assets	11,237,326			9
10	Due from other funds				10
11	Total current assets (sum of lines 1-10)	100,317,992			11
FIXED ASSETS					
12	Land	12,500,000			12
13	Land improvements	987,143			13
14	Accumulated depreciation	-212,104			14
15	Buildings	60,563,417			15
16	Accumulated depreciation	-14,255,052			16
17	Leasehold improvements				17
18	Accumulated depreciation				18
19	Fixed equipment				19
20	Accumulated depreciation				20
21	Automobiles and trucks				21
22	Accumulated depreciation				22
23	Major movable equipment	35,093,184			23
24	Accumulated depreciation	-15,854,350			24
25	Minor equipment depreciable				25
26	Accumulated depreciation				26
27	HIT designated assets				27
28	Accumulated depreciation				28
29	Minor equipment-nondepreciable				29
30	Total fixed assets (sum of lines 12-29)	78,822,238			30
OTHER ASSETS					
31	Investments				31
32	Deposits on leases				32
33	Due from owners/officers				33
34	Other assets	3,930,071			34
35	Total other assets (sum of lines 31-34)	3,930,071			35
36	Total assets (sum of lines 11, 30 and 35)	183,070,301			36
Liabilities and Fund Balances (Omit Cents)					
		1	2	3	4
CURRENT LIABILITIES					
37	Accounts payable	40,743,188			37
38	Salaries, wages and fees payable	6,062,909			38
39	Payroll taxes payable				39
40	Notes and loans payable (short term)				40
41	Deferred income				41
42	Accelerated payments				42
43	Due to other funds	9,589,236			43
44	Other current liabilities	372,264			44
45	Total current liabilities (sum of lines 37 thru 44)	56,767,597			45
LONG TERM LIABILITIES					
46	Mortgage payable				46
47	Notes payable				47
48	Unsecured loans				48
49	Other long term liabilities	46,825,182			49
50	Total long term liabilities (sum of lines 46 thru 49)	46,825,182			50
51	Total liabilities (sum of lines 45 and 50)	103,592,779			51
CAPITAL ACCOUNTS					
52	General fund balance	79,477,522			52
53	Specific purpose fund				53
54	Donor created - endowment fund balance - restricted				54
55	Donor created - endowment fund balance - unrestricted				55
56	Governing body created - endowment fund balance				56
57	Plant fund balance - invested in plant				57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion				58
59	Total fund balances (sum of lines 52 thru 58)	79,477,522			59
60	Total liabilities and fund balances (sum of lines 51 and 59)	183,070,301			60

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		82,084,302			1
2	Net income (loss) (from Worksheet G-3, line 29)		-3,190,927			2
3	Total (sum of line 1 and line 2)		78,893,375			3
4	Additions (credit adjustments) (specify)	584,147				4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		584,147			10
11	Subtotal (line 3 plus line 10)		79,477,522			11
12	Deductions (debit adjustments) (specify)					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)		79,477,522			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					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)					11
12	Deductions (debit adjustments) (specify)					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)					19

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2
PARTS I & II**

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	69,284,111		69,284,111	1
2	Subprovider IPF	7,547,040		7,547,040	2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	7,404,404		7,404,404	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	84,235,555		84,235,555	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	13,844,695		13,844,695	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	13,844,695		13,844,695	16
17	Total inpatient routine care services (sum of lines 10 and 16)	98,080,250		98,080,250	17
18	Ancillary services	178,722,214		178,722,214	18
19	Outpatient services		229,824,783	229,824,783	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		3,192,246	3,192,246	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	OTHER PATIENT REVENUES		1,550,742	1,550,742	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	276,802,464	234,567,771	511,370,235	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		123,289,614	29
30	Add (specify)			30
31	AFFILIATE			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 Worksheet G-3, line 4)		123,289,614	43

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	511,370,235	1
2	Less contractual allowances and discounts on patients' accounts	405,007,077	2
3	Net patient revenues (line 1 minus line 2)	106,363,158	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	123,289,614	4
5	Net income from service to patients (line 3 minus line 4)	-16,926,456	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 medical and surgical supplies to otehr 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, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial 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
24.04	Other (OTHER INCOME)	13,109,797	24.04
24.05	Other (PHYSICIAN INCOME)		24.05
24.06	Other (STRATEGIC SUPPORT)	625,732	24.06
25	Total other income (sum of lines 6-24)	13,735,529	25
26	Total (line 5 plus line 25)	-3,190,927	26
29	Net income (or loss) for the period (line 26 minus line 28)	-3,190,927	29

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7255

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	563,750		35,446		58,570	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	722,796					6
7	Physical Therapy	335,352					7
8	Occupational Therapy	11,867					8
9	Speech Pathology						9
10	Medical Social Services	56,916					10
11	Home Health Aide	49,007					11
12	Supplies (see instructions)					36,312	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)	1,739,688		35,446		94,882	24

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7255

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	657,766		657,766		657,766	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	722,796		722,796		722,796	6
7	Physical Therapy	335,352		335,352		335,352	7
8	Occupational Therapy	11,867		11,867		11,867	8
9	Speech Pathology						9
10	Medical Social Services	56,916		56,916		56,916	10
11	Home Health Aide	49,007		49,007		49,007	11
12	Supplies (see instructions)	36,312		36,312		36,312	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)	1,870,016		1,870,016		1,870,016	24

Column 6, line 24 should agree with Worksheet A, column 3, line 101, or subscript as applicable.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7255

