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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 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: 02/26/2015 TIME: 16:17 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 NORTHWEST COMMUNITY HOSPITAL (14-0252) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 10/01/2013 AND ENDING 09/30/2014, 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		61,132	27,557	-81,168		1
2	SUBPROVIDER - IPF		36,389				2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		97,521	27,557	-81,168		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

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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: 800 WEST CENTRAL ROAD	P.O. Box:		1
2	City: ARLINGTON HEIGHTS	State: IL	ZIP Code: 60005	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	NORTHWEST COMMUNITY HOSPITAL	14-0252	16974	1	07/01/1966	N	P	O	3
4	Subprovider - IPF	NWCH PSYCHIATRIC UNIT	14-S252	16974	4	11/01/1985	N	P	O	4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	NORTHWEST COMMUNITY HOME CARE SERVIC	14-7094	16974		07/01/1966	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									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: 10 / 01 / 2013	To: 09 / 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.	N	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	N	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.	6,944				1,266		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	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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.	N			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)	Y			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	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.					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.			N		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:		4,499,357			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)	N		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:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Worksheet A, 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			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)	0.50			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10/01/2013	09/30/2014	170

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 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)	N			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.	Y			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.		Y		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.		N		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
BAD DEBTS				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
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)	Y	02/09/2015	Y	02/09/2015	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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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: RAJ	LAST NAME: SHAH	TITLE: SR. REIMBURSEMENT CONSULTA	41
42	EMPLOYER: STRATEGIC REIMBURSEMENT GROUP, LLC			42
43	PHONE NUMBER: 630-530-7100 EXT 107	E-MAIL ADDRESS: RAJ.SHAH@SRGROUPLLC.COM		43

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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	268	97,820			29,847	4,654	58,326	1
2	HMO AND OTHER (see instructions)						3,021	1,266		2
3	HMO IPF SUBPROVIDER						105	259		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)		268	97,820			29,847	4,654	58,326	7
8	INTENSIVE CARE UNIT	31	60	21,900			4,239		8,537	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	NEONATAL INTENSIVE CARE UNIT	35	8	2,920					923	12
13	NURSERY	43						2,290	8,440	13
14	TOTAL (see instructions)		336	122,640			34,086	6,944	76,226	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40	32	11,680			1,548	2,364	8,993	16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101					29,638		44,326	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)		368							27
28	OBSERVATION BED DAYS								5,503	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 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)					7,579	1,481	17,148	1
2	HMO AND OTHER (see instructions)					671	344		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	NEONATAL INTENSIVE CARE UNIT								12
13	NURSERY								13
14	TOTAL (see instructions)		2,344.64			7,579	1,481	17,148	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF		51.88			202	321	1,318	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		62.72						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)		2,459.24						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	169,010,377	2,248,418	171,258,795	5,077,210.00	33.73	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							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						9
10	EXCLUDED AREA SALARIES (see instructions)		12,514,989	-562,041	11,952,948	314,835.00	37.97	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		3,701,282		3,701,282	55,238.00	67.01	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							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)		49,649,796		49,649,796			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		3,914,273		3,914,273			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							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		2,588,352		2,588,352	44,169.00	58.60	26
27	ADMINISTRATIVE & GENERAL		24,720,773	2,248,418	26,969,191	623,344.00	43.27	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)		5,734,866		5,734,866	38,308.00	149.70	28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		3,948,850		3,948,850	134,027.00	29.46	30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING		3,319,367		3,319,367	233,768.00	14.20	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		2,803,218	-1,303,161	1,500,057	86,757.00	17.29	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA			1,303,161	1,303,161	75,375.00	17.29	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		8,486,595		8,486,595	193,968.00	43.75	38
39	CENTRAL SERVICES AND SUPPLY		1,418,567		1,418,567	85,139.00	16.66	39
40	PHARMACY		3,990,719		3,990,719	91,404.00	43.66	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		2,374,005		2,374,005	94,905.00	25.01	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)	174,745,243	2,248,418	176,993,661	5,115,518.00	34.60	1
2	EXCLUDED AREA SALARIES (see instructions)	12,514,989	-562,041	11,952,948	314,835.00	37.97	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	162,230,254	2,810,459	165,040,713	4,800,683.00	34.38	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)	3,701,282		3,701,282	55,238.00	67.01	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)	49,649,796		49,649,796		30.08%	5

