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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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. [X] ELECTRONICALLY FILED COST REPORT DATE: 11/21/2014 TIME: 07:35 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [F] MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.	
CONTRACTOR USE ONLY	5. [ ] 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. [ ] INITIAL REPORT FOR THIS PROVIDER CCN 9. [ ] FINAL REPORT FOR THIS PROVIDER CCN	10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ___ 12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY GOTTLIEB MEMORIAL HOSPITAL (14-0008) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 07/01/2013 AND ENDING 06/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		941,795	189,345	-93,482		1
2	SUBPROVIDER - IPF		20,896				2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY		2,471				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		965,162	189,345	-93,482		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 OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital 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	Prov-ider 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 / 2013	To: 06 / 30 / 2014	20
21	Type of control (see instructions)	2		21

	Inpatient PPS Information	1	2	
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)	N	Y	22.01
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	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 col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	3,771	2,015			921	243	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.			37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

		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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N	45
46	Is this facility eligible for additional paymetn exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the 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 osteopathci 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 reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings					
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

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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 non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 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 non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

	Inpatient Psychiatric Facilty 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, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.	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, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.				76

	Long Term Care Hospital PPS			
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
	TEFRA Providers			
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86

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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 appilcable column.				N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.					95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.					97
Rural Providers				1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. If yes, the GME elinination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.					107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
		Physical	Occupational	Speech	Respiratory	
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.		N	N	N	109
Miscellaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98'		N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.			N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.			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:		51,740		877,510	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 cetfified 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 cetfified 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: 08000		141
142	Street: 20555 VICTORY PARKWAY	P.O. Box:		142
143	City: 20555 VICTORY PARKWAY	State: MI	ZIP Code: 48152	143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	Y		145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
			1	2	3	
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.		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)	0.75			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10/01/2013	09/30/2014	170

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	Y			3

		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		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5

		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 INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	Y		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11

		Y/N	
BAD DEBTS			
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.	Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.	N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.	N	14

BED COMPLEMENT			
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)	N		N		16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	N		N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN 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 CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.		29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.		30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.		31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.		32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.		34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		35

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

COST REORT PREPARER INFORMATION				
41	FIRST NAME: PATRICK	LAST NAME: FITZGIBBONS	TITLE: MANAGER OF REIMBURSEMENT	41
42	EMPLOYER: LOYOLA UNIVERSITY HEALTH SYSTEM			42
43	PHONE NUMBER: 708-216-0746	E-MAIL ADDRESS: PFITZGIBBONS@LUMC.EDU		43

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	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			13,711	5,756	28,123	1
2	HMO AND OTHER (see instructions)						2,436	921		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			13,711	5,756	28,123	7
8	INTENSIVE CARE UNIT	31	24	8,760			1,916	757	3,772	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						438	593	13
14	TOTAL (see instructions)		209	76,285			15,627	6,951	32,488	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40	12	4,380			3,582		3,592	16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44	34	12,410			7,338	344	9,781	19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101							15,952	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									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)								297	30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)		2	730				243	358	32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	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)					2,888	1,405	7,647	1
2	HMO AND OTHER (see instructions)					456			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)	4.11	1,379.00			2,888	1,405	7,647	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF					230		242	16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								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)	4.11	1,379.00						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF-ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (see instructions)	200	55,224,223		55,224,223	1,910,240.00	28.91	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B		72,036		72,036	1,411.00	51.05	5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44	2,081,604	10,640	2,092,244	80,175.00	26.10	9
10	EXCLUDED AREA SALARIES (see instructions)		3,188,016	73,812	3,261,828	106,996.00	30.49	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		609,771		609,771	8,616.00	70.77	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		1,621,484		1,621,484	14,146.00	114.62	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		2,955,153		2,955,153	46,719.00	63.25	14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (core)(see instructions)		15,792,029		15,792,029			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		880,907		880,907			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B		20,211		20,211			23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		1,307,438	-72,524	1,234,914	53,481.00	23.09	26
27	ADMINISTRATIVE & GENERAL		6,409,856	-654,724	5,755,132	114,212.00	50.39	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)							28
29	MAINTENANCE & REPAIRS		796,964		796,964	30,250.00	26.35	29
30	OPERATION OF PLANT		1,067,125		1,067,125	48,521.00	21.99	30
31	LAUNDRY & LINEN SERVICE		739		739	22.00	33.59	31
32	HOUSEKEEPING		1,030,349		1,030,349	91,608.00	11.25	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		760,169	-225,045	535,124	40,607.00	13.18	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA		142,643	225,242	367,885	31,069.00	11.84	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		2,136,688		2,136,688	58,677.00	36.41	38
39	CENTRAL SERVICES AND SUPPLY		509,819	45,074	554,893	31,037.00	17.88	39
40	PHARMACY		1,987,499		1,987,499	49,494.00	40.16	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		1,289,877		1,289,877	47,964.00	26.89	41
42	SOCIAL SERVICE		314,030		314,030	10,287.00	30.53	42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		55,152,187		55,152,187	1,908,829.00	28.89	1
2	EXCLUDED AREA SALARIES (see instructions)		5,269,620	84,452	5,354,072	187,171.00	28.61	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		49,882,567	-84,452	49,798,115	1,721,658.00	28.92	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		5,186,408		5,186,408	69,481.00	74.64	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		15,792,029		15,792,029		31.71%	5
6	TOTAL (sum of lines 3 through 5)		70,861,004	-84,452	70,776,552	1,791,139.00	39.51	6
7	TOTAL OVERHEAD COST (see instructions)		17,753,196	-681,977	17,071,219	607,229.00	28.11	7

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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
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	4,560,400	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	5,058,783	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	240,989	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	154,620	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	-19,172	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	1,191,193	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	4,209,285	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	257,595	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	110,205	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	15,763,898	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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

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

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

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

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

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

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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA **HHA CCN: 14-7255** **WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA COUNTY: COOK

		TITLE V	TITLE XVIII	TITLE XIX	OTHER	TOTAL	
	DESCRIPTION	1	2	3	4	5	
1	HOME HEALTH AIDE HOURS	3,106				3,106	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	7.44		7.44	5
6	DIRECT NURSING SERVICE	9.95		9.95	6
7	NURSING SUPERVISOR				7
8	PHYSICAL THERAPY SERVICE	3.53		3.53	8
9	PHYSICAL THERAPY SUPERVISOR				9
10	OCCUPATIONAL THERAPY SERVICE	0.64		0.64	10
11	OCCUPATIONAL THERAPY SUPERVISOR				11
12	SPEECH PATHOLOGY SERVICE				12
13	SPEECH PATHOLOGY SUPERVISOR				13
14	MEDICAL SOCIAL SERVICE	0.81		0.81	14
15	MEDICAL SOCIAL SERVICE SUPERVISOR				15
16	HOME HEALTH AIDE	1.50		1.50	16
17	HOME HEALTH AIDE SUPERVISOR				17
18	OTHER (SPECIFY)				18

HOME HEALTH AGENCY - CBSA CODES

19	ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.	1	19
20	LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (line 20 contains the first code).	16974	20

PPS ACTIVITY

		FULL EPISODES					
		WITHOUT OUTLIERS	WITH OUTLIERS	LUPA EPISODES	PEP ONLY EPISODES	TOTAL (columns 1 through 4)	
		1	2	3	4	5	
21	SKILLED NURSING VISITS	5,547	277	193	70	6,087	21
22	SKILLED NURSING VISIT CHARGES	1,053,628	54,633	28,948	12,732	1,149,941	22
23	PHYSICAL THERAPY VISITS	3,128	90	22	55	3,295	23
24	PHYSICAL THERAPY VISIT CHARGES	807,814	23,541	5,254	14,032	850,641	24
25	OCCUPATIONAL THERAPY VISITS	530	37		17	584	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	139,293	9,078		4,367	152,738	26
27	SPEECH PATHOLOGY VISITS						27
28	SPEECH PATHOLOGY VISIT CHARGES						28
29	MEDICAL SOCIAL SERVICE VISITS	435	18	1	11	465	29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	132,371	5,477	304	3,347	141,499	30
31	HOME HEALTH AIDE VISITS	1,341	136	6	9	1,492	31
32	HOME HEALTH AIDE VISIT CHARGES	168,692	17,495	639	1,149	187,975	32
33	TOTAL VISITS (sum of lines 21, 23, 25, 27, 29, and 31)	10,981	558	222	162	11,923	33
34	OTHER CHARGES	24,705	1,419	462		26,586	34
35	TOTAL CHARGES (sum of lines 22, 24, 26, 28, 30, 32 and 34)	2,326,503	111,643	35,607	35,627	2,509,380	35
36	TOTAL NUMBER OF EPISODES (standard/non-outlier)	604		64	13	681	36
37	TOTAL NUMBER OF OUTLIER EPISODES		8		1	9	37
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	24,705	1,419	462		26,586	38

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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 IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	N	/ /	2

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL	33		33	6
7	RHX	14		14	7
8	RHL	28		28	8
9	RMX				9
10	RML	24		24	10
11	RLX				11
12	RUC				12
13	RUB	31		31	13
14	RUA	21		21	14
15	RVC	496		496	15
16	RVB	2,415		2,415	16
17	RVA	1,402		1,402	17
18	RHC	278		278	18
19	RHB	803		803	19
20	RHA	399		399	20
21	RMC	87		87	21
22	RMB	282		282	22
23	RMA	176		176	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2	7		7	27
28	ES1	4		4	28
29	HE2	13		13	29
30	HE1				30
31	HD2	20		20	31
32	HD1	17		17	32
33	HC2	60		60	33
34	HC1	24		24	34
35	HB2	55		55	35
36	HB1	83		83	36
37	LE2	7		7	37
38	LE1				38
39	LD2	41		41	39
40	LD1	10		10	40
41	LC2	21		21	41
42	LC1	21		21	42
43	LB2				43
44	LB1	20		20	44
45	CE2	20		20	45
46	CE1				46
47	CD2	9		9	47
48	CD1	7		7	48
49	CC2	26		26	49
50	CC1	87		87	50
51	CB2				51
52	CB1	153		153	52
53	CA2	21		21	53
54	CA1				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	23		23	66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70

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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	
71	PD2				71
72	PD1	10		10	72
73	PC2				73
74	PC1	37		37	74
75	PB2				75
76	PB1	46		46	76
77	PA2				77
78	PA1				78
199	AAA	7		7	199
200	TOTAL	7,338		7,338	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	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)	7,619,916			207

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

HOSPICE IDENTIFICATION DATA **HOSPICE CCN: 14-1561** **WORKSHEET S-9 PARTS I & II**

PART I - ENROLLMENT DAYS

		UNDUPLICATED DAYS						
		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	
1	CONTINUOUS HOME CARE							1
2	ROUTINE HOME CARE	2,444	85			234	2,763	2
3	INPATIENT RESPITE CARE							3
4	GENERAL INPATIENT CARE	301	23			23	347	4
5	TOTAL HOSPICE DAYS	2,745	108			257	3,110	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	129	10			13	152	6
7	TOTAL NUMBER OF UNDUPLICATED CONTINUOUS C							7
8	AVERAGE LENGTH OF STAY (line 5/line 6)	21.28	10.80			19.77	20.46	8
9	UNDUPLICATED CENSUS COUNT							9

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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)	0.218475	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	10,308,222	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	72,313,847	6
7	MEDICAID COST (line 1 times line 6)	15,798,768	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.	5,490,546	8

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

9	NET REVENUE FROM STAND-ALONE SCHIP	308,841	9
10	STAND-ALONE SCHIP CHARGES	4,577,491	10
11	STAND-ALONE SCHIP COST (line 1 times line 10)	1,000,067	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.	691,226	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)	25	13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)	259,765	14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)	56,752	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.	56,727	16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS	11,950	18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	6,238,499	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	20,107,331		20,107,331	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	4,392,949		4,392,949	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	230,560		230,560	22
23	COST OF CHARITY CARE (line 21 minus line 22)	4,162,389		4,162,389	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)	519,521	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	9,374,371	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	2,048,066	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	6,210,455	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	12,448,954	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		3,350,438	3,350,438		3,350,438		3,350,438	1
2	00200	CAP REL COSTS-MVBLE EQUIP		4,219,163	4,219,163		4,219,163		4,219,163	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	1,307,438	12,882,494	14,189,932	-79,208	14,110,724	-812,285	13,298,439	4
5	00500	ADMINISTRATIVE & GENERAL	6,409,856	18,163,144	24,573,000	-4,158,152	20,414,848	-6,633,346	13,781,502	5
6	00600	MAINTENANCE & REPAIRS	796,964	1,823,196	2,620,160		2,620,160		2,620,160	6
7	00700	OPERATION OF PLANT	1,067,125	3,146,314	4,213,439		4,213,439	-1,498	4,211,941	7
8	00800	LAUNDRY & LINEN SERVICE	739	750,833	751,572		751,572		751,572	8
9	00900	HOUSEKEEPING	1,030,349	1,077,658	2,108,007		2,108,007		2,108,007	9
10	01000	DIETARY	760,169	1,520,518	2,280,687	-843,826	1,436,861		1,436,861	10
11	01100	CAFETERIA	142,643	811	143,454	844,150	987,604	-330,184	657,420	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	2,136,688	380,492	2,517,180		2,517,180		2,517,180	13
14	01400	CENTRAL SERVICES & SUPPLY	509,819	492,028	1,001,847	-233,271	768,576		768,576	14
15	01500	PHARMACY	1,987,499	3,139,001	5,126,500	-3,320,225	1,806,275		1,806,275	15
16	01600	MEDICAL RECORDS & LIBRARY	1,289,877	637,235	1,927,112		1,927,112	-3,713	1,923,399	16
17	01700	SOCIAL SERVICE	314,030	2,203	316,233		316,233		316,233	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 SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	10,782,512	1,412,539	12,195,051	-735,811	11,459,240	-1,910,036	9,549,204	30
31	03100	INTENSIVE CARE UNIT	3,224,237	645,963	3,870,200	480,533	4,350,733	-303,019	4,047,714	31
40	04000	SUBPROVIDER - IPF	893,690	10,651	904,341	88,279	992,620	-77,600	915,020	40
43	04300	NURSERY		39	39	673,033	673,072		673,072	43
44	04400	SKILLED NURSING FACILITY	2,081,604	182,357	2,263,961	-97,948	2,166,013		2,166,013	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	2,582,648	7,836,700	10,419,348	-5,373,431	5,045,917	-93,720	4,952,197	50
51	05100	RECOVERY ROOM	374,993	70,244	445,237	8,756	453,993		453,993	51
52	05200	DELIVERY ROOM & LABOR ROOM	1,690,890	263,450	1,954,340	-152,803	1,801,537	-549	1,800,988	52
53	05300	ANESTHESIOLOGY		244,224	244,224	786,000	1,030,224	-382,318	647,906	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,559,770	312,372	1,872,142	399	1,872,541		1,872,541	54
56	05600	RADIOISOTOPE	58,317	397,373	455,690	12,398	468,088	-3,315	464,773	56
56.01	03630	ULTRASOUND	553,301	66,104	619,405	21,253	640,658		640,658	56.01
57	05700	CT SCAN	639,293	150,590	789,883	64,182	854,065		854,065	57
59	05900	CARDIAC CATHETERIZATION	656,423	2,130,590	2,787,013	-1,845,302	941,711		941,711	59
60	06000	LABORATORY	2,348,619	2,774,793	5,123,412		5,123,412	-5,641	5,117,771	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	06400	INTRAVENOUS THERAPY	1,000,355	204,433	1,204,788		1,204,788		1,204,788	64
65	06500	RESPIRATORY THERAPY				499	499		499	65
66	06600	PHYSICAL THERAPY	2,060,777	128,514	2,189,291	74	2,189,365	-29,076	2,160,289	66
69	06900	ELECTROCARDIOLOGY	395,755	54,142	449,897	30,532	480,429		480,429	69
70	07000	ELECTROENCEPHALOGRAPHY	85,333	15,471	100,804	1,172	101,976		101,976	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				4,946,060	4,946,060		4,946,060	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				4,914,604	4,914,604		4,914,604	72
73	07300	DRUGS CHARGED TO PATIENTS				3,646,381	3,646,381		3,646,381	73
73.01	07301	OUTPATIENT PHARMACY	329,267	1,409,882	1,739,149	74	1,739,223	-61,620	1,677,603	73.01
76	03950	LITHOTRIPSY								76
76.01	03951	CARDIAC REHABILITATION	178,329	8,181	186,510	25	186,535		186,535	76.01
76.05	03954	INPATIENT RENAL DIALYSIS				333,319	333,319		333,319	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				10,976	10,976		10,976	90
90.01	09001	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	09002	WOUND CARE	529,882	778,064	1,307,946	6,261	1,314,207	-153,000	1,161,207	90.02
90.03	09003	RIVER FOREST		54,062	54,062		54,062		54,062	90.03
91	09100	EMERGENCY	3,150,706	1,186,071	4,336,777	-394,699	3,942,078		3,942,078	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	1,827,496	143,302	1,970,798		1,970,798		1,970,798	101
		SPECIAL PURPOSE COST CENTERS								
116	11600	HOSPICE	279,390	92,151	371,541		371,541		371,541	116
118		SUBTOTALS (sum of lines 1-117)	55,036,783	72,157,790	127,194,573	-79,208	127,115,365	-10,800,920	116,314,445	118
		NONREIMBURSABLE COST CENTERS								