WORKSHEET H-1
PART I

		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	CAPITAL RELATED COSTS			
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	657,766				5
HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	722,796				6
7	Physical Therapy	335,352				7
8	Occupational Therapy	11,867				8
9	Speech Pathology					9
10	Medical Social Services	56,916				10
11	Home Health Aide	49,007				11
12	Supplies (see instructions)	36,312				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 Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	1,870,016				24

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7255

**WORKSHEET H-1
PART I**

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		657,766	657,766		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		722,796	394,737	1,117,533	6
7	Physical Therapy		335,352	173,867	509,219	7
8	Occupational Therapy		11,867	16,320	28,187	8
9	Speech Pathology					9
10	Medical Social Services		56,916	29,461	86,377	10
11	Home Health Aide		49,007	25,480	74,487	11
12	Supplies (see instructions)		36,312	17,901	54,213	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 Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		1,870,016		1,870,016	24

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 14-7255

WORKSHEET H-1
PART II

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORTATION (Mileage)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
	GENERAL SERVICE COST CENTERS							
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-657,766	2,579,289	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care					825,085	1,547,881	6
7	Physical Therapy					346,430	681,782	7
8	Occupational Therapy					52,127	63,994	8
9	Speech Pathology							9
10	Medical Social Services					58,609	115,525	10
11	Home Health Aide					50,906	99,913	11
12	Supplies (see instructions)					33,882	70,194	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 Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					709,273	2,579,289	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						657,766	25
26	Unit Cost Multiplier						0.255018	26

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7255

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINI- STRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	Administrative and General				127,856	127,856	20,093	1
2	Skilled Nursing Care	1,117,533			163,926	1,281,459	201,381	2
3	Physical Therapy	509,219			76,056	585,275	91,976	3
4	Occupational Therapy	28,187			7,104	35,291	5,546	4
5	Speech Pathology							5
6	Medical Social Services	86,377			10,640	97,017	15,246	6
7	Home Health Aide	74,487			11,115	85,602	13,452	7
8	Supplies	54,213				54,213	8,520	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	Totals (sum of lines 1-19)(2)	1,870,016			396,697	2,266,713	356,214	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7255

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	MAINTEN- ANCE AND REPAIRS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	Administrative and General	6,446			157,310		40,946	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							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	Totals (sum of lines 1-19)(2)	6,446			157,310		40,946	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7255

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	MAIN- TENANCE OF PERSONNEL	NURSING ADMINI- STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	Administrative and General		120,655		2,274			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			11,274				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	Totals (sum of lines 1-19)(2)		120,655	11,274	2,274			20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7255

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	
		19	20	21	22	23	24	
1	Administrative and General						475,580	1
2	Skilled Nursing Care						1,482,840	2
3	Physical Therapy						677,251	3
4	Occupational Therapy						40,837	4
5	Speech Pathology							5
6	Medical Social Services						112,263	6
7	Home Health Aide						99,054	7
8	Supplies						74,007	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	Totals (sum of lines 1-19)(2)						2,961,832	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7255

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL (cols 23 +/- 24)	ALLOCATED HHA A&G (see PtII)	TOTAL HHA COSTS		
		25	26	27	28		
1	Administrative and General		475,580				1
2	Skilled Nursing Care		1,482,840	283,645	1,766,485		2
3	Physical Therapy		677,251	129,547	806,798		3
4	Occupational Therapy		40,837	7,811	48,648		4
5	Speech Pathology						5
6	Medical Social Services		112,263	21,474	133,737		6
7	Home Health Aide		99,054	18,947	118,001		7
8	Supplies		74,007	14,156	88,163		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	Totals (sum of lines 1-19)(2)		2,961,832	475,580	2,961,832		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.191284			21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 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)	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINI- STRATIVE & GENERAL ACCUM COST	MAINTEN- ANCE AND REPAIRS MAINT REQS	
		1	2	4	4A	5	6	
1	Administrative and General			563,750		127,856	2,780	1
2	Skilled Nursing Care			722,796		1,281,459		2
3	Physical Therapy			335,352		585,275		3
4	Occupational Therapy			31,323		35,291		4
5	Speech Pathology							5
6	Medical Social Services			46,916		97,017		6
7	Home Health Aide			49,007		85,602		7
8	Supplies					54,213		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	Totals (sum of lines 1-19)			1,749,144		2,266,713	2,780	20
21	Total cost to be allocated			396,697		356,214	6,446	21
22	Unit Cost Multiplier			0.226795		0.157150		22
22	Unit Cost Multiplier						2.318705	22

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7255

WORKSHEET H-2
PART II

	HHA COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	MAIN- TENANCE OF PERSONNEL (FTES SERVED)	
		7	8	9	10	11	12	
1	Administrative and General			1,234		2,267		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							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	Totals (sum of lines 1-19)			1,234		2,267		20
21	Total cost to be allocated			157,310		40,946		21
22	Unit Cost Multiplier			127.479741		18.061756		22
22	Unit Cost Multiplier							22

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7255

WORKSHEET H-2
PART II

	HHA COST CENTER	NURSING ADMINI- STRATION (FTES SERVED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	Administrative and General	2,267		338				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		40,150					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	Totals (sum of lines 1-19)	2,267	40,150	338				20
21	Total cost to be allocated	120,655	11,274	2,274				21
22	Unit Cost Multiplier	53.222320		6.727811				22
22	Unit Cost Multiplier		0.280797					22

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7255

WORKSHEET H-2
PART II

	HHA COST CENTER	NURSING SCHOOL ASSIGNED TIME	I/R-SALARY AND FRINGES (ASSIGNED TIME)	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)	PARAMED EDUCATION ASSIGNED TIME		
		20	21	22	23		
1	Administrative and General						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						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	Totals (sum of lines 1-19)						20
21	Total cost to be allocated						21
22	Unit Cost Multiplier						22
22	Unit Cost Multiplier						22