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

6	TOTAL (sum of lines 3 through 5)		215,581,332	2,810,459	218,391,791	4,855,921.00	44.97	6
7	TOTAL OVERHEAD COST (see instructions)		59,385,312	2,248,418	61,633,730	1,701,164.00	36.23	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	8,358,800	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	72,539	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	8,413,423	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)	19,722,241	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	1,188,169	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	157,967	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	688,548	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	1,161,308	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	11,755,108	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	374,743	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES	294	20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)	418,344	21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	1,252,585	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	53,564,069	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 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	09/30/2018		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)	10/01/2013	09/30/2014	2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH	4/01/2014		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)	10/01/2012		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)	10/01/2015		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	10/01/2012		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5	10/01/2015		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
11.01		09/30/2013	8,400,000	11.01
11.02		09/30/2014	8,400,000	11.02
11.03		09/30/2015	8,400,000	11.03
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)	36		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD	25,200,000		13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)	700,000		14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2	12		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)	8,400,000		16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)	13,423		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)	13,423		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	8,413,423		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: 14-7094** **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		2,228		953	3,181	1
2	UNDUPLICATED CENSUS COUNT (see instructions)		1,987.00		996.00	2,983.00	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)	1.00		1.00	3
4	DIRECTOR(S) AND ASSISTANT DIRECTOR(S)				4
5	OTHER ADMINISTRATIVE PERSONNEL	21.71		21.71	5
6	DIRECT NURSING SERVICE	20.35		20.35	6
7	NURSING SUPERVISOR				7
8	PHYSICAL THERAPY SERVICE	14.47		14.47	8
9	PHYSICAL THERAPY SUPERVISOR				9
10	OCCUPATIONAL THERAPY SERVICE	1.55		1.55	10
11	OCCUPATIONAL THERAPY SUPERVISOR				11
12	SPEECH PATHOLOGY SERVICE	0.22		0.22	12
13	SPEECH PATHOLOGY SUPERVISOR				13
14	MEDICAL SOCIAL SERVICE	1.88		1.88	14
15	MEDICAL SOCIAL SERVICE SUPERVISOR				15
16	HOME HEALTH AIDE	1.53		1.53	16
17	HOME HEALTH AIDE SUPERVISOR				17
18	CONTINUUM PERSONNEL				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).	11340	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	14,460	17	709	729	15,915	21
22	SKILLED NURSING VISIT CHARGES	2,207,059	2,640	86,594	109,825	2,406,118	22
23	PHYSICAL THERAPY VISITS	9,990	15	263	436	10,704	23
24	PHYSICAL THERAPY VISIT CHARGES	2,294,331	3,495	49,862	100,656	2,448,344	24
25	OCCUPATIONAL THERAPY VISITS	1,087	3	1	57	1,148	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	253,271	699	233	13,281	267,484	26
27	SPEECH PATHOLOGY VISITS	160			4	164	27
28	SPEECH PATHOLOGY VISIT CHARGES	37,280			932	38,212	28
29	MEDICAL SOCIAL SERVICE VISITS	439		1	30	470	29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	92,418		211	6,330	98,959	30
31	HOME HEALTH AIDE VISITS	1,176	6		55	1,237	31
32	HOME HEALTH AIDE VISIT CHARGES	135,252	702		6,435	142,389	32
33	TOTAL VISITS (sum of lines 21, 23, 25, 27, 29, and 31)	27,312	41	974	1,311	29,638	33
34	OTHER CHARGES						34
35	TOTAL CHARGES (sum of lines 22, 24, 26, 28, 30, 32 and 34)	5,019,611	7,536	136,900	237,459	5,401,506	35
36	TOTAL NUMBER OF EPISODES (standard/non-outlier)	2,085		253	109	2,447	36
37	TOTAL NUMBER OF OUTLIER EPISODES				1	1	37
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	165,766	110	4,756	6,069	176,701	38

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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)	0.239744	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	12,514,148	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	102,710,930	6
7	MEDICAID COST (line 1 times line 6)	24,624,329	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.	12,110,181	8