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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	
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,302	33,829	67,131		67,131		67,131	190
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER				79,208	79,208		79,208	192.01
193	19300	NONPAID WORKERS	154,138	14,540	168,678		168,678		168,678	193
200		TOTAL (sum of lines 118-199)	55,224,223	72,206,159	127,430,382		127,430,382	-10,800,920	116,629,462	200

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES			
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DRUGS SOLD TO PTS	A	DRUGS CHARGED TO PATIENTS	73		3,320,225	1
500	TOTAL RECLASSIFICATIONS					3,320,225	500
	CODE LETTER - A						
1	PURCHASED SERVICES	B	INPATIENT RENAL DIALYSIS	76.05		333,319	1
2							2
500	TOTAL RECLASSIFICATIONS					333,319	500
	CODE LETTER - B						
1	SHARED DIETARY COST	C	CAFETERIA	11	225,045	618,781	1
500	TOTAL RECLASSIFICATIONS				225,045	618,781	500
	CODE LETTER - C						
1	NONEMP CHILD CARE	D	NON-EMPLOYEE CHILD CARE CENTE	192.01	72,524	6,684	1
500	TOTAL RECLASSIFICATIONS				72,524	6,684	500
	CODE LETTER - D						
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	INTENSIVE CARE UNIT	31		930,744	1
2			OPERATING ROOM	50		456,190	2
3			ADULTS & PEDIATRICS	30		1,006,529	3
4			ANESTHESIOLOGY	53		786,000	4
5			SUBPROVIDER - IPF	40		86,159	5
500	TOTAL RECLASSIFICATIONS					3,265,622	500
	CODE LETTER - F						
1	PT TRANSPORT	H	CAFETERIA	11	197	127	1
2			CENTRAL SERVICES & SUPPLY	14	45,074	29,110	2
3			ADULTS & PEDIATRICS	30	145,953	94,261	3
4			INTENSIVE CARE UNIT	31	12,822	8,281	4
5			SUBPROVIDER - IPF	40	1,288	832	5
6			NURSERY	43	364	235	6
7			SKILLED NURSING FACILITY	44	10,640	6,871	7
8			OPERATING ROOM	50	485	313	8
9			RECOVERY ROOM	51	5,320	3,436	9
10			DELIVERY ROOM & LABOR ROOM	52	1,879	1,214	10
11			RADIOLOGY-DIAGNOSTIC	54	242	157	11
12			RADIOISOTOPE	56	7,533	4,865	12
13			ULTRASOUND	56.01	12,913	8,340	13
14			CT SCAN	57	38,997	25,185	14
15			CARDIAC CATHETERIZATION	59	773	499	15
16			RESPIRATORY THERAPY	65	303	196	16
17			PHYSICAL THERAPY	66	45	29	17
18			ELECTROCARDIOLOGY	69	18,551	11,981	18
19			ELECTROENCEPHALOGRAPHY	70	712	460	19
20			OUTPATIENT PHARMACY	73.01	45	29	20
21			CARDIAC REHABILITATION	76.01	15	10	21
22			CLINIC	90	6,669	4,307	22
23			WOUND CARE	90.02	3,804	2,457	23
24			EMERGENCY	91	53,592	34,611	24
500	TOTAL RECLASSIFICATIONS				368,216	237,806	500
	CODE LETTER - H						
1	FLOOR STOCK SUPPLIES	I	MEDICAL SUPPLIES CHARGED TO P	71		4,946,060	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500	TOTAL RECLASSIFICATIONS					4,946,060	500
	CODE LETTER - I						
1	CHEMO INFUSION	J	DRUGS CHARGED TO PATIENTS	73	288,378	37,778	1
500	TOTAL RECLASSIFICATIONS				288,378	37,778	500
	CODE LETTER - J						
1	IMPLANTS	L	IMPL. DEV. CHARGED TO PATIENT	72		4,914,604	1
2							2
3							3
500	TOTAL RECLASSIFICATIONS					4,914,604	500

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
	CODE LETTER - L						
1	NURSERY	M	NURSERY	43	615,360	57,113	1
500	TOTAL RECLASSIFICATIONS				615,360	57,113	500
	CODE LETTER - M						
	GRAND TOTAL (INCREASES)				1,856,031	17,737,992	

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	DRUGS SOLD TO PTS	A	PHARMACY	15		3,320,225		1
500	TOTAL RECLASSIFICATIONS					3,320,225		500
	CODE LETTER - A							
1	PURCHASED SERVICES	B	INTENSIVE CARE UNIT	31		88,409		1
2			ADULTS & PEDIATRICS	30		244,910		2
500	TOTAL RECLASSIFICATIONS					333,319		500
	CODE LETTER - B							
1	SHARED DIETARY COST	C	DIETARY	10	225,045	618,781		1
500	TOTAL RECLASSIFICATIONS				225,045	618,781		500
	CODE LETTER - C							
1	NONEMP CHILD CARE	D	EMPLOYEE BENEFITS DEPARTMENT	4	72,524	6,684		1
500	TOTAL RECLASSIFICATIONS				72,524	6,684		500
	CODE LETTER - D							
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		3,265,622		1
2								2
3								3
4								4
5								5
500	TOTAL RECLASSIFICATIONS					3,265,622		500
	CODE LETTER - F							
1	PT TRANSPORT	H	ADMINISTRATIVE & GENERAL	5	368,216	237,806		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				368,216	237,806		500
	CODE LETTER - H							
1	FLOOR STOCK SUPPLIES	I	CENTRAL SERVICES & SUPPLY	14		307,455		1
2			ADULTS & PEDIATRICS	30		739,015		2
3			INTENSIVE CARE UNIT	31		382,905		3
4			NURSERY	43		39		4
5			SKILLED NURSING FACILITY	44		115,459		5
6			OPERATING ROOM	50		1,676,975		6
7			DELIVERY ROOM & LABOR ROOM	52		155,896		7
8			CARDIAC CATHETERIZATION	59		1,089,944		8
9			EMERGENCY	91		478,372		9
500	TOTAL RECLASSIFICATIONS					4,946,060		500
	CODE LETTER - I							
1	CHEMO INFUSION	J	ADULTS & PEDIATRICS	30	288,378	37,778		1
500	TOTAL RECLASSIFICATIONS				288,378	37,778		500
	CODE LETTER - J							
1	IMPLANTS	L	OPERATING ROOM	50		4,153,444		1
2			CARDIAC CATHETERIZATION	59		756,630		2
3			EMERGENCY	91		4,530		3

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
500	TOTAL RECLASSIFICATIONS					4,914,604		500
	CODE LETTER - L							
1	NURSERY	M	ADULTS & PEDIATRICS	30	615,360	57,113		1
500	TOTAL RECLASSIFICATIONS				615,360	57,113		500
	CODE LETTER - M							
	GRAND TOTAL (DECREASES)				1,856,031	17,737,992		

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		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	45,774,699	3,815,614		3,815,614	629,019	48,961,294		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	8,331,706	256,861		256,861		8,588,567		5
6	MOVABLE EQUIPMENT	25,209,189	2,418,538		2,418,538	647,184	26,980,543		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	92,802,737	6,491,013		6,491,013	1,276,203	98,017,547		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	92,802,737	6,491,013		6,491,013	1,276,203	98,017,547		10

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

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	3,350,438						3,350,438	1
2	CAP REL COSTS-MVBLE EQUIP	4,219,163						4,219,163	2
3	TOTAL (sum of lines 1-2)	7,569,601						7,569,601	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

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	DESCRIPTION	GROSS ASSETS	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	68,489,461		68,489,461	0.698747					1
2	CAP REL COSTS-MVBLE EQU	29,528,086		29,528,086	0.301253					2
3	TOTAL (sum of lines 1-2)	98,017,547		98,017,547	1.000000					3

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	3,350,438						3,350,438	1
2	CAP REL COSTS-MVBLE EQUIP	4,219,163						4,219,163	2
3	TOTAL (sum of lines 1-2)	7,569,601						7,569,601	3

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

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				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	
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	-101,439	ADMINISTRATIVE & GENERAL	5		7
8	TELEVISION AND RADIO SERVICE (chapter 21)	A	-1,498	OPERATION OF PLANT	7		8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,008,599				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	594,389				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-327,126	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	-3,713	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES	B	-3,058	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 AND						32
33							33
34							34
35							35
35.04	VOLUNTEER SALARIES (632.186)	A	-270,796	ADMINISTRATIVE & GENERAL	5		35.04
35.07	MISC INCOME A&G	B	-6,346,951	ADMINISTRATIVE & GENERAL	5		35.07
35.15	WEST TOWNS (958.729)	A	-540,017	ADMINISTRATIVE & GENERAL	5		35.15
35.19	EMPLOYEE DAY CARE REVENUE	B	-500,817	EMPLOYEE BENEFITS DEPARTMENT	4		35.19
36	NON ALLOWABLE TAXES	A	-62,205	ADMINISTRATIVE & GENERAL	5		36
37							37
38	AHA LOBBYING FEES	A	-100,226	ADMINISTRATIVE & GENERAL	5		38
39	HOME OFFICE LOBBYING FEES	A	-12,081	ADMINISTRATIVE & GENERAL	5		39
40	OB/GYN OTHER REV	B	-920,599	ADULTS & PEDIATRICS	30		40
41	ADVERTISING	A	-71,441	ADMINISTRATIVE & GENERAL	5		41
42							42
42.01	MED STAFF CONTRIBUTION ADD BACK	A	28,143	ADMINISTRATIVE & GENERAL	5		42.01
43							43
44							44
44.02	INTERDEPT RENT CONFERENCE	A	-61,380	ADMINISTRATIVE & GENERAL	5		44.02
44.03	INTERDEPT RENT AUDIOLOGY	A	-29,076	PHYSICAL THERAPY	66		44.03
44.05	INTERDEPT RENT OP PHARMACY	A	-61,620	OUTPATIENT PHARMACY	73.01		44.05
44.06	EMPLOYEE HEALTH CENTER	B	-810	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)		-10,800,920				50

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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	

(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.

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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 ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE OPERATING	4,293,175	3,129,796	1,163,379		1
2	5	ADMINISTRATIVE & GENERAL	TIS OPERATING EXPENSE	490,125		490,125		2
3	5	ADMINISTRATIVE & GENERAL	INSURANCE	1,333,381	2,081,838	-748,457		3
3.01	4	EMPLOYEE BENEFITS DEPARTMENT	PENSION	3,258,000	3,258,000			3.01
3.02	4	EMPLOYEE BENEFITS DEPARTMENT	WORKERS COMP	1,205,429	1,177,798	27,631		3.02
3.03	4	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE STOP LOSS	2,585	340,874	-338,289		3.03
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			10,582,695	9,988,306	594,389		5

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

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

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

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

				RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6	B	TRINITY HEALTH		TRINITY HEALTH			6
7							7
8							8
9							9
10							10

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	52	DELIVERY ROOM & LABO AGGREGATE	549	549						1
2	57	CT SCAN AGGREGATE								2
3	90.02	WOUND CARE AGGREGATE	153,000	153,000						3
4	30	ADULTS & PEDIATRICS OB COVERAGE	267,750	267,750						4
5	50	OPERATING ROOM AGGREGATE	71,487	71,487						5
6	91	EMERGENCY ER								6
7	56	RADIOISOTOPE AGGREGATE	3,315	3,315						7
8	60	LABORATORY AGGREGATE	5,641	5,641						8
9	30	ADULTS & PEDIATRICS MOONLIGHTERS	606,159	606,159						9
10	54	RADIOLOGY-DIAGNOSTIC AGGREGATE								10
11	50	OPERATING ROOM TRAUMA CALL	178,857		178,857	208,000	3,179	317,900	15,895	11
12	53	ANESTHESIOLOGY TRAUMA CALL	786,000		786,000	200,300	4,192	403,682	20,184	12
13	69	ELECTROCARDIOLOGY CHAIR								13
14	40	SUBPROVIDER - IPF DIRECTOR	25,002	25,002						14
15	30	ADULTS & PEDIATRICS CR CHAIR	2,000	2,000						15
16	5	ADMINISTRATIVE & GEN MISC								16
17	5	ADMINISTRATIVE & GEN QA								17
18	30	ADULTS & PEDIATRICS CHAIR	25,385		25,385	196,400	181	17,091	855	18
19	30	ADULTS & PEDIATRICS ORTHO CHAIR	62,218	62,218						19
20	50	OPERATING ROOM DIRECTOR	144,000		144,000	208,000	3,600	360,000	18,000	20
21	50	OPERATING ROOM TRAUMA CALL	133,333		133,333	208,000	1,111	111,100	5,555	21
22	40	SUBPROVIDER - IPF CALL	86,159		86,159	154,100	453	33,561	1,678	22
23	31	INTENSIVE CARE UNIT ICU	930,744		930,744	196,400	6,648	627,725	31,386	23
24	50	OPERATING ROOM VASCULAR								24
25	30	ADULTS & PEDIATRICS QUALITY	43,016	43,016						25
200		TOTAL	3,524,615	1,240,137	2,284,478		19,364	1,871,059	93,553	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATION	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT-ICE INSURANCE	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW-ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1	52	DELIVERY ROOM & LABO AGGREGATE							549	1
2	57	CT SCAN AGGREGATE								2
3	90.02	WOUND CARE AGGREGATE							153,000	3
4	30	ADULTS & PEDIATRICS OB COVERAGE							267,750	4
5	50	OPERATING ROOM AGGREGATE							71,487	5
6	91	EMERGENCY ER								6
7	56	RADIOISOTOPE AGGREGATE							3,315	7
8	60	LABORATORY AGGREGATE							5,641	8
9	30	ADULTS & PEDIATRICS MOONLIGHTERS							606,159	9
10	54	RADIOLOGY-DIAGNOSTIC AGGREGATE								10
11	50	OPERATING ROOM TRAUMA CALL					317,900			11
12	53	ANESTHESIOLOGY TRAUMA CALL					403,682	382,318	382,318	12
13	69	ELECTROCARDIOLOGY CHAIR								13
14	40	SUBPROVIDER - IPF DIRECTOR							25,002	14
15	30	ADULTS & PEDIATRICS CR CHAIR							2,000	15
16	5	ADMINISTRATIVE & GEN MISC								16
17	5	ADMINISTRATIVE & GEN QA								17
18	30	ADULTS & PEDIATRICS CHAIR					17,091	8,294	8,294	18
19	30	ADULTS & PEDIATRICS ORTHO CHAIR							62,218	19
20	50	OPERATING ROOM DIRECTOR					360,000			20
21	50	OPERATING ROOM TRAUMA CALL					111,100	22,233	22,233	21
22	40	SUBPROVIDER - IPF CALL					33,561	52,598	52,598	22
23	31	INTENSIVE CARE UNIT ICU					627,725	303,019	303,019	23
24	50	OPERATING ROOM VASCULAR								24
25	30	ADULTS & PEDIATRICS QUALITY							43,016	25
200		TOTAL					1,871,059	768,462	2,008,599	200