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7255

**WORKSHEET H-3
PARTS I & II**

Check applicable box: Title V Title XVIII Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation								
	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	Skilled Nursing Care	2	1,766,485		1,766,485	6,888	256.46	1
2	Physical Therapy	3	806,798	393,767	1,200,565	4,430	271.01	2
3	Occupational Therapy	4	48,648		48,648	130	374.22	3
4	Speech Pathology	5				7		4
5	Medical Social Services	6	133,737		133,737	540	247.66	5
6	Home Health Aide	7	118,001		118,001	1,400	84.29	6
7	Total (sum of lines 1-6)		2,873,669	393,767	3,267,436	13,395		7

Limitation Cost Comoputation				Program Visits		
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	16974		4,722		8
9	Physical Therapy	16974		3,095		9
10	Occupational Therapy	16974		178		10
11	Speech Pathology	16974		7		11
12	Medical Social Services	16974		416		12
13	Home Health Aide	16974		1,180		13
14	Total (sum of lines 8-13)			9,598		14

Supplies and Drugs Cost Computations							
	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
			1	2	3	4	5
15	Cost of Medical Supplies	8	88,163	27,514	115,677		15
16	Cost of Drugs	9					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	2	3	4	
1	Physical Therapy	66	0.274304	1,435,513	393,767	col. 2, line 2	1
2	Occupational Therapy	67		31,947		col. 2, line 3	2
3	Speech Pathology	68		1,680		col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.456748	60,240	27,514	col. 2, line 15	4
5	Drugs Charged to Patients	73	0.136793			col. 2, line 16	5
5.01	OUTPATIENT PHARMACY	73.01	3.086916			col. 2, line 16	5.01

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7255

WORKSHEET H-3
PARTS I & II

Check applicable box: Title V Title XVIII Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services				
		Part B			Part B				
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		4,722			1,211,004		1,211,004	1
2	Physical Therapy		3,095			838,776		838,776	2
3	Occupational Therapy		178			66,611		66,611	3
4	Speech Pathology		7						4
5	Medical Social Services		416			103,027		103,027	5
6	Home Health Aide		1,180			99,462		99,462	6
7	Total (sum of lines 1-6)		9,598			2,318,880		2,318,880	7

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services			
		Part B			Part B			
	Other Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6	7	8	9	10	11	
15	Cost of Medical Supplies							15
16	Cost of Drugs							16

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 14-7255

**WORKSHEET H-4
PARTS I & II**

Check applicable box: Title V Title XVIII Title XIX

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

		Part B		
Description		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1	2	3
Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)			1
2	Total charges			2
	Customary Charges			
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)			3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)			4
5	Ratio of line 3 to line 4 (not to exceed 1.000000)			5
6	Total customary charges (see instructions)			6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)			7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)			8
9	Primary payer amounts			9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

Description		Part A Services	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers		1,471,555	11
12	Total PPS Reimbursement - Full Episodes with Outliers		8,908	12
13	Total PPS Reimbursement - LUPA Episodes		27,271	13
14	Total PPS Reimbursement - PEP Episodes		18,995	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		3,622	15
16	Total PPS Outlier Reimbursement - PSP 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 thru 20 minus line 8)		1,530,351	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		1,530,351	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		1,530,351	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		1,530,351	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		1,530,351	31
31.01	Sequestration adjustment (see instructions)		30,110	31.01
32	Interim payments (see instructions)		1,500,241	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, §115-2			35

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

HHa CCN: 14-7255

WORKSHEET H-5

	DESCRIPTION	Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1	2	3	4	
1	Total interim payments paid to provider				1,500,241	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				3.01
		.02				3.02
	Program	.03				3.03
	To	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	To	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				1,500,241	4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	Program	.03				5.03
	To	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	To	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions)	.01				6.01
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				1,500,241	7
8	Name of Contractor	Contractor Number		NPR Date: Month, Day, Year		8

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

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE CCN: 14-1561

WORKSHEET K

	COST CENTER DESCRIPTIONS	SALARIES (from Wkst. K-1)	EMPLOYEE BENEFITS (from Wkst. K-2)	TRANSPOR- TATION (see inst.)	CONTRACTED SERVICES (from Wkst. K-3)	OTHER	
		1	2	3	4	5	
	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	119,026				125,343	6
	INPATIENT CARE SERVICE						
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	VISITING SERVICES						
9	Physician Services						9
10	Nursing Care	132,987					10
11	Nursing Care-Continuous Home Care						11
12	Physical Therapy	947					12
13	Occupational Therapy						13
14	Speech / Language Pathology						14
15	Medical Social Services	16,842					15
16	Spiritual Counseling	10,565					16
17	Dietary Counseling						17
18	Counseling - Other	19,682					18
19	Home Health Aide and Homemaker	16,604					19
20	HH Aide & Homemaker - Cont. Home Care						20
21	Other						21
	OTHER HOSPICE SERVICE COSTS						
22	Drugs, Biological and Infusion Therapy						22
23	Analgesics						23
24	Sedatives / Hypnotics						24
25	Other - Specify						25
26	Durable Medical Equipment/Oxygen						26
27	Patient Transportation						27
28	Imaging Services						28
29	Labs and Diagnostics						29
30	Medical Supplies						30
31	Outpatient Services (including E/R Dept.)						31
32	Radiation Therapy						32
33	Chemotherapy						33
34	Other						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	Bereavement Program Costs						35
36	volunteer Program Costs						36
37	Fundraising						37
38	Other Program Costs						38
39	Total (sum of lines 1-38)	316,653				125,343	39