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

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED 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		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	12,110,181	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	54,789,935		54,789,935	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	13,135,558		13,135,558	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				22
23	COST OF CHARITY CARE (line 21 minus line 22)	13,135,558		13,135,558	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?		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)	4,907,383	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	646,324	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	4,261,059	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	1,021,563	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	14,157,121	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	26,267,302	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		62,589,417	62,589,417	-36,922,488	25,666,929	6,342,373	32,009,302	1
2	00200	CAP REL COSTS-MVBLE EQUIP				14,375,309	14,375,309	193,629	14,568,938	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	2,588,352	35,166,489	37,754,841		37,754,841	-26,649	37,728,192	4
5	00500	ADMINISTRATIVE & GENERAL	24,720,773	34,970,477	59,691,250	22,523,290	82,214,540	-25,420,166	56,794,374	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	3,948,850	7,567,504	11,516,354	215,468	11,731,822	-5,269	11,726,553	7
8	00800	LAUNDRY & LINEN SERVICE								8
9	00900	HOUSEKEEPING	3,319,367	3,335,581	6,654,948		6,654,948		6,654,948	9
10	01000	DIETARY	2,803,218	2,715,889	5,519,107	-2,565,725	2,953,382	-39,692	2,913,690	10
11	01100	CAFETERIA				2,565,725	2,565,725	-1,696,323	869,402	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	8,486,595	1,232,279	9,718,874		9,718,874	-130,785	9,588,089	13
14	01400	CENTRAL SERVICES & SUPPLY	1,418,567	1,543,911	2,962,478	-911,500	2,050,978	95	2,051,073	14
15	01500	PHARMACY	3,990,719	16,424,864	20,415,583	-15,893,194	4,522,389	-19,500	4,502,889	15
16	01600	MEDICAL RECORDS & LIBRARY	2,374,005	3,093,467	5,467,472	-67	5,467,405	-370,242	5,097,163	16
17	01700	SOCIAL SERVICE								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								22
23	02300	PARAMED ED PRGM-(SPECIFY)				218,446	218,446	-263,649	-45,203	23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	29,551,197	6,805,549	36,356,746	-9,410,047	26,946,699	-1,212,751	25,733,948	30
31	03100	INTENSIVE CARE UNIT	8,166,903	2,514,743	10,681,646	-884,838	9,796,808	-824,880	8,971,928	31
35	02060	NEONATAL INTENSIVE CARE UNIT	2,290,310	518,256	2,808,566	-172,330	2,636,236		2,636,236	35
40	04000	SUBPROVIDER - IPF	3,933,676	589,190	4,522,866	-361,301	4,161,565	-115,597	4,045,968	40
43	04300	NURSERY				921,808	921,808		921,808	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	11,687,349	25,237,442	36,924,791	-21,074,462	15,850,329	-423,935	15,426,394	50
52	05200	DELIVERY ROOM & LABOR ROOM				6,063,364	6,063,364		6,063,364	52
53	05300	ANESTHESIOLOGY	115,405	746,613	862,018	-714,771	147,247		147,247	53
54	05400	RADIOLOGY-DIAGNOSTIC	12,605,674	8,940,169	21,545,843	-2,264,053	19,281,790	-22,260	19,259,530	54
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	1,661,043	1,590,971	3,252,014	-37,708	3,214,306	-27,975	3,186,331	54.01
56.01	03480	ONCOLOGY	1,173,838	236,813	1,410,651	-76,662	1,333,989	-3,093	1,330,896	56.01
60	06000	LABORATORY	5,333,915	6,295,093	11,629,008	-187,499	11,441,509	-89,752	11,351,757	60
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	533,671	1,991,867	2,525,538	-1,517	2,524,021		2,524,021	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	2,202,110	739,661	2,941,771	-412,255	2,529,516		2,529,516	65
66	06600	PHYSICAL THERAPY	5,754,852	1,776,922	7,531,774	-192,315	7,339,459	-248,075	7,091,384	66
69	06900	ELECTROCARDIOLOGY	2,318,743	1,138,922	3,457,665	-99,906	3,357,759	-410,856	2,946,903	69
69.01	03630	CARDIAC CATH LAB	1,747,618	6,724,278	8,471,896	-5,883,648	2,588,248	-23,777	2,564,471	69.01
69.02	03160	CARDIAC REHABILITATION	708,143	278,289	986,432	-6,005	980,427	-103,766	876,661	69.02
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				22,091,808	22,091,808		22,091,808	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				15,167,532	15,167,532		15,167,532	72
73	07300	DRUGS CHARGED TO PATIENTS				15,732,949	15,732,949		15,732,949	73
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS				114,052	114,052		114,052	73.01
74	07400	RENAL DIALYSIS		778,735	778,735	-9,710	769,025	-2,180	766,845	74
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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	4,405,025	1,795,347	6,200,372	-320,336	5,880,036		5,880,036	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM				1,341,335	1,341,335		1,341,335	90.02
91	09100	EMERGENCY	12,589,146	4,276,234	16,865,380	-2,445,494	14,419,886	-4,429	14,415,457	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