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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	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	3,350,438	3,350,438					1
2	CAP REL COSTS-MVBLE EQUIP	4,219,163		4,219,163				2
4	EMPLOYEE BENEFITS DEPARTMENT	13,298,439	22,826	88	13,321,353			4
5	ADMINISTRATIVE & GENERAL	13,781,502	322,779	29,991	1,420,027	15,554,299	15,554,299	5
6	MAINTENANCE & REPAIRS	2,620,160	16,296	719,258	196,644	3,552,358	546,665	6
7	OPERATION OF PLANT	4,211,941	428,687	296,799	263,303	5,200,730	800,330	7
8	LAUNDRY & LINEN SERVICE	751,572	15,644	486,072	182	1,253,470	192,894	8
9	HOUSEKEEPING	2,108,007	14,558	8,068	254,229	2,384,862	367,002	9
10	DIETARY	1,436,861	83,814	32,022	132,037	1,684,734	259,260	10
11	CAFETERIA	657,420	73,910	12,189	90,772	834,291	128,387	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	2,517,180	41,970	58,444	527,209	3,144,803	483,947	13
14	CENTRAL SERVICES & SUPPLY	768,576	91,545	108,605	136,915	1,105,641	170,145	14
15	PHARMACY	1,806,275	35,131	3,565	490,397	2,335,368	359,385	15
16	MEDICAL RECORDS & LIBRARY	1,923,399	31,975		318,266	2,273,640	349,886	16
17	SOCIAL SERVICE	316,233	18,652		77,484	412,369	63,459	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			70,693	357,201	54,969	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	9,549,204	629,114	62,649	2,473,487	12,714,454	1,956,650	30
31	INTENSIVE CARE UNIT	4,047,714	125,795	96,782	798,715	5,069,006	780,059	31
40	SUBPROVIDER - IPF	915,020		1,669	220,828	1,137,517	175,050	40
43	NURSERY	673,072	14,798		151,924	839,794	129,234	43
44	SKILLED NURSING FACILITY	2,166,013	137,437	4,445	516,242	2,824,137	434,601	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	4,952,197	290,804	548,375	637,365	6,428,741	989,306	50
51	RECOVERY ROOM	453,993	17,348		93,839	565,180	86,974	51
52	DELIVERY ROOM & LABOR ROOM	1,800,988	64,910	33,178	417,676	2,316,752	356,520	52
53	ANESTHESIOLOGY	647,906	5,341	47,905		701,152	107,899	53
54	RADIOLOGY-DIAGNOSTIC	1,872,541	113,787	450,399	384,919	2,821,646	434,217	54
56	RADIOISOTOPE	464,773	21,751		16,248	502,772	77,371	56
56.01	ULTRASOUND	640,658	21,888	6,701	139,708	808,955	124,488	56.01
57	CT SCAN	854,065	40,792	36,022	167,362	1,098,241	169,006	57
59	CARDIAC CATHETERIZATION	941,711	23,592	285,092	162,157	1,412,552	217,375	59
60	LABORATORY	5,117,771	112,278	311,352	579,501	6,120,902	941,933	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	1,204,788			246,829	1,451,617	223,386	64
65	RESPIRATORY THERAPY	499	12,499	69,824	75	82,897	12,757	65
66	PHYSICAL THERAPY	2,160,289	124,834	8,743	508,489	2,802,355	431,249	66
69	ELECTROCARDIOLOGY	480,429	23,535	75,215	102,226	681,405	104,860	69
70	ELECTROENCEPHALOGRAPHY	101,976	11,928		21,231	135,135	20,796	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,946,060				4,946,060	761,139	71
72	IMPL. DEV. CHARGED TO PATIENTS	4,914,604				4,914,604	756,299	72
73	DRUGS CHARGED TO PATIENTS	3,646,381			71,155	3,717,536	572,084	73
73.01	OUTPATIENT PHARMACY	1,677,603	22,712	2,941	81,255	1,784,511	274,615	73.01
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	186,535	41,272	3,339	44,005	275,151	42,342	76.01
76.05	INPATIENT RENAL DIALYSIS	333,319				333,319	51,294	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	10,976	1,052		1,646	13,674	2,104	90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	1,161,207	23,535	3,336	131,682	1,319,760	203,095	90.02
90.03	RIVER FOREST	54,062	114,359	290,908		459,329	70,685	90.03
91	EMERGENCY	3,942,078	157,290	125,187	790,632	5,015,187	771,777	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	1,970,798			450,918	2,421,716	372,673	101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	371,541			68,937	440,478	67,784	116
118	SUBTOTALS (sum of lines 1-117)	116,314,445	3,350,438	4,219,163	13,257,209	116,250,301	15,495,951	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	67,131			8,217	75,348	11,595	190

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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	
192.01	NON-EMPLOYEE CHILD CARE CENTER	79,208			17,895	97,103	14,943	192.01
193	NONPAID WORKERS	168,678			38,032	206,710	31,810	193
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	116,629,462	3,350,438	4,219,163	13,321,353	116,629,462	15,554,299	202

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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	4,099,023						6
7	OPERATION OF PLANT	1,406,653	7,407,713					7
8	LAUNDRY & LINEN SERVICE		45,272	1,491,636				8
9	HOUSEKEEPING	456,896	42,128	24,073	3,274,961			9
10	DIETARY	236,888	242,541	103,529	88,443	2,615,395		10
11	CAFETERIA	81	213,882		77,480		1,254,121	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	135,228	121,453		6,775		53,884	13
14	CENTRAL SERVICES & SUPPLY	41,636	264,912	639	49,764		25,445	14
15	PHARMACY	10,162	101,663	10,996	39,417		44,287	15
16	MEDICAL RECORDS & LIBRARY	4,841	92,529		23,034		44,900	16
17	SOCIAL SERVICE	1,469	53,975				9,449	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	23,415	1,820,528	131	1,284,758	1,620,573	295,683	30
31	INTENSIVE CARE UNIT	19,518	364,027		137,961	217,927	64,970	31
40	SUBPROVIDER - IPF	1,854				207,583	31,248	40
43	NURSERY		42,823		30,179			43
44	SKILLED NURSING FACILITY	1,707	397,716	66	275,921	569,312	70,791	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	475,901	841,531	1,334,384	323,715		79,738	50
51	RECOVERY ROOM	7,037	50,203		31,287		8,537	51
52	DELIVERY ROOM & LABOR ROOM	5,105	187,838	3,562	63,191		40,957	52
53	ANESTHESIOLOGY	12	15,455		4,558		49,513	53
54	RADIOLOGY-DIAGNOSTIC	761,098	329,279	303	82,160			54
56	RADIOISOTOPE	2,124	62,944	131	32,642		1,135	56
56.01	ULTRASOUND	45,557	63,341	246	6,775		12,146	56.01
57	CT SCAN	3,828	118,044	115	36,091		16,033	57
59	CARDIAC CATHETERIZATION	1,565	68,272				17,521	59
60	LABORATORY	142,394	324,910	991	120,839		83,607	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY	505	36,171		16,136		30,411	65
66	PHYSICAL THERAPY	12,614	361,247		183,783		56,321	66
69	ELECTROCARDIOLOGY	3,344	68,106		34,983		14,099	69
70	ELECTROENCEPHALOGRAPHY		34,516		3,572		3,032	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	3,140	65,723				9,430	73.01
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	2,190	119,434		45,330		4,055	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		3,045					90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	442	68,106				12,350	90.02
90.03	RIVER FOREST		330,933				27,658	90.03
91	EMERGENCY	276,198	455,166	12,470	117,266		86,081	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	8,353			152,003		45,421	101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	1,469			6,898		7,421	116
118	SUBTOTALS (sum of lines 1-117)	4,093,224	7,407,713	1,491,636	3,274,961	2,615,395	1,246,123	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,670					2,046	190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
193	NONPAID WORKERS	129					5,952	193

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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	
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	4,099,023	7,407,713	1,491,636	3,274,961	2,615,395	1,254,121	202

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	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	
	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	3,946,090						13
14	CENTRAL SERVICES & SUPPLY	83,656	1,741,838					14
15	PHARMACY	145,603	47,062	3,093,943				15
16	MEDICAL RECORDS & LIBRARY	147,621	2		2,936,453			16
17	SOCIAL SERVICE	31,065	1			571,787		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						412,170	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	972,139	155,617	61,451	468,854	363,112	4,122	30
31	INTENSIVE CARE UNIT	213,605	82,267	28,815	124,858	37,493		31
40	SUBPROVIDER - IPF	102,736	3,629	551	178,878	139,270		40
43	NURSERY		7		17,837			43
44	SKILLED NURSING FACILITY	232,745	22,893	3,266				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	262,159	506,814	35,225	470,383			50
51	RECOVERY ROOM	28,069	9,319	478	23,443			51
52	DELIVERY ROOM & LABOR ROOM	134,657	36,974	12,575	36,693			52
53	ANESTHESIOLOGY	162,787	40,315	23,789	47,905			53
54	RADIOLOGY-DIAGNOSTIC		15,419	6,163	83,069			54
56	RADIOISOTOPE	3,730	23,009	68,084	38,731			56
56.01	ULTRASOUND	39,932	8,628	946	21,914			56.01
57	CT SCAN	52,713	19,523	291	75,934			57
59	CARDIAC CATHETERIZATION	57,605	248,871	43,684	88,165			59
60	LABORATORY	274,879	323,404		256,341			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY	99,984	23,201	920	94,790			65
66	PHYSICAL THERAPY	185,169	7,047	814	50,962			66
69	ELECTROCARDIOLOGY	46,353	8,344	198	64,722			69
70	ELECTROENCEPHALOGRAPHY	9,968	2,541		3,567			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				131,483			71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS				514,210			73
73.01	OUTPATIENT PHARMACY	31,004	11,175	2,619,425				73.01
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	13,331	565		1,529			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				1,019			90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	40,605	15,964	83,670				90.02
90.03	RIVER FOREST	90,933						90.03
91	EMERGENCY	283,012	119,726	58,642	141,166	31,912	408,048	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	149,334	7,486	2,458				101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	24,400	2,027	42,498				116
118	SUBTOTALS (sum of lines 1-117)	3,919,794	1,741,830	3,093,943	2,936,453	571,787	412,170	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,727	1					190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
193	NONPAID WORKERS	19,569	7					193

KPMG LLP

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	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	
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	3,946,090	1,741,838	3,093,943	2,936,453	571,787	412,170	202

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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	21,741,487	-4,122	21,737,365				30
31	INTENSIVE CARE UNIT	7,140,506		7,140,506				31
40	SUBPROVIDER - IPF	1,978,316		1,978,316				40
43	NURSERY	1,059,874		1,059,874				43
44	SKILLED NURSING FACILITY	4,833,155		4,833,155				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	11,747,897		11,747,897				50
51	RECOVERY ROOM	810,527		810,527				51
52	DELIVERY ROOM & LABOR ROOM	3,194,824		3,194,824				52
53	ANESTHESIOLOGY	1,153,385		1,153,385				53
54	RADIOLOGY-DIAGNOSTIC	4,533,354		4,533,354				54
56	RADIOISOTOPE	812,673		812,673				56
56.01	ULTRASOUND	1,132,928		1,132,928				56.01
57	CT SCAN	1,589,819		1,589,819				57
59	CARDIAC CATHETERIZATION	2,155,610		2,155,610				59
60	LABORATORY	8,590,200		8,590,200				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	1,675,003		1,675,003				64
65	RESPIRATORY THERAPY	397,772		397,772				65
66	PHYSICAL THERAPY	4,091,561		4,091,561				66
69	ELECTROCARDIOLOGY	1,026,414		1,026,414				69
70	ELECTROENCEPHALOGRAPHY	213,127		213,127				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,838,682		5,838,682				71
72	IMPL. DEV. CHARGED TO PATIENTS	5,670,903		5,670,903				72
73	DRUGS CHARGED TO PATIENTS	4,803,830		4,803,830				73
73.01	OUTPATIENT PHARMACY	4,799,023		4,799,023				73.01
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	503,927		503,927				76.01
76.05	INPATIENT RENAL DIALYSIS	384,613		384,613				76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	19,842		19,842				90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	1,743,992		1,743,992				90.02
90.03	RIVER FOREST	979,538		979,538				90.03
91	EMERGENCY	7,776,651	-408,048	7,368,603				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	3,159,444		3,159,444				101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	592,975		592,975				116
118	SUBTOTALS (sum of lines 1-117)	116,151,852	-412,170	115,739,682				118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	101,387		101,387				190
192.01	NON-EMPLOYEE CHILD CARE CENTER	112,046		112,046				192.01
193	NONPAID WORKERS	264,177		264,177				193

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COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	116,629,462	-412,170	116,217,292				202

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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		22,826	88	22,914	22,914		4
5	ADMINISTRATIVE & GENERAL		322,779	29,991	352,770	2,440	355,210	5
6	MAINTENANCE & REPAIRS		16,296	719,258	735,554	338	12,483	6
7	OPERATION OF PLANT		428,687	296,799	725,486	452	18,275	7
8	LAUNDRY & LINEN SERVICE		15,644	486,072	501,716		4,405	8
9	HOUSEKEEPING		14,558	8,068	22,626	437	8,380	9
10	DIETARY		83,814	32,022	115,836	227	5,920	10
11	CAFETERIA		73,910	12,189	86,099	156	2,932	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		41,970	58,444	100,414	906	11,051	13
14	CENTRAL SERVICES & SUPPLY		91,545	108,605	200,150	235	3,885	14
15	PHARMACY		35,131	3,565	38,696	843	8,206	15
16	MEDICAL RECORDS & LIBRARY		31,975		31,975	547	7,990	16
17	SOCIAL SERVICE		18,652		18,652	133	1,449	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					121	1,255	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		629,114	62,649	691,763	4,274	44,713	30
31	INTENSIVE CARE UNIT		125,795	96,782	222,577	1,373	17,812	31
40	SUBPROVIDER - IPF			1,669	1,669	379	3,997	40
43	NURSERY		14,798		14,798	261	2,951	43
44	SKILLED NURSING FACILITY		137,437	4,445	141,882	887	9,924	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		290,804	548,375	839,179	1,095	22,591	50
51	RECOVERY ROOM		17,348		17,348	161	1,986	51
52	DELIVERY ROOM & LABOR ROOM		64,910	33,178	98,088	718	8,141	52
53	ANESTHESIOLOGY		5,341	47,905	53,246		2,464	53
54	RADIOLOGY-DIAGNOSTIC		113,787	450,399	564,186	661	9,915	54
56	RADIOISOTOPE		21,751		21,751	28	1,767	56
56.01	ULTRASOUND		21,888	6,701	28,589	240	2,843	56.01
57	CT SCAN		40,792	36,022	76,814	288	3,859	57
59	CARDIAC CATHETERIZATION		23,592	285,092	308,684	279	4,964	59
60	LABORATORY		112,278	311,352	423,630	996	21,509	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY					424	5,101	64
65	RESPIRATORY THERAPY		12,499	69,824	82,323		291	65
66	PHYSICAL THERAPY		124,834	8,743	133,577	874	9,847	66
69	ELECTROCARDIOLOGY		23,535	75,215	98,750	176	2,394	69
70	ELECTROENCEPHALOGRAPHY		11,928		11,928	36	475	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						17,380	71
72	IMPL. DEV. CHARGED TO PATIENTS						17,270	72
73	DRUGS CHARGED TO PATIENTS					122	13,063	73
73.01	OUTPATIENT PHARMACY		22,712	2,941	25,653	140	6,271	73.01
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION		41,272	3,339	44,611	76	967	76.01
76.05	INPATIENT RENAL DIALYSIS						1,171	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		1,052		1,052	3	48	90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE		23,535	3,336	26,871	226	4,638	90.02
90.03	RIVER FOREST		114,359	290,908	405,267		1,614	90.03
91	EMERGENCY		157,290	125,187	282,477	1,359	17,623	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					775	8,510	101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE					118	1,548	116
118	SUBTOTALS (sum of lines 1-117)		3,350,438	4,219,163	7,569,601	22,804	353,878	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					14	265	190
192.01	NON-EMPLOYEE CHILD CARE CENTER					31	341	192.01
193	NONPAID WORKERS					65	726	193

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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	
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		3,350,438	4,219,163	7,569,601	22,914	355,210	202

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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	748,375						6
7	OPERATION OF PLANT	256,817	1,001,030					7
8	LAUNDRY & LINEN SERVICE		6,118	512,239				8
9	HOUSEKEEPING	83,417	5,693	8,267	128,820			9
10	DIETARY	43,250	32,775	35,553	3,479	237,040		10
11	CAFETERIA	15	28,903		3,048		121,153	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	24,689	16,412		266		5,205	13
14	CENTRAL SERVICES & SUPPLY	7,602	35,799	219	1,957		2,458	14
15	PHARMACY	1,855	13,738	3,776	1,550		4,278	15
16	MEDICAL RECORDS & LIBRARY	884	12,504		906		4,338	16
17	SOCIAL SERVICE	268	7,294				913	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	4,275	246,015	45	50,536	146,877	28,561	30
31	INTENSIVE CARE UNIT	3,564	49,192		5,427	19,751	6,276	31
40	SUBPROVIDER - IPF	338				18,814	3,019	40
43	NURSERY		5,787		1,187			43
44	SKILLED NURSING FACILITY	312	53,745	22	10,853	51,598	6,839	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	86,887	113,719	458,240	12,733		7,703	50
51	RECOVERY ROOM	1,285	6,784		1,231		825	51
52	DELIVERY ROOM & LABOR ROOM	932	25,383	1,223	2,486		3,957	52
53	ANESTHESIOLOGY	2	2,088		179		4,783	53
54	RADIOLOGY-DIAGNOSTIC	138,957	44,497	104	3,232			54
56	RADIOISOTOPE	388	8,506	45	1,284		110	56
56.01	ULTRASOUND	8,317	8,559	84	266		1,173	56.01
57	CT SCAN	699	15,952	39	1,420		1,549	57
59	CARDIAC CATHETERIZATION	286	9,226				1,693	59
60	LABORATORY	25,997	43,906	340	4,753		8,077	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY	92	4,888		635		2,938	65
66	PHYSICAL THERAPY	2,303	48,817		7,229		5,441	66
69	ELECTROCARDIOLOGY	611	9,203		1,376		1,362	69
70	ELECTROENCEPHALOGRAPHY		4,664		141		293	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	573	8,881				911	73.01
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	400	16,140		1,783		392	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		411					90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	81	9,203				1,193	90.02
90.03	RIVER FOREST		44,720				2,672	90.03
91	EMERGENCY	50,427	61,508	4,282	4,613		8,316	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	1,525			5,979		4,388	101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	268			271		717	116
118	SUBTOTALS (sum of lines 1-117)	747,316	1,001,030	512,239	128,820	237,040	120,380	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,035					198	190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
193	NONPAID WORKERS	24					575	193

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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	
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	748,375	1,001,030	512,239	128,820	237,040	121,153	202