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE CCN: 14-1561

WORKSHEET K

	TOTAL (cols. 1-5) 6	RECLASSI- FICATION 7	SUBTOTAL (col. 6 ± col. 7) 8	ADJUST- MENTS 9	TOTAL (col. 8 ± col. 9) 10	
GENERAL SERVICE COST CENTER						
1 Capital Related Costs-Bldg and Fixt.						1
2 Capital Related Costs-Movable Equip.						2
3 Plant Operation and Maintenance						3
4 Transportation - Staff						4
5 Volunteer Service Coordination						5
6 Administrative and General	244,369		244,369		244,369	6
INPATIENT CARE SERVICE						
7 Inpatient - General Care						7
8 Inpatient - Respite Care						8
VISITING SERVICES						
9 Physician Services						9
10 Nursing Care	132,987		132,987	-44,446	88,541	10
11 Nursing Care-Continuous Home Care						11
12 Physical Therapy	947		947		947	12
13 Occupational Therapy						13
14 Speech / Language Pathology						14
15 Medical Social Services	16,842		16,842		16,842	15
16 Spiritual Counseling	10,565		10,565		10,565	16
17 Dietary Counseling						17
18 Counseling - Other	19,682		19,682		19,682	18
19 Home Health Aide and Homemaker	16,604		16,604		16,604	19
20 HH Aide & Homemaker - Cont. Home Care						20
21 Other						21
OTHER HOSPICE SERVICE COSTS						
22 Drugs, Biological and Infusion Therapy						22
23 Analgesics						23
24 Sedatives / Hypnotics						24
25 Other - Specify						25
26 Durable Medical Equipment/Oxygen						26
27 Patient Transportation						27
28 Imaging Services						28
29 Labs and Diagnostics						29
30 Medical Supplies						30
31 Outpatient Services (including E/R Dept.)						31
32 Radiation Therapy						32
33 Chemotherapy						33
34 Other						34
HOSPICE NONREIMBURSABLE SERVICE						
35 Bereavement Program Costs						35
36 volunteer Program Costs						36
37 Fundraising						37
38 Other Program Costs						38
39 Total (sum of lines 1-38)	441,996		441,996	-88,892	397,550	39

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

HOSPICE CCN: 14-1561

WORKSHEET K-1

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	Capital Related Costs-Bldg and Fix						1
2	Capital Related Costs-Movable Eqiu						2
3	Plant Operation and Maintenance						3
4	Transportation - Staff						4
5	Volunteer Service Coordination						5
6	Administrative and General	1,523			99,132		6
	INPATIENT CARE SERVICE						
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	VISITING SERVICES						
9	Physician Services						9
10	Nursing Care					132,987	10
11	Nursing Care-Continuous Home Care						11
12	Physical Therapy						12
13	Occupational Therapy						13
14	Speech / Language Pathology						14
15	Medical Social Services						15
16	Spiritual Counseling						16
17	Dietary Counseling						17
18	Counseling - Other						18
19	Home Health Aide and Homemaker						19
20	HH Aide & Homemaker - Cont. Home C						20
21	Other						21
	OTHER HOSPICE SERVICE COSTS						
22	Drugs, Biological and Infusion The						22
23	Analgesics						23
24	Sedatives / Hypnotics						24
25	Other - Specify						25
26	Durable Medical Equipment/Oxygen						26
27	Patient Transportation						27
28	Imaging Services						28
29	Labs and Diagnostics						29
30	Medical Supplies						30
31	Outpatient Services (including E/R						31
32	Radiation Therapy						32
33	Chemotherapy						33
34	Other						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	Bereavement Program Costs						35
36	volunteer Program Costs						36
37	Fundraising						37
38	Other Program Costs						38
39	Total (sum of lines 1-38)	1,523			99,132	132,987	39

(1) Transfer the amount in column 9 to Wkst. K, column 1.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

HOSPICE CCN: 14-1561

WORKSHEET K-1

	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	6	7	8	9	
GENERAL SERVICE COST CENTER					
1 Capital Related Costs-Bldg and Fix					1
2 Capital Related Costs-Movable Equi					2
3 Plant Operation and Maintenance					3
4 Transportation - Staff					4
5 Volunteer Service Coordination					5
6 Administrative and General			18,371	119,026	6
INPATIENT CARE SERVICE					
7 Inpatient - General Care					7
8 Inpatient - Respite Care					8
VISITING SERVICES					
9 Physician Services					9
10 Nursing Care				132,987	10
11 Nursing Care-Continuous Home Care					11
12 Physical Therapy	947			947	12
13 Occupational Therapy					13
14 Speech / Language Pathology					14
15 Medical Social Services			16,842	16,842	15
16 Spiritual Counseling			10,565	10,565	16
17 Dietary Counseling					17
18 Counseling - Other			19,682	19,682	18
19 Home Health Aide and Homemaker		16,604		16,604	19
20 HH Aide & Homemaker - Cont. Home C					20
21 Other					21
OTHER HOSPICE SERVICE COSTS					
22 Drugs, Biological and Infusion The					22
23 Analgesics					23
24 Sedatives / Hypnotics					24
25 Other - Specify					25
26 Durable Medical Equipment/Oxygen					26
27 Patient Transportation					27
28 Imaging Services					28
29 Labs and Diagnostics					29
30 Medical Supplies					30
31 Outpatient Services (including E/R					31
32 Radiation Therapy					32
33 Chemotherapy					33
34 Other					34
HOSPICE NONREIMBURSABLE SERVICE					
35 Bereavement Program Costs					35
36 volunteer Program Costs					36
37 Fundraising					37
38 Other Program Costs					38
39 Total (sum of lines 1-38)	947	16,604	65,460	316,653	39