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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	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
101	10100	HOME HEALTH AGENCY	5,074,919	872,772	5,947,691	808	5,948,499		5,948,499	101
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	165,503,983	242,487,744	407,991,727	484,063	408,475,790	-24,949,504	383,526,286	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	141,476	243,498	384,974		384,974		384,974	190
192	19200	PHYSICIANS' PRIVATE OFFICES		1,308,141	1,308,141		1,308,141		1,308,141	192
192.01	19201	DAY SURGERY CENTER								192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	1,285,810	224,160	1,509,970	-978,309	531,661		531,661	192.02
192.03	19203	MOBILE DENTAL CLINIC	222,008	81,538	303,546		303,546		303,546	192.03
192.04	19204	EMS CONTINUING EDUCATION				494,246	494,246		494,246	192.04
194	07950	CORPORATE HEALTH	110,009	67,887	177,896		177,896		177,896	194
194.01	07951	MARKETING/COMMUNICATION	501,223	1,810,611	2,311,834		2,311,834		2,311,834	194.01
194.02	07952	FOUNDATION								194.02
194.03	07953	OTHER NRCC	1,245,868	945,296	2,191,164		2,191,164	6,790,649	8,981,813	194.03
200		TOTAL (sum of lines 118-199)	169,010,377	247,168,875	416,179,252		416,179,252	-18,158,855	398,020,397	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES			
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	SHARED EXPENSES	A	CAFETERIA	11	1,303,161	1,262,564	1
500	TOTAL RECLASSIFICATIONS				1,303,161	1,262,564	500
	CODE LETTER - A						
1	FLOAT POOL	B	INTENSIVE CARE UNIT	31	37,113	3,034	1
2			SUBPROVIDER - IPF	40	12,205	998	2
3			NEONATAL INTENSIVE CARE UNIT	35	3,238	265	3
4			OPERATING ROOM	50	747	61	4
5			EMERGENCY	91	3,736	305	5
6			HOME HEALTH AGENCY	101	747	61	6
500	TOTAL RECLASSIFICATIONS				57,786	4,724	500
	CODE LETTER - B						
1	TREATMENT CENTER LEASE EXP	C	CAP REL COSTS-BLDG & FIXT	1		149,840	1
500	TOTAL RECLASSIFICATIONS					149,840	500
	CODE LETTER - C						
1	COST OF MEDICAL SUPPLIES SOLD	D	MEDICAL SUPPLIES CHARGED TO P	71		22,091,808	1
2			IMPL. DEV. CHARGED TO PATIENT	72		15,167,532	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
500	TOTAL RECLASSIFICATIONS					37,259,340	500
	CODE LETTER - D						
1	COST OF DRUGS SOLD	E	DRUGS CHARGED TO PATIENTS	73		15,834,589	1
500	TOTAL RECLASSIFICATIONS					15,834,589	500
	CODE LETTER - E						
1	PARAMEDICAL EDUCATION	F	PARAMED ED PRGM-(SPECIFY)	23	181,151	37,295	1
2			EMS CONTINUING EDUCATION	192.04	409,864	84,382	2
500	TOTAL RECLASSIFICATIONS				591,015	121,677	500
	CODE LETTER - F						
1	NON DEPT ITEMS-COST ALLOCATION	G	CAP REL COSTS-MVBLE EQUIP	2		14,325,685	1
2			ADMINISTRATIVE & GENERAL	5		22,887,531	2
500	TOTAL RECLASSIFICATIONS					37,213,216	500
	CODE LETTER - G						
1	SALT CREEK OCCUPANCY COSTS	H	CAP REL COSTS-BLDG & FIXT	1		23,234	1
2			OPERATION OF PLANT	7		215,468	2
500	TOTAL RECLASSIFICATIONS					238,702	500
	CODE LETTER - H						
1	PARTIAL HOSPITALIZATION PROGRAM	I	PARTIAL HOSPITALIZATION PROGR	90.02	1,166,008	175,327	1
2							2
500	TOTAL RECLASSIFICATIONS				1,166,008	175,327	500
	CODE LETTER - I						
1	PROPERTY INSURANCE	J	CAP REL COSTS-BLDG & FIXT	1		117,654	1
2			CAP REL COSTS-MVBLE EQUIP	2		49,624	2
3							3
500	TOTAL RECLASSIFICATIONS					167,278	500