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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	
	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	158,943						13
14	CENTRAL SERVICES & SUPPLY	3,370	255,675					14
15	PHARMACY	5,865	6,908	85,715				15
16	MEDICAL RECORDS & LIBRARY	5,946			65,090			16
17	SOCIAL SERVICE	1,251				29,960		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						1,376	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	39,156	22,842	1,702	10,393	19,026		30
31	INTENSIVE CARE UNIT	8,604	12,075	798	2,768	1,965		31
40	SUBPROVIDER - IPF	4,138	533	15	3,965	7,297		40
43	NURSERY		1		395			43
44	SKILLED NURSING FACILITY	9,375	3,360	90				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	10,559	74,396	976	10,427			50
51	RECOVERY ROOM	1,131	1,368	13	520			51
52	DELIVERY ROOM & LABOR ROOM	5,424	5,427	348	813			52
53	ANESTHESIOLOGY	6,557	5,918	659	1,062			53
54	RADIOLOGY-DIAGNOSTIC		2,263	171	1,841			54
56	RADIOISOTOPE	150	3,377	1,886	859			56
56.01	ULTRASOUND	1,608	1,266	26	486			56.01
57	CT SCAN	2,123	2,866	8	1,683			57
59	CARDIAC CATHETERIZATION	2,320	36,530	1,210	1,954			59
60	LABORATORY	11,072	47,470		5,682			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY	4,027	3,406	25	2,101			65
66	PHYSICAL THERAPY	7,458	1,034	23	1,130			66
69	ELECTROCARDIOLOGY	1,867	1,225	5	1,435			69
70	ELECTROENCEPHALOGRAPHY	401	373		79			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				2,914			71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS				11,397			73
73.01	OUTPATIENT PHARMACY	1,249	1,640	72,572				73.01
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	537	83		34			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				23			90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	1,636	2,343	2,318				90.02
90.03	RIVER FOREST	3,663						90.03
91	EMERGENCY	11,399	17,574	1,625	3,129	1,672		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	6,015	1,099	68				101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	983	297	1,177				116
118	SUBTOTALS (sum of lines 1-117)	157,884	255,674	85,715	65,090	29,960		118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	271						190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
193	NONPAID WORKERS	788	1					193

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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	
200	CROSS FOOT ADJUSTMENTS						1,376	200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	158,943	255,675	85,715	65,090	29,960	1,376	202

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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	1,310,178		1,310,178				30
31	INTENSIVE CARE UNIT	352,182		352,182				31
40	SUBPROVIDER - IPF	44,164		44,164				40
43	NURSERY	25,380		25,380				43
44	SKILLED NURSING FACILITY	288,887		288,887				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,638,505		1,638,505				50
51	RECOVERY ROOM	32,652		32,652				51
52	DELIVERY ROOM & LABOR ROOM	152,940		152,940				52
53	ANESTHESIOLOGY	76,958		76,958				53
54	RADIOLOGY-DIAGNOSTIC	765,827		765,827				54
56	RADIOISOTOPE	40,151		40,151				56
56.01	ULTRASOUND	53,457		53,457				56.01
57	CT SCAN	107,300		107,300				57
59	CARDIAC CATHETERIZATION	367,146		367,146				59
60	LABORATORY	593,432		593,432				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	5,525		5,525				64
65	RESPIRATORY THERAPY	100,726		100,726				65
66	PHYSICAL THERAPY	217,733		217,733				66
69	ELECTROCARDIOLOGY	118,404		118,404				69
70	ELECTROENCEPHALOGRAPHY	18,390		18,390				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,294		20,294				71
72	IMPL. DEV. CHARGED TO PATIENTS	17,270		17,270				72
73	DRUGS CHARGED TO PATIENTS	24,582		24,582				73
73.01	OUTPATIENT PHARMACY	117,890		117,890				73.01
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	65,023		65,023				76.01
76.05	INPATIENT RENAL DIALYSIS	1,171		1,171				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	1,537		1,537				90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	48,509		48,509				90.02
90.03	RIVER FOREST	457,936		457,936				90.03
91	EMERGENCY	466,004		466,004				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	28,359		28,359				101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	5,379		5,379				116
118	SUBTOTALS (sum of lines 1-117)	7,563,891		7,563,891				118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,783		1,783				190
192.01	NON-EMPLOYEE CHILD CARE CENTER	372		372				192.01
193	NONPAID WORKERS	2,179		2,179				193

KPMG LLP

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
200	CROSS FOOT ADJUSTMENTS	1,376		1,376				200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	7,569,601		7,569,601				202

KPMG LLP

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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 REQS	
		1	2	4	5A	5	6	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	292,975						1
2	CAP REL COSTS-MVBLE EQUIP		3,361,183					2
4	EMPLOYEE BENEFITS DEPARTMENT	1,996	70	53,989,309				4
5	ADMINISTRATIVE & GENERAL	28,225	23,892	5,755,132	-15,554,299	101,075,163		5
6	MAINTENANCE & REPAIRS	1,425	572,995	796,964		3,552,358	1,364,218	6
7	OPERATION OF PLANT	37,486	236,444	1,067,125		5,200,730	468,156	7
8	LAUNDRY & LINEN SERVICE	1,368	387,228	739		1,253,470		8
9	HOUSEKEEPING	1,273	6,427	1,030,349		2,384,862	152,062	9
10	DIETARY	7,329	25,510	535,124		1,684,734	78,840	10
11	CAFETERIA	6,463	9,710	367,885		834,291	27	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	3,670	46,559	2,136,688		3,144,803	45,006	13
14	CENTRAL SERVICES & SUPPLY	8,005	86,520	554,893		1,105,641	13,857	14
15	PHARMACY	3,072	2,840	1,987,499		2,335,368	3,382	15
16	MEDICAL RECORDS & LIBRARY	2,796		1,289,877		2,273,640	1,611	16
17	SOCIAL SERVICE	1,631		314,030		412,369	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		357,201		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	55,012	49,909	10,024,727		12,714,454	7,793	30
31	INTENSIVE CARE UNIT	11,000	77,101	3,237,059		5,069,006	6,496	31
40	SUBPROVIDER - IPF		1,330	894,978		1,137,517	617	40
43	NURSERY	1,294		615,724		839,794		43
44	SKILLED NURSING FACILITY	12,018	3,541	2,092,244		2,824,137	568	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	25,429	436,861	2,583,133		6,428,741	158,387	50
51	RECOVERY ROOM	1,517		380,313		565,180	2,342	51
52	DELIVERY ROOM & LABOR ROOM	5,676	26,431	1,692,769		2,316,752	1,699	52
53	ANESTHESIOLOGY	467	38,163			701,152	4	53
54	RADIOLOGY-DIAGNOSTIC	9,950	358,809	1,560,012		2,821,646	253,305	54
56	RADIOISOTOPE	1,902		65,850		502,772	707	56
56.01	ULTRASOUND	1,914	5,338	566,214		808,955	15,162	56.01
57	CT SCAN	3,567	28,697	678,290		1,098,241	1,274	57
59	CARDIAC CATHETERIZATION	2,063	227,118	657,196		1,412,552	521	59
60	LABORATORY	9,818	248,038	2,348,619		6,120,902	47,391	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY			1,000,355		1,451,617		64
65	RESPIRATORY THERAPY	1,093	55,625	303		82,897	168	65
66	PHYSICAL THERAPY	10,916	6,965	2,060,822		2,802,355	4,198	66
69	ELECTROCARDIOLOGY	2,058	59,920	414,306		681,405	1,113	69
70	ELECTROENCEPHALOGRAPHY	1,043		86,045		135,135		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					4,946,060		71
72	IMPL. DEV. CHARGED TO PATIENTS					4,914,604		72
73	DRUGS CHARGED TO PATIENTS			288,378		3,717,536		73
73.01	OUTPATIENT PHARMACY	1,986	2,343	329,312		1,784,511	1,045	73.01
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	3,609	2,660	178,344		275,151	729	76.01
76.05	INPATIENT RENAL DIALYSIS					333,319		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		6,669		13,674		90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	2,058	2,658	533,686		1,319,760	147	90.02
90.03	RIVER FOREST	10,000	231,751			459,329		90.03
91	EMERGENCY	13,754	99,730	3,204,298		5,015,187	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			1,827,496		2,421,716	2,780	101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE			279,390		440,478	489	116
118	SUBTOTALS (sum of lines 1-117)	292,975	3,361,183	53,729,345	-15,554,299	100,696,002	1,362,288	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			33,302		75,348	1,887	190
192.01	NON-EMPLOYEE CHILD CARE CENTER			72,524		97,103		192.01

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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 REQS	
		1	2	4	5A	5	6	
193	NONPAID WORKERS			154,138		206,710	43	193
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	3,350,438	4,219,163	13,321,353		15,554,299	4,099,023	202
203	UNIT COST MULT-WS B PT I	11.435918	1.255261	0.246741		0.153888	3.004669	203
204	COST TO BE ALLOC PER B PT II			22,914		355,210	748,375	204
205	UNIT COST MULT-WS B PT II			0.000424		0.003514	0.548574	205

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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)	MAIN-TENANCE OF PERSONNEL (FTES SERVED)	
		7	8	9	10	11	12	
	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	223,843						7
8	LAUNDRY & LINEN SERVICE	1,368	182,174					8
9	HOUSEKEEPING	1,273	2,940	26,587				9
10	DIETARY	7,329	12,644	718	146,391			10
11	CAFETERIA	6,463		629		67,426		11
12	MAINTENANCE OF PERSONNEL						67,426	12
13	NURSING ADMINISTRATION	3,670		55		2,897	2,897	13
14	CENTRAL SERVICES & SUPPLY	8,005	78	404		1,368	1,368	14
15	PHARMACY	3,072	1,343	320		2,381	2,381	15
16	MEDICAL RECORDS & LIBRARY	2,796		187		2,414	2,414	16
17	SOCIAL SERVICE	1,631				508	508	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	55,012	16	10,430	90,708	15,897	15,897	30
31	INTENSIVE CARE UNIT	11,000		1,120	12,198	3,493	3,493	31
40	SUBPROVIDER - IPF				11,619	1,680	1,680	40
43	NURSERY	1,294		245				43
44	SKILLED NURSING FACILITY	12,018	8	2,240	31,866	3,806	3,806	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	25,429	162,969	2,628		4,287	4,287	50
51	RECOVERY ROOM	1,517		254		459	459	51
52	DELIVERY ROOM & LABOR ROOM	5,676	435	513		2,202	2,202	52
53	ANESTHESIOLOGY	467		37		2,662	2,662	53
54	RADIOLOGY-DIAGNOSTIC	9,950	37	667				54
56	RADIOISOTOPE	1,902	16	265		61	61	56
56.01	ULTRASOUND	1,914	30	55		653	653	56.01
57	CT SCAN	3,567	14	293		862	862	57
59	CARDIAC CATHETERIZATION	2,063				942	942	59
60	LABORATORY	9,818	121	981		4,495	4,495	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY	1,093		131		1,635	1,635	65
66	PHYSICAL THERAPY	10,916		1,492		3,028	3,028	66
69	ELECTROCARDIOLOGY	2,058		284		758	758	69
70	ELECTROENCEPHALOGRAPHY	1,043		29		163	163	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				507	507	73.01
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	3,609		368		218	218	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				664	664	90.02
90.03	RIVER FOREST	10,000				1,487	1,487	90.03
91	EMERGENCY	13,754	1,523	952		4,628	4,628	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		2,442	2,442	101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE			56		399	399	116
118	SUBTOTALS (sum of lines 1-117)	223,843	182,174	26,587	146,391	66,996	66,996	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					110	110	190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01

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COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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)	MAIN-TENANCE OF PERSONNEL (FTES SERVED)	
		7	8	9	10	11	12	
193	NONPAID WORKERS					320	320	193
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	7,407,713	1,491,636	3,274,961	2,615,395	1,254,121		202
203	UNIT COST MULT-WS B PT I	33.093342	8.187974	123.179035	17.865818	18.599961		203
204	COST TO BE ALLOC PER B PT II	1,001,030	512,239	128,820	237,040	121,153		204
205	UNIT COST MULT-WS B PT II	4.472018	2.811812	4.845225	1.619225	1.796829		205

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	NURSING ADMINI-STRATION (FTES SERVED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)	
		13	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	64,529						13
14	CENTRAL SERVICES & SUPPLY	1,368	9,771,108					14
15	PHARMACY	2,381	264,001	1,436,328				15
16	MEDICAL RECORDS & LIBRARY	2,414	10		5,762			16
17	SOCIAL SERVICE	508	5			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	15,897	872,960	28,528	920	5,530	1	30
31	INTENSIVE CARE UNIT	3,493	461,491	13,377	245	571		31
40	SUBPROVIDER - IPF	1,680	20,355	256	351	2,121		40
43	NURSERY		39		35			43
44	SKILLED NURSING FACILITY	3,806	128,420	1,516				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	4,287	2,843,058	16,353	923			50
51	RECOVERY ROOM	459	52,274	222	46			51
52	DELIVERY ROOM & LABOR ROOM	2,202	207,413	5,838	72			52
53	ANESTHESIOLOGY	2,662	226,153	11,044	94			53
54	RADIOLOGY-DIAGNOSTIC		86,494	2,861	163			54
56	RADIOISOTOPE	61	129,072	31,607	76			56
56.01	ULTRASOUND	653	48,401	439	43			56.01
57	CT SCAN	862	109,519	135	149			57
59	CARDIAC CATHETERIZATION	942	1,396,080	20,280	173			59
60	LABORATORY	4,495	1,814,185		503			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY	1,635	130,152	427	186			65
66	PHYSICAL THERAPY	3,028	39,530	378	100			66
69	ELECTROCARDIOLOGY	758	46,807	92	127			69
70	ELECTROENCEPHALOGRAPHY	163	14,256		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	507	62,687	1,216,038				73.01
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	218	3,167		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	664	89,552	38,843				90.02
90.03	RIVER FOREST	1,487						90.03
91	EMERGENCY	4,628	671,621	27,224	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	2,442	41,993	1,141				101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	399	11,368	19,729				116
118	SUBTOTALS (sum of lines 1-117)	64,099	9,771,063	1,436,328	5,762	8,708	100	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	110	8					190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	NURSING ADMINI-STRATION (FTES SERVED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)	
		13	14	15	16	17	22	
193	NONPAID WORKERS	320	37					193
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	3,946,090	1,741,838	3,093,943	2,936,453	571,787	412,170	202
203	UNIT COST MULT-WS B PT I	61.152195	0.178264	2.154064	509.623915	65.662265	4,121.700000	203
204	COST TO BE ALLOC PER B PT II	158,943	255,675	85,715	65,090	29,960	1,376	204
205	UNIT COST MULT-WS B PT II	2.463125	0.026166	0.059676	11.296425	3.440514	13.760000	205

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS							
	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							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
64	INTRAVENOUS THERAPY							64
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
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							

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
193	NONPAID WORKERS							193
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I							202
203	UNIT COST MULT-WS B PT I							203
204	COST TO BE ALLOC PER B PT II							204
205	UNIT COST MULT-WS B PT II							205

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	21,737,365		21,737,365	8,294	21,745,659	30
31	INTENSIVE CARE UNIT	7,140,506		7,140,506	303,019	7,443,525	31
40	SUBPROVIDER - IPF	1,978,316		1,978,316	52,598	2,030,914	40
43	NURSERY	1,059,874		1,059,874		1,059,874	43
44	SKILLED NURSING FACILITY	4,833,155		4,833,155		4,833,155	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	11,747,897		11,747,897	22,233	11,770,130	50
51	RECOVERY ROOM	810,527		810,527		810,527	51
52	DELIVERY ROOM & LABOR ROOM	3,194,824		3,194,824		3,194,824	52
53	ANESTHESIOLOGY	1,153,385		1,153,385	382,318	1,535,703	53
54	RADIOLOGY-DIAGNOSTIC	4,533,354		4,533,354		4,533,354	54
56	RADIOISOTOPE	812,673		812,673		812,673	56
56.01	ULTRASOUND	1,132,928		1,132,928		1,132,928	56.01
57	CT SCAN	1,589,819		1,589,819		1,589,819	57
59	CARDIAC CATHETERIZATION	2,155,610		2,155,610		2,155,610	59
60	LABORATORY	8,590,200		8,590,200		8,590,200	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	1,675,003		1,675,003		1,675,003	64
65	RESPIRATORY THERAPY	397,772		397,772		397,772	65
66	PHYSICAL THERAPY	4,091,561		4,091,561		4,091,561	66
69	ELECTROCARDIOLOGY	1,026,414		1,026,414		1,026,414	69
70	ELECTROENCEPHALOGRAPHY	213,127		213,127		213,127	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,838,682		5,838,682		5,838,682	71
72	IMPL. DEV. CHARGED TO PATIENTS	5,670,903		5,670,903		5,670,903	72
73	DRUGS CHARGED TO PATIENTS	4,803,830		4,803,830		4,803,830	73
73.01	OUTPATIENT PHARMACY	4,799,023		4,799,023		4,799,023	73.01
76	LITHOTRIPSY						76
76.01	CARDIAC REHABILITATION	503,927		503,927		503,927	76.01
76.05	INPATIENT RENAL DIALYSIS	384,613		384,613		384,613	76.05
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	19,842		19,842		19,842	90
90.01	OUTPATIENT INFUSION PROCEDURES						90.01
90.02	WOUND CARE	1,743,992		1,743,992		1,743,992	90.02
90.03	RIVER FOREST	979,538		979,538		979,538	90.03
91	EMERGENCY	7,368,603		7,368,603		7,368,603	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	3,159,444		3,159,444		3,159,444	101
116	HOSPICE	592,975		592,975		592,975	116
200	SUBTOTAL (SEE INSTRUCTIONS)	115,739,682		115,739,682	768,462	116,508,144	200
201	LESS OBSERVATION BEDS						201
202	TOTAL (SEE INSTRUCTIONS)	115,739,682		115,739,682		116,508,144	202