(1) Transfer the amount in column 9 to Wkst. K, column 1.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

HOSPICE CCN: 14-1561

WORKSHEET K-2

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	Capital Related Costs-Bldg and Fix						1
2	Capital Related Costs-Movable Eqiu						2
3	Plant Operation and Maintenance						3
4	Transportation - Staff						4
5	Volunteer Service Coordination						5
6	Administrative and General						6
	INPATIENT CARE SERVICE						
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	VISITING SERVICES						
9	Physician Services						9
10	Nursing Care						10
11	Nursing Care-Continuous Home Care						11
12	Physical Therapy						12
13	Occupational Therapy						13
14	Speech / Language Pathology						14
15	Medical Social Services						15
16	Spiritual Counseling						16
17	Dietary Counseling						17
18	Counseling - Other						18
19	Home Health Aide and Homemaker						19
20	HH Aide & Homemaker - Cont. Home C						20
21	Other						21
	OTHER HOSPICE SERVICE COSTS						
22	Drugs, Biological and Infusion The						22
23	Analgesics						23
24	Sedatives / Hypnotics						24
25	Other - Specify						25
26	Durable Medical Equipment/Oxygen						26
27	Patient Transportation						27
28	Imaging Services						28
29	Labs and Diagnostics						29
30	Medical Supplies						30
31	Outpatient Services (including E/R						31
32	Radiation Therapy						32
33	Chemotherapy						33
34	Other						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	Bereavement Program Costs						35
36	volunteer Program Costs						36
37	Fundraising						37
38	Other Program Costs						38
39	Total (sum of lines 1-38)						39

(1) Transfer the amount in column 9 to Wkst. K, column 2.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

HOSPICE CCN: 14-1561

WORKSHEET K-2

	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	6	7	8	9	
GENERAL SERVICE COST CENTER					
1 Capital Related Costs-Bldg and Fix					1
2 Capital Related Costs-Movable Equi					2
3 Plant Operation and Maintenance					3
4 Transportation - Staff					4
5 Volunteer Service Coordination					5
6 Administrative and General					6
INPATIENT CARE SERVICE					
7 Inpatient - General Care					7
8 Inpatient - Respite Care					8
VISITING SERVICES					
9 Physician Services					9
10 Nursing Care					10
11 Nursing Care-Continuous Home Care					11
12 Physical Therapy					12
13 Occupational Therapy					13
14 Speech / Language Pathology					14
15 Medical Social Services					15
16 Spiritual Counseling					16
17 Dietary Counseling					17
18 Counseling - Other					18
19 Home Health Aide and Homemaker					19
20 HH Aide & Homemaker - Cont. Home C					20
21 Other					21
OTHER HOSPICE SERVICE COSTS					
22 Drugs, Biological and Infusion The					22
23 Analgesics					23
24 Sedatives / Hypnotics					24
25 Other - Specify					25
26 Durable Medical Equipment/Oxygen					26
27 Patient Transportation					27
28 Imaging Services					28
29 Labs and Diagnostics					29
30 Medical Supplies					30
31 Outpatient Services (including E/R					31
32 Radiation Therapy					32
33 Chemotherapy					33
34 Other					34
HOSPICE NONREIMBURSABLE SERVICE					
35 Bereavement Program Costs					35
36 volunteer Program Costs					36
37 Fundraising					37
38 Other Program Costs					38
39 Total (sum of lines 1-38)					39

(1) Transfer the amount in column 9 to Wkst. K, column 2.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

HOSPICE CCN: 14-1561

WORKSHEET K-3

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	Capital Related Costs-Bldg and Fix						1
2	Capital Related Costs-Movable Eqiu						2
3	Plant Operation and Maintenance						3
4	Transportation - Staff						4
5	Volunteer Service Coordination						5
6	Administrative and General						6
	INPATIENT CARE SERVICE						
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	VISITING SERVICES						
9	Physician Services						9
10	Nursing Care						10
11	Nursing Care-Continuous Home Care						11
12	Physical Therapy						12
13	Occupational Therapy						13
14	Speech / Language Pathology						14
15	Medical Social Services						15
16	Spiritual Counseling						16
17	Dietary Counseling						17
18	Counseling - Other						18
19	Home Health Aide and Homemaker						19
20	HH Aide & Homemaker - Cont. Home C						20
21	Other						21
	OTHER HOSPICE SERVICE COSTS						
22	Drugs, Biological and Infusion The						22
23	Analgesics						23
24	Sedatives / Hypnotics						24
25	Other - Specify						25
26	Durable Medical Equipment/Oxygen						26
27	Patient Transportation						27
28	Imaging Services						28
29	Labs and Diagnostics						29
30	Medical Supplies						30
31	Outpatient Services (including E/R						31
32	Radiation Therapy						32
33	Chemotherapy						33
34	Other						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	Bereavement Program Costs						35
36	volunteer Program Costs						36
37	Fundraising						37
38	Other Program Costs						38
39	Total (sum of lines 1-38)						39

(1) Transfer the amount in column 9 to Wkst. K, column 4.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