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
	CODE LETTER - J						
1	LDR COST ALLOCATION	K	NURSERY	43	797,026	124,782	1
2			DELIVERY ROOM & LABOR ROOM	52	4,758,455	1,304,909	2
500	TOTAL RECLASSIFICATIONS				5,555,481	1,429,691	500
	CODE LETTER - K						
1	OUTCOME BONUS	L	ADMINISTRATIVE & GENERAL	5	2,248,418		1
500	TOTAL RECLASSIFICATIONS				2,248,418		500
	CODE LETTER - L						
1	VACCINE COST	M	FLU VACCINE DRUGS CHG TO PATI	73.01		114,052	1
2							2
500	TOTAL RECLASSIFICATIONS					114,052	500
	CODE LETTER - M						
	GRAND TOTAL (INCREASES)				10,921,869	93,971,000	

(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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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	SHARED EXPENSES	A	DIETARY	10	1,303,161	1,262,564		1
500	TOTAL RECLASSIFICATIONS				1,303,161	1,262,564		500
	CODE LETTER - A							
1	FLOAT POOL	B	ADULTS & PEDIATRICS	30	57,786	4,724		1
2								2
3								3
4								4
5								5
6								6
500	TOTAL RECLASSIFICATIONS				57,786	4,724		500
	CODE LETTER - B							
1	TREATMENT CENTER LEASE EXP	C	OUTPATIENT TREATMENT CENTERS	90.01		149,840	10	1
500	TOTAL RECLASSIFICATIONS					149,840		500
	CODE LETTER - C							
1	COST OF MEDICAL SUPPLIES SOLD	D	CENTRAL SERVICES & SUPPLY	14		911,500		1
2			PHARMACY	15		58,605		2
3			MEDICAL RECORDS & LIBRARY	16		67		3
4			ADULTS & PEDIATRICS	30		2,362,365		4
5			INTENSIVE CARE UNIT	31		924,985		5
6			NEONATAL INTENSIVE CARE UNIT	35		175,833		6
7			SUBPROVIDER - IPF	40		11,478		7
8			OPERATING ROOM	50		21,075,270		8
9			ANESTHESIOLOGY	53		714,771		9
10			RADIOLOGY-DIAGNOSTIC	54		2,264,053		10
11			OFFSITE-DIAGNOSTIC SERVICES	54.01		37,708		11
12			ONCOLOGY	56.01		76,662		12
13			LABORATORY	60		187,499		13
14			WHOLE BLOOD & PACKED RED BLOO	62		1,517		14
15			RESPIRATORY THERAPY	65		412,255		15
16			PHYSICAL THERAPY	66		173,558		16
17			ELECTROCARDIOLOGY	69		99,906		17
18			CARDIAC CATH LAB	69.01		5,883,648		18
19			CARDIAC REHABILITATION	69.02		6,005		19
20			RENAL DIALYSIS	74		9,710		20
21			OUTPATIENT TREATMENT CENTERS	90.01		135,102		21
22			EMERGENCY	91		1,736,843		22
500	TOTAL RECLASSIFICATIONS					37,259,340		500
	CODE LETTER - D							
1	COST OF DRUGS SOLD	E	PHARMACY	15		15,834,589		1
500	TOTAL RECLASSIFICATIONS					15,834,589		500
	CODE LETTER - E							
1	PARAMEDICAL EDUCATION	F	EMERGENCY	91	591,015	121,677		1
2								2
500	TOTAL RECLASSIFICATIONS				591,015	121,677		500
	CODE LETTER - F							
1	NON DEPT ITEMS-COST ALLOCATION	G	CAP REL COSTS-BLDG & FIXT	1		37,213,216	9	1
2								2
500	TOTAL RECLASSIFICATIONS					37,213,216		500
	CODE LETTER - G							
1	SALT CREEK OCCUPANCY COSTS	H	ADMINISTRATIVE & GENERAL	5		23,234	10	1
2			ADMINISTRATIVE & GENERAL	5		215,468	14	2
500	TOTAL RECLASSIFICATIONS					238,702		500
	CODE LETTER - H							
1	PARTIAL HOSPITALIZATION PROGRAM	I	SUBPROVIDER - IPF	40	332,932	30,094		1
2			RESIDENTIAL TREATMENT CENTER	192.02	833,076	145,233		2
500	TOTAL RECLASSIFICATIONS				1,166,008	175,327		500
	CODE LETTER - I							
1	PROPERTY INSURANCE	J	ADMINISTRATIVE & GENERAL	5		125,539	12	1
2			PHYSICAL THERAPY	66		18,757	12	2
3			OUTPATIENT TREATMENT CENTERS	90.01		22,982		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					167,278		500
	CODE LETTER - J							
1	LDR COST ALLOCATION	K	ADULTS & PEDIATRICS	30	797,026	124,782		1
2			ADULTS & PEDIATRICS	30	4,758,455	1,304,909		2
500	TOTAL RECLASSIFICATIONS				5,555,481	1,429,691		500
	CODE LETTER - K							
1	OUTCOME BONUS	L	ADMINISTRATIVE & GENERAL	5		2,248,418		1
500	TOTAL RECLASSIFICATIONS					2,248,418		500
	CODE LETTER - L							
1	VACCINE COST	M	DRUGS CHARGED TO PATIENTS	73		101,640		1
2			OUTPATIENT TREATMENT CENTERS	90.01		12,412		2
500	TOTAL RECLASSIFICATIONS					114,052		500
	CODE LETTER - M							
	GRAND TOTAL (DECREASES)				8,673,451	96,219,418		