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	67,893,483		67,893,483				30
31	INTENSIVE CARE UNIT	15,184,484		15,184,484				31
40	SUBPROVIDER - IPF	7,752,211		7,752,211				40
43	NURSERY	3,476,951		3,476,951				43
44	SKILLED NURSING FACILITY	7,588,784		7,588,784				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	11,909,940	12,663,966	24,573,906	0.478064	0.478064	0.478969	50
51	RECOVERY ROOM	5,914,220	2,818,375	8,732,595	0.092816	0.092816	0.092816	51
52	DELIVERY ROOM & LABOR ROOM	7,267,523	270,122	7,537,645	0.423849	0.423849	0.423849	52
53	ANESTHESIOLOGY	12,358,031	15,242,262	27,600,293	0.041789	0.041789	0.055641	53
54	RADIOLOGY-DIAGNOSTIC	4,682,421	13,722,423	18,404,844	0.246313	0.246313	0.246313	54
56	RADIOISOTOPE	2,219,287	5,090,210	7,309,497	0.111180	0.111180	0.111180	56
56.01	ULTRASOUND	2,714,281	7,712,330	10,426,611	0.108657	0.108657	0.108657	56.01
57	CT SCAN	15,677,866	35,979,608	51,657,474	0.030776	0.030776	0.030776	57
59	CARDIAC CATHETERIZATION	10,280,452	9,684,673	19,965,125	0.107969	0.107969	0.107969	59
60	LABORATORY	32,282,156	29,269,336	61,551,492	0.139561	0.139561	0.139561	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	29,939	2,415,578	2,445,517	0.684928	0.684928	0.684928	64
65	RESPIRATORY THERAPY	9,823,939	1,741,167	11,565,106	0.034394	0.034394	0.034394	65
66	PHYSICAL THERAPY	9,661,998	4,053,307	13,715,305	0.298321	0.298321	0.298321	66
69	ELECTROCARDIOLOGY	9,512,658	10,503,258	20,015,916	0.051280	0.051280	0.051280	69
70	ELECTROENCEPHALOGRAPHY	280,006	1,585,490	1,865,496	0.114247	0.114247	0.114247	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,581,028	3,870,045	10,451,073	0.558668	0.558668	0.558668	71
72	IMPL. DEV. CHARGED TO PATIENTS	9,753,343	3,933,861	13,687,204	0.414322	0.414322	0.414322	72
73	DRUGS CHARGED TO PATIENTS	20,726,341	5,185,101	25,911,442	0.185394	0.185394	0.185394	73
73.01	OUTPATIENT PHARMACY	191	1,605,568	1,605,759	2.988632	2.988632	2.988632	73.01
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	294	950,948	951,242	0.529757	0.529757	0.529757	76.01
76.05	INPATIENT RENAL DIALYSIS	2,954,197	158,425	3,112,622	0.123566	0.123566	0.123566	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		331,038	331,038	0.059939	0.059939	0.059939	90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	16,878	2,364,393	2,381,271	0.732379	0.732379	0.732379	90.02
90.03	RIVER FOREST	322		322	3,042.043478	3,042.043478	3,042.043478	90.03
91	EMERGENCY	17,927,214	40,635,591	58,562,805	0.125824	0.125824	0.125824	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,933,482	14,573,393	18,506,875				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		3,631,436	3,631,436				101
116	HOSPICE		1,365,102	1,365,102				116
200	SUBTOTAL (SEE INSTRUCTIONS)	298,403,920	231,357,006	529,760,926				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	298,403,920	231,357,006	529,760,926				202

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] PPS**
[XX] TITLE XVIII, PART A **[ ] TEFRA**
[ ] TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	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)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	1,310,178		1,310,178	28,123	46.59	13,711	638,795	30
31	INTENSIVE CARE UNIT	352,182		352,182	3,772	93.37	1,916	178,897	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	44,164		44,164	3,592	12.30	3,582	44,059	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	25,380		25,380	593	42.80			43
44	SKILLED NURSING FACILITY	288,887		288,887	9,781	29.54	7,338	216,765	44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	2,020,791		2,020,791	45,861		26,547	1,078,516	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0008** **WORKSHEET D PART II**

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

		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)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,638,505	24,573,906	0.066677	6,924,183	461,684	50
51	RECOVERY ROOM	32,652	8,732,595	0.003739	2,711,353	10,138	51
52	DELIVERY ROOM & LABOR ROOM	152,940	7,537,645	0.020290	33,958	689	52
53	ANESTHESIOLOGY	76,958	27,600,293	0.002788	5,117,529	14,268	53
54	RADIOLOGY-DIAGNOSTIC	765,827	18,404,844	0.041610	3,316,200	137,987	54
56	RADIOISOTOPE	40,151	7,309,497	0.005493	258,823	1,422	56
56.01	ULTRASOUND	53,457	10,426,611	0.005127	1,379,156	7,071	56.01
57	CT SCAN	107,300	51,657,474	0.002077	7,616,962	15,820	57
59	CARDIAC CATHETERIZATION	367,146	19,965,125	0.018389	2,434,949	44,776	59
60	LABORATORY	593,432	61,551,492	0.009641	15,718,332	151,540	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	5,525	2,445,517	0.002259			64
65	RESPIRATORY THERAPY	100,726	11,565,106	0.008709	3,925,639	34,188	65
66	PHYSICAL THERAPY	217,733	13,715,305	0.015875	2,474,855	39,288	66
69	ELECTROCARDIOLOGY	118,404	20,015,916	0.005915	5,247,218	31,037	69
70	ELECTROENCEPHALOGRAPHY	18,390	1,865,496	0.009858	157,812	1,556	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,294	10,451,073	0.001942	6,133,144	11,911	71
72	IMPL. DEV. CHARGED TO PATIENTS	17,270	13,687,204	0.001262			72
73	DRUGS CHARGED TO PATIENTS	24,582	25,911,442	0.000949	9,146,591	8,680	73
73.01	OUTPATIENT PHARMACY	117,890	1,605,759	0.073417			73.01
76	LITHOTRIPSY						76
76.01	CARDIAC REHABILITATION	65,023	951,242	0.068356			76.01
76.05	INPATIENT RENAL DIALYSIS	1,171	3,112,622	0.000376	1,669,873	628	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	1,537	331,038	0.004643			90
90.01	OUTPATIENT INFUSION PROCEDURES						90.01
90.02	WOUND CARE	48,509	2,381,271	0.020371			90.02
90.03	RIVER FOREST	457,936	322	1,422.161491			90.03
91	EMERGENCY	466,004	58,562,805	0.007957	8,237,150	65,543	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		18,506,875		2,121,676		92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	5,509,362	422,868,475		84,625,403	1,038,226	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	28,123		13,711		30
31	INTENSIVE CARE UNIT	3,772		1,916		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	3,592		3,582		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	593				43
44	SKILLED NURSING FACILITY	9,781		7,338		44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	45,861		26,547		200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0008** | **WORKSHEET D PART IV**

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

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(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
64	INTRAVENOUS THERAPY							64
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
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							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0008** | **WORKSHEET D PART IV**

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

(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)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	24,573,906			6,924,183		6,160,529		50
51	RECOVERY ROOM	8,732,595			2,711,353		2,460,134		51
52	DELIVERY ROOM & LABOR ROOM	7,537,645			33,958				52
53	ANESTHESIOLOGY	27,600,293			5,117,529		4,389,498		53
54	RADIOLOGY-DIAGNOSTIC	18,404,844			3,316,200		4,867,583		54
56	RADIOISOTOPE	7,309,497			258,823		407,790		56
56.01	ULTRASOUND	10,426,611			1,379,156		1,644,256		56.01
57	CT SCAN	51,657,474			7,616,962		10,825,847		57
59	CARDIAC CATHETERIZATION	19,965,125			2,434,949		336,840		59
60	LABORATORY	61,551,492			15,718,332		2,651,480		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	2,445,517							64
65	RESPIRATORY THERAPY	11,565,106			3,925,639		998,985		65
66	PHYSICAL THERAPY	13,715,305			2,474,855		120,766		66
69	ELECTROCARDIOLOGY	20,015,916			5,247,218		5,535,970		69
70	ELECTROENCEPHALOGRAPHY	1,865,496			157,812		91,087		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,451,073			6,133,144		3,090,232		71
72	IMPL. DEV. CHARGED TO PATIENTS	13,687,204							72
73	DRUGS CHARGED TO PATIENTS	25,911,442			9,146,591		3,224,192		73
73.01	OUTPATIENT PHARMACY	1,605,759							73.01
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	951,242							76.01
76.05	INPATIENT RENAL DIALYSIS	3,112,622			1,669,873		79,212		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	331,038					167,017		90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	2,381,271							90.02
90.03	RIVER FOREST	322							90.03
91	EMERGENCY	58,562,805			8,237,150		7,946,985		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	18,506,875			2,121,676		2,555,270		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	422,868,475			84,625,403		57,553,673		200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0008** **WORKSHEET D PART V**

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

			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.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.478064	6,160,529			2,945,127			50
51	RECOVERY ROOM	0.092816	2,460,134			228,340			51
52	DELIVERY ROOM & LABOR ROOM	0.423849							52
53	ANESTHESIOLOGY	0.041789	4,389,498			183,433			53
54	RADIOLOGY-DIAGNOSTIC	0.246313	4,867,583			1,198,949			54
56	RADIOISOTOPE	0.111180	407,790			45,338			56
56.01	ULTRASOUND	0.108657	1,644,256			178,660			56.01
57	CT SCAN	0.030776	10,825,847			333,176			57
59	CARDIAC CATHETERIZATION	0.107969	336,840			36,368			59
60	LABORATORY	0.139561	2,651,480			370,043			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	0.684928							64
65	RESPIRATORY THERAPY	0.034394	998,985			34,359			65
66	PHYSICAL THERAPY	0.298321	120,766			36,027			66
69	ELECTROCARDIOLOGY	0.051280	5,535,970			283,885			69
70	ELECTROENCEPHALOGRAPHY	0.114247	91,087			10,406			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.558668	3,090,232			1,726,414			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.414322							72
73	DRUGS CHARGED TO PATIENTS	0.185394	3,224,192			597,746			73
73.01	OUTPATIENT PHARMACY	2.988632							73.01
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	0.529757							76.01
76.05	INPATIENT RENAL DIALYSIS	0.123566	79,212			9,788			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	0.059939	167,017			10,011			90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	0.732379							90.02
90.03	RIVER FOREST	3,042.043478							90.03
91	EMERGENCY	0.125824	7,946,985			999,921			91
92	OBSERVATION BEDS (NON-DISTINCT PART)		2,555,270						92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		57,553,673			9,227,991			200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		57,553,673			9,227,991			202

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S008** **WORKSHEET D PART II**

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

(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	1,638,505	24,573,906	0.066677			50
51	RECOVERY ROOM	32,652	8,732,595	0.003739			51
52	DELIVERY ROOM & LABOR ROOM	152,940	7,537,645	0.020290			52
53	ANESTHESIOLOGY	76,958	27,600,293	0.002788			53
54	RADIOLOGY-DIAGNOSTIC	765,827	18,404,844	0.041610	30,837	1,283	54
56	RADIOISOTOPE	40,151	7,309,497	0.005493			56
56.01	ULTRASOUND	53,457	10,426,611	0.005127	11,691	60	56.01
57	CT SCAN	107,300	51,657,474	0.002077	122,878	255	57
59	CARDIAC CATHETERIZATION	367,146	19,965,125	0.018389			59
60	LABORATORY	593,432	61,551,492	0.009641	464,757	4,481	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	5,525	2,445,517	0.002259			64
65	RESPIRATORY THERAPY	100,726	11,565,106	0.008709	90,426	788	65
66	PHYSICAL THERAPY	217,733	13,715,305	0.015875	8,584	136	66
69	ELECTROCARDIOLOGY	118,404	20,015,916	0.005915	23,545	139	69
70	ELECTROENCEPHALOGRAPHY	18,390	1,865,496	0.009858	19,729	194	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,294	10,451,073	0.001942	3,182	6	71
72	IMPL. DEV. CHARGED TO PATIENTS	17,270	13,687,204	0.001262			72
73	DRUGS CHARGED TO PATIENTS	24,582	25,911,442	0.000949	598,824	568	73
73.01	OUTPATIENT PHARMACY	117,890	1,605,759	0.073417			73.01
76	LITHOTRIPSY						76
76.01	CARDIAC REHABILITATION	65,023	951,242	0.068356			76.01
76.05	INPATIENT RENAL DIALYSIS	1,171	3,112,622	0.000376			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	1,537	331,038	0.004643			90
90.01	OUTPATIENT INFUSION PROCEDURES						90.01
90.02	WOUND CARE	48,509	2,381,271	0.020371			90.02
90.03	RIVER FOREST	457,936	322	1,422.161491			90.03
91	EMERGENCY	466,004	58,562,805	0.007957	88,566	705	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		18,506,875				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	5,509,362	422,868,475		1,463,019	8,615	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S008** | **WORKSHEET D PART IV**

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

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(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
64	INTRAVENOUS THERAPY							64
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
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							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S008** | **WORKSHEET D PART IV**

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

(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)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	24,573,906							50
51	RECOVERY ROOM	8,732,595							51
52	DELIVERY ROOM & LABOR ROOM	7,537,645							52
53	ANESTHESIOLOGY	27,600,293							53
54	RADIOLOGY-DIAGNOSTIC	18,404,844			30,837				54
56	RADIOISOTOPE	7,309,497							56
56.01	ULTRASOUND	10,426,611			11,691				56.01
57	CT SCAN	51,657,474			122,878				57
59	CARDIAC CATHETERIZATION	19,965,125							59
60	LABORATORY	61,551,492			464,757				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	2,445,517							64
65	RESPIRATORY THERAPY	11,565,106			90,426				65
66	PHYSICAL THERAPY	13,715,305			8,584				66
69	ELECTROCARDIOLOGY	20,015,916			23,545				69
70	ELECTROENCEPHALOGRAPHY	1,865,496			19,729				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,451,073			3,182				71
72	IMPL. DEV. CHARGED TO PATIENTS	13,687,204							72
73	DRUGS CHARGED TO PATIENTS	25,911,442			598,824				73
73.01	OUTPATIENT PHARMACY	1,605,759							73.01
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	951,242							76.01
76.05	INPATIENT RENAL DIALYSIS	3,112,622							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	331,038							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	2,381,271							90.02
90.03	RIVER FOREST	322							90.03
91	EMERGENCY	58,562,805			88,566				91
92	OBSERVATION BEDS (NON-DISTINCT PART)	18,506,875							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	422,868,475			1,463,019				200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S008** **WORKSHEET D PART V**

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

			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.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.478064							50
51	RECOVERY ROOM	0.092816							51
52	DELIVERY ROOM & LABOR ROOM	0.423849							52
53	ANESTHESIOLOGY	0.041789							53
54	RADIOLOGY-DIAGNOSTIC	0.246313							54
56	RADIOISOTOPE	0.111180							56
56.01	ULTRASOUND	0.108657							56.01
57	CT SCAN	0.030776							57
59	CARDIAC CATHETERIZATION	0.107969							59
60	LABORATORY	0.139561							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	0.684928							64
65	RESPIRATORY THERAPY	0.034394							65
66	PHYSICAL THERAPY	0.298321							66
69	ELECTROCARDIOLOGY	0.051280							69
70	ELECTROENCEPHALOGRAPHY	0.114247							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.558668							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.414322							72
73	DRUGS CHARGED TO PATIENTS	0.185394							73
73.01	OUTPATIENT PHARMACY	2.988632							73.01
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	0.529757							76.01
76.05	INPATIENT RENAL DIALYSIS	0.123566							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	0.059939							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	0.732379							90.02
90.03	RIVER FOREST	3,042.043478							90.03
91	EMERGENCY	0.125824							91
92	OBSERVATION BEDS (NON-DISTINCT PART)								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

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-5526** | **WORKSHEET D PART IV**

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

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(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
64	INTRAVENOUS THERAPY							64
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
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							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-5526** | **WORKSHEET D PART IV**

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

		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)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	24,573,906			122,765				50
51	RECOVERY ROOM	8,732,595							51
52	DELIVERY ROOM & LABOR ROOM	7,537,645							52
53	ANESTHESIOLOGY	27,600,293			102,841				53
54	RADIOLOGY-DIAGNOSTIC	18,404,844			143,092				54
56	RADIOISOTOPE	7,309,497			17,677				56
56.01	ULTRASOUND	10,426,611			87,697				56.01
57	CT SCAN	51,657,474			6,830				57
59	CARDIAC CATHETERIZATION	19,965,125			3,208				59
60	LABORATORY	61,551,492			1,058,105				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	2,445,517							64
65	RESPIRATORY THERAPY	11,565,106			609,192				65
66	PHYSICAL THERAPY	13,715,305			4,427,787				66
69	ELECTROCARDIOLOGY	20,015,916			89,469				69
70	ELECTROENCEPHALOGRAPHY	1,865,496			1,708				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,451,073			444,702				71
72	IMPL. DEV. CHARGED TO PATIENTS	13,687,204							72
73	DRUGS CHARGED TO PATIENTS	25,911,442			1,663,653				73
73.01	OUTPATIENT PHARMACY	1,605,759							73.01
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	951,242							76.01
76.05	INPATIENT RENAL DIALYSIS	3,112,622							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	331,038							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	2,381,271							90.02
90.03	RIVER FOREST	322							90.03
91	EMERGENCY	58,562,805							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	18,506,875							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	422,868,475			8,778,726				200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-5526** **WORKSHEET D PART V**