HOSPICE CCN: 14-1561

WORKSHEET K-3

	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	6	7	8	9	
GENERAL SERVICE COST CENTER					
1 Capital Related Costs-Bldg and Fix					1
2 Capital Related Costs-Movable Equi					2
3 Plant Operation and Maintenance					3
4 Transportation - Staff					4
5 Volunteer Service Coordination					5
6 Administrative and General					6
INPATIENT CARE SERVICE					
7 Inpatient - General Care					7
8 Inpatient - Respite Care					8
VISITING SERVICES					
9 Physician Services					9
10 Nursing Care					10
11 Nursing Care-Continuous Home Care					11
12 Physical Therapy					12
13 Occupational Therapy					13
14 Speech / Language Pathology					14
15 Medical Social Services					15
16 Spiritual Counseling					16
17 Dietary Counseling					17
18 Counseling - Other					18
19 Home Health Aide and Homemaker					19
20 HH Aide & Homemaker - Cont. Home C					20
21 Other					21
OTHER HOSPICE SERVICE COSTS					
22 Drugs, Biological and Infusion The					22
23 Analgesics					23
24 Sedatives / Hypnotics					24
25 Other - Specify					25
26 Durable Medical Equipment/Oxygen					26
27 Patient Transportation					27
28 Imaging Services					28
29 Labs and Diagnostics					29
30 Medical Supplies					30
31 Outpatient Services (including E/R					31
32 Radiation Therapy					32
33 Chemotherapy					33
34 Other					34
HOSPICE NONREIMBURSABLE SERVICE					
35 Bereavement Program Costs					35
36 volunteer Program Costs					36
37 Fundraising					37
38 Other Program Costs					38
39 Total (sum of lines 1-38)					39

(1) Transfer the amount in column 9 to Wkst. K, column 4.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - HOSPICE GENERAL SERVICE COST

HOSPICE CCN: 14-1561

**WORKSHEET K-4
PART I**

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COSTS				
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	
		0	1	2	3	4
	GENERAL SERVICE COST CENTER					
1	Capital Related Costs-Bldg and Fix					1
2	Capital Related Costs-Movable Equi					2
3	Plant Operation and Maintenance					3
4	Transportation - Staff					4
5	Volunteer Service Coordination					5
6	Administrative and General	244,369				6
	INPATIENT CARE SERVICE					
7	Inpatient - General Care					7
8	Inpatient - Respite Care					8
	VISITING SERVICES					
9	Physician Services					9
10	Nursing Care	88,541				10
11	Nursing Care-Continuous Home Care					11
12	Physical Therapy	947				12
13	Occupational Therapy					13
14	Speech / Language Pathology					14
15	Medical Social Services	16,842				15
16	Spiritual Counseling	10,565				16
17	Dietary Counseling					17
18	Counseling - Other	19,682				18
19	Home Health Aide and Homemaker	16,604				19
20	HH Aide & Homemaker - Cont. Home C					20
21	Other					21
	OTHER HOSPICE SERVICE COSTS					
22	Drugs, Biological and Infusion The					22
23	Analgesics					23
24	Sedatives / Hypnotics					24
25	Other - Specify					25
26	Durable Medical Equipment/Oxygen					26
27	Patient Transportation					27
28	Imaging Services					28
29	Labs and Diagnostics					29
30	Medical Supplies					30
31	Outpatient Services (including E/R					31
32	Radiation Therapy					32
33	Chemotherapy					33
34	Other					34
	HOSPICE NONREIMBURSABLE SERVICE					
35	Bereavement Program Costs					35
36	volunteer Program Costs					36
37	Fundraising					37
38	Other Program Costs					38
39	Total (sum of lines 1-38)	397,550				39

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - HOSPICE GENERAL SERVICE COST

HOSPICE CCN: 14-1561

**WORKSHEET K-4
PART I**

	VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5 ± col. 6)	
	5	5A	6	7	
GENERAL SERVICE COST CENTER					
1	Capital Related Costs-Bldg and Fix				1
2	Capital Related Costs-Movable Equi				2
3	Plant Operation and Maintenance				3
4	Transportation - Staff				4
5	Volunteer Service Coordination				5
6	Administrative and General		244,369	244,369	6
INPATIENT CARE SERVICE					
7	Inpatient - General Care				7
8	Inpatient - Respite Care				8
VISITING SERVICES					
9	Physician Services				9
10	Nursing Care		88,541	154,314	10
11	Nursing Care-Continuous Home Care				11
12	Physical Therapy		947	1,319	12
13	Occupational Therapy				13
14	Speech / Language Pathology				14
15	Medical Social Services		16,842	23,464	15
16	Spiritual Counseling		10,565	14,719	16
17	Dietary Counseling				17
18	Counseling - Other		19,682	27,421	18
19	Home Health Aide and Homemaker		16,604	23,132	19
20	HH Aide & Homemaker - Cont. Home C				20
21	Other				21
OTHER HOSPICE SERVICE COSTS					
22	Drugs, Biological and Infusion The				22
23	Analgesics				23
24	Sedatives / Hypnotics				24
25	Other - Specify				25
26	Durable Medical Equipment/Oxygen				26
27	Patient Transportation				27
28	Imaging Services				28
29	Labs and Diagnostics				29
30	Medical Supplies				30
31	Outpatient Services (including E/R				31
32	Radiation Therapy				32
33	Chemotherapy				33
34	Other				34
HOSPICE NONREIMBURSABLE SERVICE					
35	Bereavement Program Costs				35
36	volunteer Program Costs				36
37	Fundraising				37
38	Other Program Costs				38
39	Total (sum of lines 1-38)		397,550		397,550

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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COST ALLOCATION - HOSPICE STATISTICAL BASIS