(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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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	1,789,072					1,789,072		1
2	LAND IMPROVEMENTS	14,250,270					14,250,270		2
3	BUILDINGS AND FIXTURES	308,918,933	17,598,383		17,598,383		326,517,316		3
4	BUILDING IMPROVEMENTS	1,102,550	214,645		214,645		1,317,195		4
5	FIXED EQUIPMENT	205,471,039	1,304,846		1,304,846		206,775,885		5
6	MOVABLE EQUIPMENT	109,598,225	10,467,781		10,467,781		120,066,006		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	641,130,089	29,585,655		29,585,655		670,715,744		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	641,130,089	29,585,655		29,585,655		670,715,744		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	30,286,089		9,609,909		22,593,905	99,514	62,589,417	1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (sum of lines 1-2)	30,286,089		9,609,909		22,593,905	99,514	62,589,417	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	550,649,737		550,649,737	0.820988					1
2	CAP REL COSTS-MVBLE EQU	120,066,007		120,066,007	0.179012					2
3	TOTAL (sum of lines 1-2)	670,715,744		670,715,744	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	-506,606	173,074	9,531,761	117,654	22,593,905	99,514	32,009,302	1
2	CAP REL COSTS-MVBLE EQUIP	14,519,314			49,624			14,568,938	2
3	TOTAL (sum of lines 1-2)	14,012,708	173,074	9,531,761	167,278	22,593,905	99,514	46,578,240	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)	B	-1,029,233	CAP REL COSTS-BLDG & FIXT	1	9	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)	B	-806,995	ADMINISTRATIVE & GENERAL	5		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	-47,617	ADMINISTRATIVE & GENERAL	5		7
8	TELEVISION AND RADIO SERVICE (chapter 21)	A	-5,269	OPERATION OF PLANT	7		8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,783,856				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1					12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-1,696,323	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						18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						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	PHO EXP	A	-1,998,010	ADMINISTRATIVE & GENERAL	5		35
36	OPERATING REV-OVERHEAD CC	B	236,577	ADMINISTRATIVE & GENERAL	5		36
36.01	OPERATING REV : OVERHEAD CC	B	-39,692	DIETARY	10		36.01
37							37
38	LOBBYING PORTION OF DUES	A	-57,364	ADMINISTRATIVE & GENERAL	5		38
39	PROVIDER ASSESSMENT REBATE	B	-22,277,770	ADMINISTRATIVE & GENERAL	5		39
40							40
41							41
41.09	AMORT OF CAPITALIZED INT INCOME	B	-78,148	CAP REL COSTS-BLDG & FIXT	1	11	41.09
41.14	PARAMED EDUCATION TUITION INCOM	B	-263,649	PARAMED ED PRGM-(SPECIFY)	23		41.14
41.71	NC HEALTH COST	A	6,790,649	OTHER NRCC	194.03		41.71
41.88	PIANO DEPRECTIATION	A	-1,371	CAP REL COSTS-MVBLE EQUIP	2	9	41.88
42	WELLNESS CENTER RENT TO COST	A	-31,630	PHYSICAL THERAPY	66		42
42.01	WELLNESS CENTER RENT TO COST	A	-90,224	CARDIAC REHABILITATION	69.02		42.01
43							43
44	BANK LOAN INTEREST EXP	A	-27,975	OFFSITE-DIAGNOSTIC SERVICES	54.01		44
45							45
45.01	MISC OPERATING INCOME	B	-426,147	ADMINISTRATIVE & GENERAL	5		45.01
45.02	MISC OPERATING INCOME	B	-19,500	PHARMACY	15		45.02
45.03	MISC OPERATING INCOME	B	-130,785	NURSING ADMINISTRATION	13		45.03
45.04	MISC OPERATING INCOME	B	-370,242	MEDICAL RECORDS & LIBRARY	16		45.04
45.05	MISC OPERATING INCOME	B	-83,238	ADULTS & PEDIATRICS	30		45.05