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

			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.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.478064							50
51	RECOVERY ROOM	0.092816							51
52	DELIVERY ROOM & LABOR ROOM	0.423849							52
53	ANESTHESIOLOGY	0.041789							53
54	RADIOLOGY-DIAGNOSTIC	0.246313							54
56	RADIOISOTOPE	0.111180							56
56.01	ULTRASOUND	0.108657							56.01
57	CT SCAN	0.030776							57
59	CARDIAC CATHETERIZATION	0.107969							59
60	LABORATORY	0.139561							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	0.684928							64
65	RESPIRATORY THERAPY	0.034394							65
66	PHYSICAL THERAPY	0.298321							66
69	ELECTROCARDIOLOGY	0.051280							69
70	ELECTROENCEPHALOGRAPHY	0.114247							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.558668							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.414322							72
73	DRUGS CHARGED TO PATIENTS	0.185394							73
73.01	OUTPATIENT PHARMACY	2.988632							73.01
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	0.529757							76.01
76.05	INPATIENT RENAL DIALYSIS	0.123566							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	0.059939							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	0.732379							90.02
90.03	RIVER FOREST	3,042.043478							90.03
91	EMERGENCY	0.125824							91
92	OBSERVATION BEDS (NON-DISTINCT PART)								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

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES:
[ ] TITLE V
[ ] TITLE XVIII, PART A
[XX] TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	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)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	1,310,178		1,310,178	28,123	46.59	5,756	268,172	30
31	INTENSIVE CARE UNIT	352,182		352,182	3,772	93.37	757	70,681	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	44,164		44,164	3,592	12.30			40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	25,380		25,380	593	42.80	438	18,746	43
44	SKILLED NURSING FACILITY	288,887		288,887	9,781	29.54	344	10,162	44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	2,020,791		2,020,791	45,861		7,295	367,761	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0008** **WORKSHEET D PART II**

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

		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)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,638,505	24,573,906	0.066677			50
51	RECOVERY ROOM	32,652	8,732,595	0.003739			51
52	DELIVERY ROOM & LABOR ROOM	152,940	7,537,645	0.020290			52
53	ANESTHESIOLOGY	76,958	27,600,293	0.002788			53
54	RADIOLOGY-DIAGNOSTIC	765,827	18,404,844	0.041610			54
56	RADIOISOTOPE	40,151	7,309,497	0.005493			56
56.01	ULTRASOUND	53,457	10,426,611	0.005127			56.01
57	CT SCAN	107,300	51,657,474	0.002077			57
59	CARDIAC CATHETERIZATION	367,146	19,965,125	0.018389			59
60	LABORATORY	593,432	61,551,492	0.009641			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	5,525	2,445,517	0.002259			64
65	RESPIRATORY THERAPY	100,726	11,565,106	0.008709			65
66	PHYSICAL THERAPY	217,733	13,715,305	0.015875			66
69	ELECTROCARDIOLOGY	118,404	20,015,916	0.005915			69
70	ELECTROENCEPHALOGRAPHY	18,390	1,865,496	0.009858			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,294	10,451,073	0.001942			71
72	IMPL. DEV. CHARGED TO PATIENTS	17,270	13,687,204	0.001262			72
73	DRUGS CHARGED TO PATIENTS	24,582	25,911,442	0.000949			73
73.01	OUTPATIENT PHARMACY	117,890	1,605,759	0.073417			73.01
76	LITHOTRIPSY						76
76.01	CARDIAC REHABILITATION	65,023	951,242	0.068356			76.01
76.05	INPATIENT RENAL DIALYSIS	1,171	3,112,622	0.000376			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	1,537	331,038	0.004643			90
90.01	OUTPATIENT INFUSION PROCEDURES						90.01
90.02	WOUND CARE	48,509	2,381,271	0.020371			90.02
90.03	RIVER FOREST	457,936	322	1,422.161491			90.03
91	EMERGENCY	466,004	58,562,805	0.007957			91
92	OBSERVATION BEDS (NON-DISTINCT PART)		18,506,875				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	5,509,362	422,868,475				200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES:
[ ] TITLE V
[ ] TITLE XVIII, PART A
[XX] TITLE XIX

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

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES:
[ ] TITLE V
[ ] TITLE XVIII, PART A
[XX] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	28,123		5,756		30
31	INTENSIVE CARE UNIT	3,772		757		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	3,592				40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	593		438		43
44	SKILLED NURSING FACILITY	9,781		344		44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	45,861		7,295		200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0008** | **WORKSHEET D PART IV**

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

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(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
64	INTRAVENOUS THERAPY							64
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
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							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0008** | **WORKSHEET D PART IV**

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

		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)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	24,573,906							50
51	RECOVERY ROOM	8,732,595							51
52	DELIVERY ROOM & LABOR ROOM	7,537,645							52
53	ANESTHESIOLOGY	27,600,293							53
54	RADIOLOGY-DIAGNOSTIC	18,404,844							54
56	RADIOISOTOPE	7,309,497							56
56.01	ULTRASOUND	10,426,611							56.01
57	CT SCAN	51,657,474							57
59	CARDIAC CATHETERIZATION	19,965,125							59
60	LABORATORY	61,551,492							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	2,445,517							64
65	RESPIRATORY THERAPY	11,565,106							65
66	PHYSICAL THERAPY	13,715,305							66
69	ELECTROCARDIOLOGY	20,015,916							69
70	ELECTROENCEPHALOGRAPHY	1,865,496							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,451,073							71
72	IMPL. DEV. CHARGED TO PATIENTS	13,687,204							72
73	DRUGS CHARGED TO PATIENTS	25,911,442							73
73.01	OUTPATIENT PHARMACY	1,605,759							73.01
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	951,242							76.01
76.05	INPATIENT RENAL DIALYSIS	3,112,622							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	331,038							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	2,381,271							90.02
90.03	RIVER FOREST	322							90.03
91	EMERGENCY	58,562,805							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	18,506,875							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	422,868,475							200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0008** **WORKSHEET D PART V**

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

			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.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.478064							50
51	RECOVERY ROOM	0.092816							51
52	DELIVERY ROOM & LABOR ROOM	0.423849							52
53	ANESTHESIOLOGY	0.041789							53
54	RADIOLOGY-DIAGNOSTIC	0.246313							54
56	RADIOISOTOPE	0.111180							56
56.01	ULTRASOUND	0.108657							56.01
57	CT SCAN	0.030776							57
59	CARDIAC CATHETERIZATION	0.107969							59
60	LABORATORY	0.139561							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	0.684928							64
65	RESPIRATORY THERAPY	0.034394							65
66	PHYSICAL THERAPY	0.298321							66
69	ELECTROCARDIOLOGY	0.051280							69
70	ELECTROENCEPHALOGRAPHY	0.114247							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.558668							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.414322							72
73	DRUGS CHARGED TO PATIENTS	0.185394							73
73.01	OUTPATIENT PHARMACY	2.988632							73.01
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	0.529757							76.01
76.05	INPATIENT RENAL DIALYSIS	0.123566							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	0.059939							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	0.732379							90.02
90.03	RIVER FOREST	3,042.043478							90.03
91	EMERGENCY	0.125824							91
92	OBSERVATION BEDS (NON-DISTINCT PART)								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

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0008** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	28,123	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	28,123	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)	28,123	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	13,711	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	21,745,659	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	21,745,659	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	21,745,659	37

KPMG LLP COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0008** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS
[XX] TITLE XVIII, PART A [ ] IPF [ ] TEFRA
[ ] 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)	773.23	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	10,601,757	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)	10,601,757	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	7,443,525	3,772	1,973.36	1,916	3,780,958	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 (Worksheet D-3, column 3, line 200)	15,079,013	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	29,461,728	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	817,692	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	1,038,226	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	1,855,918	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	27,605,810	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0008** **WORKSHEET D-1 PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)						87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					773.23	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S008** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	3,592	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	3,592	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)	3,592	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	3,582	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	2,030,914	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,030,914	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	2,030,914	37

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S008** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	565.40	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	2,025,263	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)	2,025,263	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	210,582	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	2,235,845	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	44,059	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	8,615	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	52,674	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	2,183,171	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5526** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	9,781	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	9,781	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)	9,781	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	7,338	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	4,833,155	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,833,155	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	4,833,155	37

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5526** **WORKSHEET D-1 PARTS III & IV**

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

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

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST (line 37)	4,833,155	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (line 70 ÷ line 2)	494.14	71
72	PROGRAM ROUTINE SERVICE COST (line 9 x line 71)	3,625,999	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (line 14 x line 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (line 72 + line 73)	3,625,999	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (from Worksheet B, Part II, column 26, line 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (line 75 ÷ line 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (line 9 x line 76)		77
78	INPATIENT ROUTINE SERVICE COST (line 74 minus line 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (from provider records)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (line 78 minus line 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (line 9 x line 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (see instructions)	3,625,999	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (see instructions)	2,161,463	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (see instructions)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (sum of lines 83 through 85)	5,787,462	86

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0008** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	28,123	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	28,123	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)	28,123	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	5,756	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)	593	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	438	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)	21,737,365	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	21,737,365	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	21,737,365	37

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0008** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] PPS
[ ] TITLE XVIII, PART A [ ] IPF [ ] TEFRA
[XX] TITLE XIX - I/P [ ] IRF [XX] 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)					772.94	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					4,449,043	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)					4,449,043	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)	1,059,874	593	1,787.31	438	782,842	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	7,140,506	3,772	1,893.03	757	1,433,024	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 (Worksheet D-3, column 3, line 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					6,664,909	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					357,599	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					357,599	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0008** **WORKSHEET D-1 PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)						87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0008** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		36,675,248		30
31	INTENSIVE CARE UNIT		7,808,770		31
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.478969	6,924,183	3,316,469	50
51	RECOVERY ROOM	0.092816	2,711,353	251,657	51
52	DELIVERY ROOM & LABOR ROOM	0.423849	33,958	14,393	52
53	ANESTHESIOLOGY	0.055641	5,117,529	284,744	53
54	RADIOLOGY-DIAGNOSTIC	0.246313	3,316,200	816,823	54
56	RADIOISOTOPE	0.111180	258,823	28,776	56
56.01	ULTRASOUND	0.108657	1,379,156	149,855	56.01
57	CT SCAN	0.030776	7,616,962	234,420	57
59	CARDIAC CATHETERIZATION	0.107969	2,434,949	262,899	59
60	LABORATORY	0.139561	15,718,332	2,193,666	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.684928			64
65	RESPIRATORY THERAPY	0.034394	3,925,639	135,018	65
66	PHYSICAL THERAPY	0.298321	2,474,855	738,301	66
69	ELECTROCARDIOLOGY	0.051280	5,247,218	269,077	69
70	ELECTROENCEPHALOGRAPHY	0.114247	157,812	18,030	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.558668	6,133,144	3,426,391	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.414322			72
73	DRUGS CHARGED TO PATIENTS	0.185394	9,146,591	1,695,723	73
73.01	OUTPATIENT PHARMACY	2.988632			73.01
76	LITHOTRIPSY				76
76.01	CARDIAC REHABILITATION	0.529757			76.01
76.05	INPATIENT RENAL DIALYSIS	0.123566	1,669,873	206,340	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	0.059939			90
90.01	OUTPATIENT INFUSION PROCEDURES				90.01
90.02	WOUND CARE	0.732379			90.02
90.03	RIVER FOREST	3,042.043478			90.03
91	EMERGENCY	0.125824	8,237,150	1,036,431	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		2,121,676		92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		84,625,403	15,079,013	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		84,625,403		202

(A) Worksheet A line numbers

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S008** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF		7,741,151		40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.478969			50
51	RECOVERY ROOM	0.092816			51
52	DELIVERY ROOM & LABOR ROOM	0.423849			52
53	ANESTHESIOLOGY	0.055641			53
54	RADIOLOGY-DIAGNOSTIC	0.246313	30,837	7,596	54
56	RADIOISOTOPE	0.111180			56
56.01	ULTRASOUND	0.108657	11,691	1,270	56.01
57	CT SCAN	0.030776	122,878	3,782	57
59	CARDIAC CATHETERIZATION	0.107969			59
60	LABORATORY	0.139561	464,757	64,862	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.684928			64
65	RESPIRATORY THERAPY	0.034394	90,426	3,110	65
66	PHYSICAL THERAPY	0.298321	8,584	2,561	66
69	ELECTROCARDIOLOGY	0.051280	23,545	1,207	69
70	ELECTROENCEPHALOGRAPHY	0.114247	19,729	2,254	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.558668	3,182	1,778	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.414322			72
73	DRUGS CHARGED TO PATIENTS	0.185394	598,824	111,018	73
73.01	OUTPATIENT PHARMACY	2.988632			73.01
76	LITHOTRIPSY				76
76.01	CARDIAC REHABILITATION	0.529757			76.01
76.05	INPATIENT RENAL DIALYSIS	0.123566			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	0.059939			90
90.01	OUTPATIENT INFUSION PROCEDURES				90.01
90.02	WOUND CARE	0.732379			90.02
90.03	RIVER FOREST	3,042.043478			90.03
91	EMERGENCY	0.125824	88,566	11,144	91
92	OBSERVATION BEDS (NON-DISTINCT PART)				92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		1,463,019	210,582	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		1,463,019		202

(A) Worksheet A line numbers

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-5526** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.478064	122,765	58,690	50
51	RECOVERY ROOM	0.092816			51
52	DELIVERY ROOM & LABOR ROOM	0.423849			52
53	ANESTHESIOLOGY	0.041789	102,841	4,298	53
54	RADIOLOGY-DIAGNOSTIC	0.246313	143,092	35,245	54
56	RADIOISOTOPE	0.111180	17,677	1,965	56
56.01	ULTRASOUND	0.108657	87,697	9,529	56.01
57	CT SCAN	0.030776	6,830	210	57
59	CARDIAC CATHETERIZATION	0.107969	3,208	346	59
60	LABORATORY	0.139561	1,058,105	147,670	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.684928			64
65	RESPIRATORY THERAPY	0.034394	609,192	20,953	65
66	PHYSICAL THERAPY	0.298321	4,427,787	1,320,902	66
69	ELECTROCARDIOLOGY	0.051280	89,469	4,588	69
70	ELECTROENCEPHALOGRAPHY	0.114247	1,708	195	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.558668	444,702	248,441	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.414322			72
73	DRUGS CHARGED TO PATIENTS	0.185394	1,663,653	308,431	73
73.01	OUTPATIENT PHARMACY	2.988632			73.01
76	LITHOTRIPSY				76
76.01	CARDIAC REHABILITATION	0.529757			76.01
76.05	INPATIENT RENAL DIALYSIS	0.123566			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	0.059939			90
90.01	OUTPATIENT INFUSION PROCEDURES				90.01
90.02	WOUND CARE	0.732379			90.02
90.03	RIVER FOREST	3,042.043478			90.03
91	EMERGENCY	0.125824			91
92	OBSERVATION BEDS (NON-DISTINCT PART)				92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		8,778,726	2,161,463	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		8,778,726		202

(A) Worksheet A line numbers

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0008** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF				40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.478064			50
51	RECOVERY ROOM	0.092816			51
52	DELIVERY ROOM & LABOR ROOM	0.423849			52
53	ANESTHESIOLOGY	0.041789			53
54	RADIOLOGY-DIAGNOSTIC	0.246313			54
56	RADIOISOTOPE	0.111180			56
56.01	ULTRASOUND	0.108657			56.01
57	CT SCAN	0.030776			57
59	CARDIAC CATHETERIZATION	0.107969			59
60	LABORATORY	0.139561			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.684928			64
65	RESPIRATORY THERAPY	0.034394			65
66	PHYSICAL THERAPY	0.298321			66
69	ELECTROCARDIOLOGY	0.051280			69
70	ELECTROENCEPHALOGRAPHY	0.114247			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.558668			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.414322			72
73	DRUGS CHARGED TO PATIENTS	0.185394			73
73.01	OUTPATIENT PHARMACY	2.988632			73.01
76	LITHOTRIPSY				76
76.01	CARDIAC REHABILITATION	0.529757			76.01
76.05	INPATIENT RENAL DIALYSIS	0.123566			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	0.059939			90
90.01	OUTPATIENT INFUSION PROCEDURES				90.01
90.02	WOUND CARE	0.732379			90.02
90.03	RIVER FOREST	3,042.043478			90.03
91	EMERGENCY	0.125824			91
92	OBSERVATION BEDS (NON-DISTINCT PART)				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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS				1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)	5,638,094			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	17,914,282			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	44,485			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	3,802,860			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	211.00			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) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002				8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)	1.97			9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	4.11			10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)	1.97			12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	1.97			13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	1.97			14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	1.97			15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT	1.97			18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)	0.009336			19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)	0.009767			20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)	0.009336			21
22	IME PAYMENT ADJUSTMENT (see instructions)	139,266			22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)	2.14			24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)	139,266			29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0462			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.2097			31
32	SUM OF LINES 30 AND 31	0.2559			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.1033			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	1,045,051			34
		PRIOR TO	ON OR AFTER		
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		
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		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		1,142,999		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	1,142,999			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
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
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)	25,924,177			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	25,924,177			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	1,994,070			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)	73,771			52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	27,992,018			59
60	PRIMARY PAYER PAYMENTS	12,908			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	27,979,110			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	2,458,048			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	163,584			63
64	ALLOWABLE BAD DEBTS (see instructions)	473,068			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	307,494			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	377,885			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	25,664,972			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	56,485			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-13,588			70.94
71	AMOUNT DUE PROVIDER (see instructions)	25,707,869			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	514,157			71.01
72	INTERIM PAYMENTS	24,251,917			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	941,795			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	417,530			75