HOSPICE CCN: 14-1561

WORKSHEET K-4
PART II

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COSTS				VOLUNTEER SERVICES COORDINATOR (Hours)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Acc. Cost)	
		BUILDINGS & FIXTURES (Sq. Ft.)	MOVABLE EQUIPMENT (\$ Value)	PLANT OPERATION & MAINT. (Sq. Ft.)	TRANSPORTATION (Mileage)				
		1	2	3	4	5	6A	6	
	GENERAL SERVICE COST CENTER								
1	Capital Related Costs-Bldg and Fix								1
2	Capital Related Costs-Movable Equi								2
3	Plant Operation and Maintenance								3
4	Transportation - Staff								4
5	Volunteer Service Coordination								5
6	Administrative and General						-244,369	350,808	6
	INPATIENT CARE SERVICE								
7	Inpatient - General Care								7
8	Inpatient - Respite Care								8
	VISITING SERVICES								
9	Physician Services								9
10	Nursing Care						132,987	221,528	10
11	Nursing Care-Continuous Home Care								11
12	Physical Therapy						947	1,894	12
13	Occupational Therapy								13
14	Speech / Language Pathology								14
15	Medical Social Services						16,842	33,684	15
16	Spiritual Counseling						10,565	21,130	16
17	Dietary Counseling								17
18	Counseling - Other						19,682	39,364	18
19	Home Health Aide and Homemaker						16,604	33,208	19
20	HH Aide & Homemaker - Cont. Home C								20
21	Other								21
	OTHER HOSPICE SERVICE COSTS								
22	Drugs, Biological and Infusion The								22
23	Analgesics								23
24	Sedatives / Hypnotics								24
25	Other - Specify								25
26	Durable Medical Equipment/Oxygen								26
27	Patient Transportation								27
28	Imaging Services								28
29	Labs and Diagnostics								29
30	Medical Supplies								30
31	Outpatient Services (including E/R								31
32	Radiation Therapy								32
33	Chemotherapy								33
34	Other								34
	HOSPICE NONREIMBURSABLE SERVICE								
35	Bereavement Program Costs								35
36	volunteer Program Costs								36
37	Fundraising								37
38	Other Program Costs								38
39	Cost to be Allocated (per Wskt K-4, Part I)							244,369	39
40	Unit Cost Multiplier							0.696589	40

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1561

**WORKSHEET K-5
PART I**

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	HOSPICE TRIAL BALANCE(1)	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	ADMINI- STRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	Administrative and General				25,503	25,503	4,008	1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care	242,855			28,495	271,350	42,642	5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy	2,266			203	2,469	388	7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services	40,306			3,609	43,915	6,901	10
11	Spiritual Counseling	25,284			2,264	27,548	4,329	11
12	Dietary Counseling							12
13	Counseling - Other	47,103			4,217	51,320	8,065	13
14	Home Health Aide and Homemaker	39,736			3,558	43,294	6,804	14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including 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) (2)	397,550			67,849	465,399	73,137	34
35	Unit Cost Multiplier (see instructions)							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1561

WORKSHEET K-5
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	MAINTEN- ANCE AND REPAIRS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	Administrative and General	1,134			7,139		7,315	1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including 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) (2)	1,134			7,139		7,315	34
35	Unit Cost Multiplier (see instructions)							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1561

WORKSHEET K-5
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	MAIN- TENANCE OF PERSONNEL	NURSING ADMINI- STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	Administrative and General		21,555	4,455	298,969			1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including 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) (2)		21,555	4,455	298,969			34
35	Unit Cost Multiplier (see instructions)							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1561

WORKSHEET K-5
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (cols. 4A-23)	
		19	20	21	22	23	24	
1	Administrative and General						370,078	1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care						313,992	5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy						2,857	7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services						50,816	10
11	Spiritual Counseling						31,877	11
12	Dietary Counseling							12
13	Counseling - Other						59,385	13
14	Home Health Aide and Homemaker						50,098	14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including 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) (2)						879,103	34
35	Unit Cost Multiplier (see instructions)							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1561

WORKSHEET K-5
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL (cols. 24 ± 25)	ALLOC HOSP A&G (See Part II)	TOTAL HOSP COSTS (col 26 ± 27)		
		25	26	27	28		
1	Administrative and General		370,078				1
2	Inpatient - General Care						2
3	Inpatient - Respite Care						3
4	Physician Services						4
5	Nursing Care		313,992	228,282	542,274		5
6	Nursing Care-Continuous Home Care						6
7	Physical Therapy		2,857	2,077	4,934		7
8	Occupational Therapy						8
9	Speech / Language Pathology						9
10	Medical Social Services		50,816	36,945	87,761		10
11	Spiritual Counseling		31,877	23,176	55,053		11
12	Dietary Counseling						12
13	Counseling - Other		59,385	43,175	102,560		13
14	Home Health Aide and Homemaker		50,098	36,423	86,521		14
15	HH Aide & Homemaker - Cont. Home Care						15
16	Other						16
17	Drugs, Biological and Infusion Therapy						17
18	Analgesics						18
19	Sedatives / Hypnotics						19
20	Other - Specify						20
21	Durable Medical Equipment/Oxygen						21
22	Patient Transportation						22
23	Imaging Services						23
24	Labs and Diagnostics						24
25	Medical Supplies						25
26	Outpatient Services (including 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) (2)		879,103		879,103		34
35	Unit Cost Multiplier (see instructions)			0.727033			35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1561