TO BE COMPLETED BY CONTRACTOR

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0008** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [XX] 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)	9,227,991			2
3	PPS PAYMENTS	9,384,705			3
4	OUTLIER PAYMENT (see instructions)	1,342			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	9,386,047			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	2,034,439			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	7,351,608			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)	17,716			28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	7,369,324			30
31	PRIMARY PAYER PAYMENTS	8,633			31
32	SUBTOTAL (line 30 minus line 31)	7,360,691			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)	289,514			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	188,184			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	256,949			36
37	SUBTOTAL (see instructions)	7,548,875			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	7,548,875			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	150,978			40.01
41	INTERIM PAYMENTS	7,208,552			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	189,345			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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

TO BE COMPLETED BY CONTRACTOR

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-5526** **WORKSHEET E PART B**

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

TO BE COMPLETED BY CONTRACTOR

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0008** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[XX] HOSPITAL [ ] SUB (OTHER) [ ] IPF [ ] SNF [ ] IRF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				24,188,563		7,207,538	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	03/17/2014	63,354	03/17/2014	1,014	3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	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		63,354		1,014	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)				24,251,917		7,208,552	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	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)		.01		1,455,952		340,323	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				25,707,869		7,548,875	7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-S008** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[ ] HOSPITAL [ ] SUB (OTHER) [XX] IPF [ ] SNF [ ] IRF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				2,965,337			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	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)				2,965,337			4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	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)		.01		81,840			6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				3,047,177			7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-5526** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[ ] HOSPITAL [ ] SUB (OTHER) [ ] IPF [XX] SNF [ ] IRF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				2,779,955			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	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)				2,779,955			4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	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)		.01		59,255			6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				2,839,210			7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK APPLICABLE BOX: **[XX] 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 FROM WKST S-3, PART I, COLUMN 15, LINE 14	7,647	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	15,627	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	2,436	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	31,895	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	529,760,926	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	20,107,331	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	1,456,856	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	29,137	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	1,427,719	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,521,201	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-93,482	32

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S008** **WORKSHEET E-3 PART II**

CHECK APPLICABLE BOX: **[ ] HOSPITAL** **[XX] SUBPROVIDER IPF**

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (excluding outlier, ECT, and medical education payments)	3,184,287	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		4
4.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)		8
9	AVERAGE DAILY CENSUS (see instructions)	9.841096	9
10	TEACHING ADJUSTMENT FACTOR {((1 + (line 8/line 9)) raised to the power of .5150 -1}		10
11	TEACHING ADJUSTMENT (line 1 multiplied by line 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (sum of lines 1, 2, 3 and 11)	3,184,287	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		15
16	SUBTOTAL (see instructions)	3,184,287	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (line 16 less line 17)	3,184,287	18
19	DEDUCTIBLES	129,536	19
20	SUBTOTAL (line 18 minus line 19)	3,054,751	20
21	COINSURANCE	28,896	21
22	SUBTOTAL (line 20 minus line 21)	3,025,855	22
23	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	32,803	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	21,322	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	27,949	25
26	SUBTOTAL (sum of lines 22 and 24)	3,047,177	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IPF only)		27
28	OTHER PASS THROUGH COSTS (see instructions)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	3,047,177	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	60,944	31.01
32	INTERIM PAYMENTS	2,965,337	32
33	TENTATIVE SETTLEMENT (for contractor use only)		33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)	20,896	34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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	3,079,345	1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
4	SUBTOTAL (sum of lines 1-3)	3,079,345	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	DO NOT USE THIS LINE		5
6	DEDUCTIBLES		6
7	COINSURANCE	242,656	7
8	ALLOWABLE BAD DEBTS (see instructions)	3,878	8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		9
10	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	2,521	10
11	UTILIZATION REVIEW		11
12	SUBTOTAL (sum of lines 4 and 5 minus 6 & 7 plus 10 and 11) (see instructions)	2,839,210	12
13	INPATIENT PRIMARY PAYER PAYMENTS		13
14	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		14
15	SUBTOTAL (line 12 minus 13 ± line 14)	2,839,210	15
15.01	SEQUESTRATION ADJUSTMENT (see instructions)	56,784	15.01
16	INTERIM PAYMENTS	2,779,955	16
17	TENTATIVE SETTLEMENT (for contractor use only)		17
18	BALANCE DUE PROVIDER/PROGRAM (line 15 minus 15.01, 16 and 17)	2,471	18
19	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0008** **WORKSHEET E-3 PART VII**

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	6,664,909		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	6,664,909		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	6,664,909		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	1	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)	6,664,909		18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)	6,664,909		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 Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

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

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			1.54	1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA				3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			0.23	3.01
4	ADJUSTMENT (plus or minus) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (see instructions for cost reporting periods straddling 7/1/2011				4.02
5	FTE ADJUSTED CAP (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			1.31	5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)			4.11	6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			1.31	7
		PRIMARY CARE	OTHER	TOTAL	
		1	2	3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	3.11	1.00	4.11	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	0.99	0.32	1.31	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		0.00		10
11	TOTAL WEIGHTED FTE COUNT	0.99	0.32		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	0.97	0.33		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	1.87	1.00		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	1.28	0.55		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	1.28	0.55		17
18	PER RESIDENT AMOUNT	83,287.86	83,287.86		18
19	APPROVED AMOUNT FOR RESIDENT COSTS	106,608	45,808	152,416	19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)			2.80	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)			152,416	25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	19,209	2,436		26
27	TOTAL INPATIENT DAYS (see instructions)	35,487	35,487		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.541297	0.068645		28
29	PROGRAM DIRECT GME AMOUNT	82,502	10,463		29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE		1,478		30
31	NET PROGRAM DIRECT GME AMOUNT			91,487	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)				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)			38,402,917	37
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)				38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)				39
40	PRIMARY PAYER PAYMENTS (see instructions)			12,908	40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)			38,390,009	41
	PART B REASONABLE COST				
42	REASONABLE COST (see instructions)			9,227,991	42
43	PRIMARY PAYER PAYMENTS (see instructions)			8,633	43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)			9,219,358	44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)			47,609,367	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)			0.806354	46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)			0.193646	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (line 31)			91,487	48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)			73,771	49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)			17,716	50

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

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

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996				1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA				3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	ADJUSTMENT (plus or minus) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (see instructions for cost reporting periods straddling 7/1/2011				4.02
5	FTE ADJUSTED CAP (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)				6
7	ENTER THE LESSER OF LINE 5 OR LINE 6				7
		PRIMARY CARE	OTHER	TOTAL	
		1	2	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		10
11	TOTAL WEIGHTED FTE COUNT	0.00	0.00		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	0.00	0.00		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	0.00	0.00		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	0.00	0.00		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	0.00	0.00		17
18	PER RESIDENT AMOUNT	0.00	0.00		18
19	APPROVED AMOUNT FOR RESIDENT COSTS				19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (see instructions)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (see instructions)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (sum of lines 19 and 24)				25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	6,513	921		26
27	TOTAL INPATIENT DAYS (see instructions)	35,487	35,487		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.183532	0.025953		28
29	PROGRAM DIRECT GME AMOUNT				29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE				30
31	NET PROGRAM DIRECT GME AMOUNT				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)				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 (Worksheet D-4, Part III, column 1, line 69)				38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)				39
40	PRIMARY PAYER PAYMENTS (see instructions)				40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)				41
	PART B REASONABLE COST				
42	REASONABLE COST (see instructions)				42
43	PRIMARY PAYER PAYMENTS (see instructions)				43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)				44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)				45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)				46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)				47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (line 31)				48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)				49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)				50

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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	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	16,634,460				1
2	TEMPORARY INVESTMENTS	-1,199,028				2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	25,709,756				4
5	OTHER RECEIVABLES	51,279,309				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-1,393,634				6
7	INVENTORY	3,111,212				7
8	PREPAID EXPENSES	511,253				8
9	OTHER CURRENT ASSETS	9,772,760				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	104,426,088				11
	FIXED ASSETS					
12	LAND	12,500,000				12
13	LAND IMPROVEMENTS	1,958,279				13
14	ACCUMULATED DEPRECIATION	-500,729				14
15	BUILDINGS	63,024,771				15
16	ACCUMULATED DEPRECIATION	-11,444,293				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	31,257,094				23
24	ACCUMULATED DEPRECIATION	-12,016,208				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)	84,778,914				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	6,827,859				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	6,827,859				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	196,032,861				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	73,859,921				37
38	SALARIES, WAGES & FEES PAYABLE	6,205,937				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	10,263,584				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	90,329,442				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	28,528,713				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	28,528,713				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	118,858,155				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	77,174,706				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	77,174,706				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	196,032,861				60

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STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		82,982,964			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		-3,353,479			2
3	TOTAL (sun of line 1 and line 2)		79,629,485			3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		79,629,485			11
12	DEDUCTIONS (debit adjustments)					12
13		2,454,779				13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		2,454,779			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		77,174,706			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 (sun of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	76,954,181		76,954,181	1
2	SUBPROVIDER IPF	7,752,211		7,752,211	2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY	7,619,916		7,619,916	7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	92,326,308		92,326,308	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	15,996,350		15,996,350	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)	15,996,350		15,996,350	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	108,322,658		108,322,658	17
18	ANCILLARY SERVICES	190,886,585		190,886,585	18
19	OUTPATIENT SERVICES		225,077,688	225,077,688	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY		3,631,436	3,631,436	22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER PATIENT REVENUES		1,353,189	1,353,189	27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	299,209,243	230,062,313	529,271,556	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		127,430,382	29
30	ADD (SPECIFY)			30
31	AFFILIATE	7,122,039		31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)		7,122,039	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)		134,552,421	43

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STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	529,271,556	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	419,737,694	2
3	NET PATIENT REVENUES (line 1 minus line 2)	109,533,862	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	134,552,421	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-25,018,559	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 OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (DAY CARE)		24
24.01	OTHER (REFERENCE LAB)		24.01
24.02	OTHER (MISCELLANEOUS)		24.02
24.03	OTHER (GAIN ON DISPOSALS)		24.03
24.04	OTHER (OTHER INCOME)	14,956,179	24.04
24.05	OTHER (PHYSICIAN INCOME)	5,465,565	24.05
24.06	OTHER (STRATEGIC SUPPORT)	1,243,336	24.06
25	TOTAL OTHER INCOME (sum of lines 6-24)	21,665,080	25
26	TOTAL (line 5 plus line 25)	-3,353,479	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	-3,353,479	29

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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 CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	467,506		39,349		96,904	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	825,085					6
7	PHYSICAL THERAPY	346,430					7
8	OCCUPATIONAL THERAPY	52,127					8
9	SPEECH PATHOLOGY						9
10	MEDICAL SOCIAL SERVICES	58,609					10
11	HOME HEALTH AIDE	50,906					11
12	SUPPLIES (see instructions)					33,882	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)	1,800,663		39,349		130,786	24

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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 CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	603,759		603,759		603,759	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	825,085		825,085		825,085	6
7	PHYSICAL THERAPY	346,430		346,430		346,430	7
8	OCCUPATIONAL THERAPY	52,127		52,127		52,127	8
9	SPEECH PATHOLOGY						9
10	MEDICAL SOCIAL SERVICES	58,609		58,609		58,609	10
11	HOME HEALTH AIDE	50,906		50,906		50,906	11
12	SUPPLIES (see instructions)	33,882		33,882		33,882	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)	1,970,798		1,970,798		1,970,798	24

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7255** **WORKSHEET H-1 PART I**

			CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL	603,759				5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE	825,085				6
7	PHYSICAL THERAPY	346,430				7
8	OCCUPATIONAL THERAPY	52,127				8
9	SPEECH PATHOLOGY					9
10	MEDICAL SOCIAL SERVICES	58,609				10
11	HOME HEALTH AIDE	50,906				11
12	SUPPLIES (see instructions)	33,882				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)	1,970,798				24

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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 CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL		603,759	603,759		5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE		825,085	364,402	1,189,487	6
7	PHYSICAL THERAPY		346,430	153,003	499,433	7
8	OCCUPATIONAL THERAPY		52,127	23,022	75,149	8
9	SPEECH PATHOLOGY					9
10	MEDICAL SOCIAL SERVICES		58,609	25,885	84,494	10
11	HOME HEALTH AIDE		50,906	22,483	73,389	11
12	SUPPLIES (see instructions)		33,882	14,964	48,846	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)		1,970,798		1,970,798	24

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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)	TRANSPORT-ATION (Mileage)	RECONCIL-IATION	ADMINI-STRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDGS & FIXTURES							1
2	CAPITAL RELATED-MOVABLE EQUIPMENT							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (see instructions)							4
5	ADMINISTRATIVE AND GENERAL					-603,759	1,367,039	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE						825,085	6
7	PHYSICAL THERAPY						346,430	7
8	OCCUPATIONAL THERAPY						52,127	8
9	SPEECH PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES						58,609	10
11	HOME HEALTH AIDE						50,906	11
12	SUPPLIES (see instructions)						33,882	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)					-603,759	1,367,039	24
25	COST TO BE ALLOC (per Worksheet H-1, Part I)						603,759	25
26	UNIT COST MULTIPLIER						0.441655	26

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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				121,974	121,974	18,770	1
2	SKILLED NURSING CARE	1,189,487			203,582	1,393,069	214,376	2
3	PHYSICAL THERAPY	499,433			85,478	584,911	90,011	3
4	OCCUPATIONAL THERAPY	75,149			12,862	88,011	13,544	4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES	84,494			14,461	98,955	15,228	6
7	HOME HEALTH AIDE	73,389			12,561	85,950	13,227	7
8	SUPPLIES	48,846				48,846	7,517	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)	1,970,798			450,918	2,421,716	372,673	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.

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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	8,353			152,003		45,421	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)	8,353			152,003		45,421	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.

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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		149,334		2,458			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			7,486				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)		149,334	7,486	2,458			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.

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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						498,313	1
2	SKILLED NURSING CARE						1,607,445	2
3	PHYSICAL THERAPY						674,922	3
4	OCCUPATIONAL THERAPY						101,555	4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES						114,183	6
7	HOME HEALTH AIDE						99,177	7
8	SUPPLIES						63,849	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)						3,159,444	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.

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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 (sum of col.4A-23)	ALLOCATED HHA A&G (see Pt.2)	TOTAL HHA COSTS			
		25	26	27	28			
1	ADMINISTRATIVE AND GENERAL		498,313					1
2	SKILLED NURSING CARE		1,607,445	301,005	1,908,450			2
3	PHYSICAL THERAPY		674,922	126,383	801,305			3
4	OCCUPATIONAL THERAPY		101,555	19,017	120,572			4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES		114,183	21,381	135,564			6
7	HOME HEALTH AIDE		99,177	18,571	117,748			7
8	SUPPLIES		63,849	11,956	75,805			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)		3,159,444	498,313	3,159,444			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.			0.187256				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.

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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			494,339		121,974	2,780	1
2	SKILLED NURSING CARE			825,085		1,393,069		2
3	PHYSICAL THERAPY			346,430		584,911		3
4	OCCUPATIONAL THERAPY			52,127		88,011		4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES			58,609		98,955		6
7	HOME HEALTH AIDE			50,906		85,950		7
8	SUPPLIES					48,846		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)			1,827,496		2,421,716	2,780	20
21	TOTAL COST TO BE ALLOCATED			450,918		372,673	8,353	21
22	UNIT COST MULTIPLIER			0.246741		0.153888		22
22	UNIT COST MULTIPLIER						3.004676	22

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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		2,442	2,442	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		2,442	2,442	20
21	TOTAL COST TO BE ALLOCATED			152,003		45,421		21
22	UNIT COST MULTIPLIER			123.179092		18.599918		22
22	UNIT COST MULTIPLIER							22

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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	2,442		1,141				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		41,993					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)	2,442	41,993	1,141				20
21	TOTAL COST TO BE ALLOCATED	149,334	7,486	2,458				21
22	UNIT COST MULTIPLIER	61.152334		2.154251				22
22	UNIT COST MULTIPLIER		0.178268					22

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7255** **WORKSHEET H-3 PARTS I & II**

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION

	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	1,908,450		1,908,450	7,824	243.92	1
2	PHYSICAL THERAPY	3	801,305	394,234	1,195,539	5,042	237.12	2
3	OCCUPATIONAL THERAPY	4	120,572		120,572	874	137.95	3
4	SPEECH PATHOLOGY	5						4
5	MEDICAL SOCIAL SERVICES	6	135,564		135,564	596	227.46	5
6	HOME HEALTH AIDE	7	117,748		117,748	1,616	72.86	6
7	TOTAL (sum of lines 1-6)		3,083,639	394,234	3,477,873	15,952		7

LIMITATION COST COMPUTATION

	PATIENT SERVICES	CBSA NO.	PROGRAM VISITS			
			PART A	PART B		
				NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	
		1	2	3	4	
8	SKILLED NURSING CARE	16974	1,236	4,851		8
9	PHYSICAL THERAPY	16974	765	2,530		9
10	OCCUPATIONAL THERAPY	16974	130	454		10
11	SPEECH PATHOLOGY	16974				11
12	MEDICAL SOCIAL SERVICES	16974	100	365		12
13	HOME HEALTH AIDE	16974	265	1,227		13
14	TOTAL (sum of lines 8-13)		2,496	9,427		14

SUPPLIES AND DRUGS COSTS 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 Record)	RATIO (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	75,805	21,648	97,453			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	0.298321	1,321,508	394,234	col. 2, line 2	1
2	OCCUPATIONAL THERAPY	67		23,431		col. 2, line 3	2
3	SPEECH PATHOLOGY	68				col. 2, line 4	3
4	MEDICAL SUPPLIES CHARGED TO PAT	71	0.558668	38,749	21,648	col. 2, line 15	4
5	DRUGS CHARGED TO PATIENTS	73	0.185394			col. 2, line 16	5
5.01	OUTPATIENT PHARMACY	73.01	2.988632			col. 2, line 16	5.01

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7255** **WORKSHEET H-3 PARTS I & II**

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		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	1,236	4,851		301,485	1,183,256		1,484,741	1
2	PHYSICAL THERAPY	765	2,530		181,397	599,914		781,311	2
3	OCCUPATIONAL THERAPY	130	454		17,934	62,629		80,563	3
4	SPEECH PATHOLOGY								4
5	MEDICAL SOCIAL SERVICES	100	365		22,746	83,023		105,769	5
6	HOME HEALTH AIDE	265	1,227		19,308	89,399		108,707	6
7	TOTAL (sum of lines 1-6)	2,496	9,427		542,870	2,018,221		2,561,091	7

SUPPLIES AND DRUGS COSTS COMPUTATIONS		PROGRAM COVERED CHARGES			COST OF SERVICES			
			PART B			PART B		
	OTHER PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINS-URANCE	SUBJECT TO DEDUCTIBLES & COINS-URANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINS-URANCE	SUBJECT TO DEDUCTIBLES & COINS-URANCE	
		6	7	8	9	10	11	
15	COST OF MEDICAL SUPPLIES							15
16	COST OF DRUGS							16

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

CALCULATION OF HHA REIMBURSEMRNT SETTLEMENT **HHA CCN: 14-7255** **WORKSHEET H-4 PARTS I & II**

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

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

			PART B		
		PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	
	DESCRIPTION	1	2	3	
	REASONABLE COST OF PART A & PART B SERVICES				
1	REASONABLE COST OF SERVICES (see instructions)				1
2	TOTAL CHARGES	3,631,436			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 I ACCORDANCE WITH 42 CFR 413.13(b)				4
5	RATIO OF LINE 3 TO LINE 4 (not to excced 1.000000)				5
6	TOTAL CUSTOMARY CHARGES (see instructions)	3,631,436			6
7	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (complete only if line 6 exceeds line 1)	3,631,436			7
8	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 1 exceeds line 6)				8
9	PRIMARY PAYER PAYMENTS				9

COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		PART A SERVICES	PART B SERVICES	
	DESCRIPTION	1	2	
10	TOTAL REASONABLE COST (see instructions)			10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	356,718	1,370,363	11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	14,395	23,718	12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES			13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES			14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	2,868	5,195	15
16	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17	TOTAL OTHER PAYMENTS			17
18	DME PAYMENTS			18
19	OXYGEN PAYMENTS			19
20	PROSTHETIC AND ORTHOTIC PAYMENTS			20
21	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (exclude coinsurance)			21
22	SUBTOTAL (sum of lines 10-20 minus line 21)	373,981	1,399,276	22
23	EXCESS REASONABLE COST (from line 8)			23
24	SUBTOTAL (line 22 minus line 23)	373,981	1,399,276	24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (from your records)			25
26	NET COST (line 24 minus line 25)	373,981	1,399,276	26
27	REIMBURSABLE BAD DEBTS (from your records)			27
28	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			28
29	TOTAL COSTS - CURRENT COST REPORTING PERIOD (line 26 plus line 27)	373,981	1,399,276	29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			30
31	SUBTOTAL (line 29 plus/minus line 30)	373,981	1,399,276	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	7,479	27,985	31.01
32	INTERIM PAYMENTS (see instructions)	366,502	1,371,291	32
33	TENTATIVE SETTLEMENT (for contractor use only)			33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)			34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115-2			35

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **HHA CCN: 14-7255** **WORKSHEET H-5**

				PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				366,502		1,371,291	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	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)				366,502		1,371,291	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	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)		.01		7,479		27,985	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				373,981		1,399,276	7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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	124,426				92,151	6
	INPATIENT CARE SERVICE						
7	INPATIENT - GENERAL CARE						7
8	INPATIENT - RESPITE CARE						8
	VISITING SERVICES						
9	PHYSICIAN SERVICES						9
10	NURSING CARE	101,950					10
11	NURSING CARE-CONTINUOUS HOME CARE						11
12	PHYSICAL THERAPY	449					12
13	OCCUPATIONAL THERAPY						13
14	SPEECH/LANGUAGE PATHOLOGY						14
15	MEDICAL SOCIAL SERVICES	13,027					15
16	SPIRITUAL COUNSELING	6,769					16
17	DIETARY COUNSELING						17
18	COUNSELING - OTHER	19,219					18
19	HOME HEALTH AIDE AND HOMEMAKER	13,550					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)	279,390				92,151	39

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS **HOSPICE CCN: 14-1561** **WORKSHEET K**

		TOTAL (cols. 1-5)	RECLASSI-FICATION	SUBTOTAL (col. 6 ± col. 7)	ADJUST-MENTS	TOTAL (col. 8 ± col. 9)	
		6	7	8	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	216,577		216,577		216,577	6
	INPATIENT CARE SERVICE						
7	INPATIENT - GENERAL CARE						7
8	INPATIENT - RESPITE CARE						8
	VISITING SERVICES						
9	PHYSICIAN SERVICES						9
10	NURSING CARE	101,950		101,950		101,950	10
11	NURSING CARE-CONTINUOUS HOME CARE						11
12	PHYSICAL THERAPY	449		449		449	12
13	OCCUPATIONAL THERAPY						13
14	SPEECH/LANGUAGE PATHOLOGY						14
15	MEDICAL SOCIAL SERVICES	13,027		13,027		13,027	15
16	SPIRITUAL COUNSELING	6,769		6,769		6,769	16
17	DIETARY COUNSELING						17
18	COUNSELING - OTHER	19,219		19,219		19,219	18
19	HOME HEALTH AIDE AND HOMEMAKER	13,550		13,550		13,550	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)	371,541		371,541		371,541	39

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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 EQUI						2
3	PLANT OPERATION AND MAINTENANCE						3
4	TRANSPORTATION - STAFF						4
5	VOLUNTEER SERVICE COORDINATION						5
6	ADMINISTRATIVE AND GENERAL	809			98,673		6
	INPATIENT CARE SERVICE						
7	INPATIENT - GENERAL CARE						7
8	INPATIENT - RESPITE CARE						8
	VISITING SERVICES						
9	PHYSICIAN SERVICES						9
10	NURSING CARE					101,950	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)	809			98,673	101,950	39

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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			24,944	124,426	6
	INPATIENT CARE SERVICE					
7	INPATIENT - GENERAL CARE					7
8	INPATIENT - RESPITE CARE					8
	VISITING SERVICES					
9	PHYSICIAN SERVICES					9
10	NURSING CARE				101,950	10
11	NURSING CARE-CONTINUOUS HOME CARE					11
12	PHYSICAL THERAPY	449			449	12
13	OCCUPATIONAL THERAPY					13
14	SPEECH/LANGUAGE PATHOLOGY					14
15	MEDICAL SOCIAL SERVICES			13,027	13,027	15
16	SPIRITUAL COUNSELING			6,769	6,769	16
17	DIETARY COUNSELING					17
18	COUNSELING - OTHER			19,219	19,219	18
19	HOME HEALTH AIDE AND HOMEMAKER		13,550		13,550	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)	449	13,550	63,959	279,390	39

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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 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

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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 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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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.

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COST ALLOCATION - HOSPICE GENERAL SERVICE COST **HOSPICE CCN: 14-1561** **WORKSHEET K-4 PART I**

			CAPITAL RELATED COSTS				
	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANS-PORTATION	
		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	216,577					6
	INPATIENT CARE SERVICE						
7	INPATIENT - GENERAL CARE						7
8	INPATIENT - RESPITE CARE						8
	VISITING SERVICES						
9	PHYSICIAN SERVICES						9
10	NURSING CARE	101,950					10
11	NURSING CARE-CONTINUOUS HOME CARE						11
12	PHYSICAL THERAPY	449					12
13	OCCUPATIONAL THERAPY						13
14	SPEECH/LANGUAGE PATHOLOGY						14
15	MEDICAL SOCIAL SERVICES	13,027					15
16	SPIRITUAL COUNSELING	6,769					16
17	DIETARY COUNSELING						17
18	COUNSELING - OTHER	19,219					18
19	HOME HEALTH AIDE AND HOMEMAKER	13,550					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)	371,541					39

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COST ALLOCATION - HOSPICE GENERAL SERVICE COST **HOSPICE CCN: 14-1561** **WORKSHEET K-4 PART I**

		VOLUNTEER SERVICES COORDI-NATOR	SUBTOTAL (cols. 0 - 5)	ADMINIS-TRATIVE & 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		216,577	216,577		6
	INPATIENT CARE SERVICE					
7	INPATIENT - GENERAL CARE					7
8	INPATIENT - RESPITE CARE					8
	VISITING SERVICES					
9	PHYSICIAN SERVICES					9
10	NURSING CARE		101,950	142,486	244,436	10
11	NURSING CARE-CONTINUOUS HOME CARE					11
12	PHYSICAL THERAPY		449	628	1,077	12
13	OCCUPATIONAL THERAPY					13
14	SPEECH/LANGUAGE PATHOLOGY					14
15	MEDICAL SOCIAL SERVICES		13,027	18,206	31,233	15
16	SPIRITUAL COUNSELING		6,769	9,460	16,229	16
17	DIETARY COUNSELING					17
18	COUNSELING - OTHER		19,219	26,860	46,079	18
19	HOME HEALTH AIDE AND HOMEMAKER		13,550	18,937	32,487	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)		371,541		371,541	39

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

COST ALLOCATION - HOSPICE STATISTICAL BASIS **HOSPICE CCN: 14-1561** **WORKSHEET K-4 PART II**

		CAPITAL RELATED COSTS							
	COST CENTER DESCRIPTIONS	BUILDINGS & FIXTURES (Sq. Ft.)	MOVABLE EQUIPMENT ($ Value)	PLANT OPERATION & MAINT. (Sq. Ft.)	TRANS-PORTATION (Mileage)	VOLUNTEER SERVICES COORDI-NATOR (Hours)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Acc. Cost)	
		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						-216,577	154,964	6
	INPATIENT CARE SERVICE								
7	INPATIENT - GENERAL CARE								7
8	INPATIENT - RESPITE CARE								8
	VISITING SERVICES								
9	PHYSICIAN SERVICES								9
10	NURSING CARE							101,950	10
11	NURSING CARE-CONTINUOUS HOME CARE								11
12	PHYSICAL THERAPY							449	12
13	OCCUPATIONAL THERAPY								13
14	SPEECH/LANGUAGE PATHOLOGY								14
15	MEDICAL SOCIAL SERVICES							13,027	15
16	SPIRITUAL COUNSELING							6,769	16
17	DIETARY COUNSELING								17
18	COUNSELING - OTHER							19,219	18
19	HOME HEALTH AIDE AND HOMEMAKER							13,550	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)							216,577	39
40	UNIT COST MULTIPLIER							1.397596	40

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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				30,702	30,702	4,725	1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE	244,436			25,155	269,591	41,486	5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY	1,077			111	1,188	183	7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES	31,233			3,214	34,447	5,301	10
11	SPIRITUAL COUNSELING	16,229			1,670	17,899	2,754	11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER	46,079			4,742	50,821	7,821	13
14	HOME HEALTH AIDE AND HOMEMAKER	32,487			3,343	35,830	5,514	14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. 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/							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)	371,541			68,937	440,478	67,784	34
35	UNIT COST MULTIPLIER (see instruc							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.

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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	1,469			6,898		7,421	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							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. 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/							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)	1,469			6,898		7,421	34
35	UNIT COST MULTIPLIER (see instruc							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.

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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		24,400	2,027	42,498			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							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. 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/							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)		24,400	2,027	42,498			34
35	UNIT COST MULTIPLIER (see instruc							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.

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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						120,140	1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE						311,077	5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY						1,371	7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES						39,748	10
11	SPIRITUAL COUNSELING						20,653	11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER						58,642	13
14	HOME HEALTH AIDE AND HOMEMAKER						41,344	14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. 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/							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)						592,975	34
35	UNIT COST MULTIPLIER (see instruc							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.

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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		120,140					1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE		311,077	79,040	390,117			5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY		1,371	348	1,719			7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES		39,748	10,099	49,847			10
11	SPIRITUAL COUNSELING		20,653	5,248	25,901			11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER		58,642	14,900	73,542			13
14	HOME HEALTH AIDE AND HOMEMAKER		41,344	10,505	51,849			14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. 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/							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)		592,975		592,975			34
35	UNIT COST MULTIPLIER (see instruc			0.254084				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.

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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			124,426		30,702	489	1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE			101,950		269,591		5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY			449		1,188		7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES			13,027		34,447		10
11	SPIRITUAL COUNSELING			6,769		17,899		11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER			19,219		50,821		13
14	HOME HEALTH AIDE AND HOMEMAKER			13,550		35,830		14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. 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/							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)			279,390		440,478	489	34
35	TOTAL COST TO BE ALLOCATED			68,937		67,784	1,469	35
36	UNIT COST MULTIPLIER			0.246741		0.153887		36
36	UNIT COST MULTIPLIER						3.004090	36

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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		399	399	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							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. 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/							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		399	399	34
35	TOTAL COST TO BE ALLOCATED			6,898		7,421		35
36	UNIT COST MULTIPLIER			123.178571		18.598997		36
36	UNIT COST MULTIPLIER							36

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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	399	11,368	19,729				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							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. 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/							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)	399	11,368	19,729				34
35	TOTAL COST TO BE ALLOCATED	24,400	2,027	42,498				35
36	UNIT COST MULTIPLIER	61.152882		2.154088				36
36	UNIT COST MULTIPLIER		0.178308					36

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. 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/							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							36
36	UNIT COST MULTIPLIER							36

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

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	0.298321			1
2	OCCUPATIONAL THERAPY	67				2
3	SPEECH/LANGUAGE PATHOLOGY	68				3
4	DRUGS, BIOLOGICAL AND INFUSION THERAPY	73	0.185394			4
4.01	OUTPATIENT PHARMACY	73.01	2.988632			4.01
5	DURABLE MEDICAL EQUIPMENT/OXYGEN	96				5
6	LABS AND DIAGNOSTICS	60	0.139561			6
7	MEDICAL SUPPLIES	71	0.558668			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	0.529757			10.01
10.05	INPATIENT RENAL DIALYSIS	76.05	0.123566			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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

CALCULATION OF HOSPICE PER DIEM COST **HOSPICE CCN: 14-1561** **WORKSHEET K-6**

	COMPUTATION OF PER DIEM COSTS	TITLE XVIII	TITLE XIX	OTHER	TOTAL	
		1	2	3	4	
1	TOTAL COST (see instructions)				592,975	1
2	TOTAL UNDUPLICATED DAYS (Worksheet S-9, column 6, line 5)				3,110	2
3	AVERAGE COST PER DIEM (line 1 divided by line 2)				190.67	3
4	UNDUPLICATED MEDICARE DAYS (Worksheet S-9, column 1, line 5)	2,745				4
5	AGGREGATE MEDICARE COST (line 3 times line 4)	523,389				5
6	UNDUPLICATED MEDICAID DAYS (Worksheet S-9, column 2, line 5)		108			6
7	AGGREGATE MEDICAID COST (line 3 times line 6)		20,592			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)			257		12
13	AGGREGATE COST FOR OTHER DAYS (line 3 times line 12)			49,002		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.

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0008** **WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	1,879,827	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	2,393	2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	88.20	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)	1.97	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)	0.63	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)	11,843	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.0462	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.2097	8
9	SUM OF LINES 7 AND 8	0.2559	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0532	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	100,007	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	1,994,070	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
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
64	INTRAVENOUS THERAPY							64
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
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
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
193	NONPAID WORKERS							193

KPMG LLP

COMPU-MAX

GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/21/2014 Run Time: 07:35 Version: 2014.10

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202