WORKSHEET K-5
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	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	MAINTEN- ANCE AND REPAIRS MAINT REQS	
		1	2	4	4A	5	6	
1	Administrative and General			119,025		25,503	489	1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care			132,987		271,350		5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy			947		2,469		7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services			16,842		43,915		10
11	Spiritual Counseling			10,565		27,548		11
12	Dietary Counseling							12
13	Counseling - Other			19,682		51,320		13
14	Home Health Aide and Homemaker			16,604		43,294		14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including 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)			316,652		465,399	489	34
35	Total cost to be allocated			67,849		73,137	1,134	35
36	Unit Cost Multiplier (see instructions)			0.214270		0.157149		36
36	Unit Cost Multiplier (see instructions)						2.319018	36

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1561

WORKSHEET K-5
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	MAIN- TENANCE OF PERSONNEL (FTES SERVED)	
		7	8	9	10	11	12	
1	Administrative and General			56		405	405	1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including 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		405	405	34
35	Total cost to be allocated			7,139		7,315		35
36	Unit Cost Multiplier (see instructions)			127.482143		18.061728		36
36	Unit Cost Multiplier (see instructions)							36

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1561

WORKSHEET K-5
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	NURSING ADMINI- STRATION (FTES SERVED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	Administrative and General	405	15,866	44,446				1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including 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)	405	15,866	44,446				34
35	Total cost to be allocated	21,555	4,455	298,969				35
36	Unit Cost Multiplier (see instructions)	53.222222		6.726567				36
36	Unit Cost Multiplier (see instructions)		0.280789					36

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1561

WORKSHEET K-5
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	NURSING SCHOOL ASSIGNED TIME	I/R-SALARY AND FRINGES (ASSIGNED TIME)	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)	PARAMED EDUCATION ASSIGNED TIME		
		20	21	22	23		
1	Administrative and General						1
2	Inpatient - General Care						2
3	Inpatient - Respite Care						3
4	Physician Services						4
5	Nursing Care						5
6	Nursing Care-Continuous Home Care						6
7	Physical Therapy						7
8	Occupational Therapy						8
9	Speech / Language Pathology						9
10	Medical Social Services						10
11	Spiritual Counseling						11
12	Dietary Counseling						12
13	Counseling - Other						13
14	Home Health Aide and Homemaker						14
15	HH Aide & Homemaker - Cont. Home Care						15
16	Other						16
17	Drugs, Biological and Infusion Therapy						17
18	Analgesics						18
19	Sedatives / Hypnotics						19
20	Other - Specify						20
21	Durable Medical Equipment/Oxygen						21
22	Patient Transportation						22
23	Imaging Services						23
24	Labs and Diagnostics						24
25	Medical Supplies						25
26	Outpatient Services (including 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)						34
35	Total cost to be allocated						35
36	Unit Cost Multiplier (see instructions)						36
36	Unit Cost Multiplier (see instructions)						36

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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APPORTIONMENT OF HOSPICE SHARED SERVICES

HOSPICE CCN: 14-1561

WORKSHEET K-5
PART III

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

	COST CENTER	Wkst C, Part I, col. 9, line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1	2	3	
	ANCILLARY SERVICE COST CENTERS					
1	Physical Therapy	66	0.274304			1
2	Occupational Therapy	67				2
3	Speech / Language Pathology	68				3
4	Drugs, Biological and Infusion Therapy	73	0.136793			4
4.01	OUTPATIENT PHARMACY	73.01	3.086916			4.01
5	Durable Medical Equipment/Oxygen	96				5
6	Labs and Diagnostics	60	0.128565			6
7	Medical Supplies	71	0.456748			7
8	Outpatient Services (including E/R Dept.)	93				8
9	Radiation Therapy	55				9
10	LITHOTRIPSY	76				10
10.01	CARDIAC REHABILITATION	76.01	0.713526			10.01
10.05	INPATIENT RENAL DIALYSIS	76.05				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

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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CALCULATION OF HOSPICE PER DIEM COST

HOSPICE CCN: 14-1561

WORKSHEET K-6

COMPUTATION OF PER DIEM COST		TITLE XVIII	TITLE XIX	OTHER	TOTAL	
		1	2	3	4	
1	Total cost (see instructions)				879,103	1
2	Total unduplicated days (Worksheet S-9, column 6, line 5)				4,111	2
3	Average cost per diem (line 1 divided by line 2)				213.84	3
4	Unduplicated Medicare days (Worksheet S-9, column 1, line 5)	3,868				4
5	Aggregate Medicare cost (line 3 times line 4)	827,133				5
6	Unduplicated Medicaid days (Worksheet S-9, column 2, line 5)		131			6
7	Aggregate Medicaid cost (line 3 times line 6)		28,013			7
8	Unduplicated SNF days (Worksheet S-9, column 3, line 5)					8
9	Aggregate SNF cost (line 3 times line 8)					9
10	Unduplicated NF days (Worksheet S-9, column 4, line 5)					10
11	Aggregate NF cost (line 3 times line 10)					11
12	Other Unduplicated days (Worksheet S-9, column 5, line 5)			112		12
13	Aggregate cost for other days (line 3 times line 12)			23,950		13

Note: The data for the SNF and NF on lines 8 through 11 are included in the Medicare and Medicaid lines 4 through 7.

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS 0	SUBTOTAL (cols.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits 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 SERVICE 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 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							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice							116
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192

KPMG LLP Compu-Max 2552-10

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 12:30 Version: 2015.10 (11/29/2015)
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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26		
192.0 1	NON-EMPLOYEE CHILD CARE CENTER	0	2A	24	25	26		192.0 1
193.0 1	ADULT DAY CARE							193.0 1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202