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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	
45.06	MISC OPERATING INCOME	B	-115,597	SUBPROVIDER - IPF	40		45.06
45.07	MISC OPERATING INCOME	B	-127,185	OPERATING ROOM	50		45.07
45.08	MISC OPERATING INCOME	B	-6,860	RADIOLOGY-DIAGNOSTIC	54		45.08
45.09	MISC OPERATING INCOME	B	-1,230	LABORATORY	60		45.09
45.10	MISC OPERATING INCOME	B	-650	PHYSICAL THERAPY	66		45.10
45.11	MISC OPERATING INCOME	B	-66,540	ELECTROCARDIOLOGY	69		45.11
45.12	MISC OPERATING INCOME	B	-355	CARDIAC REHABILITATION	69.02		45.12
45.14	MISC OPERATING INCOME	B	-3,093	ONCOLOGY	56.01		45.14
45.15	MISC OPERATING INCOME	B	-4,429	EMERGENCY	91		45.15
45.17	MISC OPERATING INCOME	B	95	CENTRAL SERVICES & SUPPLY	14		45.17
45.26	NON ALLOWABLE TRAVEL	A	-24,767	ADMINISTRATIVE & GENERAL	5		45.26
45.32	CSM AND 901 DEPRECIATION	A	-1,295,508	CAP REL COSTS-BLDG & FIXT	1	9	45.32
45.33	AMORT OF DEPR EXP OF DEMOLISHED	A	68,111	CAP REL COSTS-BLDG & FIXT	1	9	45.33
45.35	MED VS BOOK DEP DIFF	A	8,677,151	CAP REL COSTS-BLDG & FIXT	1	9	45.35
46	MAINFRAME SERVER EDITION-RECORD	A	195,000	CAP REL COSTS-MVBLE EQUIP	2	9	46
47	PT B NON PHY COST	A	-215,186	PHYSICAL THERAPY	66		47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-18,158,855				50

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

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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12							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							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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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

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	4	EMPLOYEE BENEFITS DE AGGREGATE	26,649	26,649						1
2	5	ADMINISTRATIVE & GEN AGGREGATE	37,497		37,497	177,200	228	19,424	971	2
3										3
4	30	ADULTS & PEDIATRICS AGGREGATE	1,129,513	1,129,513						4
5	31	INTENSIVE CARE UNIT AGGREGATE	858,000	817,255	40,745	165,600	416	33,120	1,656	5
6										6
7	50	OPERATING ROOM AGGREGATE	415,321	296,750	118,571	208,000	1,594	159,400	7,970	7
8	54	RADIOLOGY-DIAGNOSTIC AGGREGATE	38,038		38,038	225,300	209	22,638	1,132	8
9										9
10	60	LABORATORY AGGREGATE	309,200		309,200	215,700	2,128	220,678	11,034	10
11	66	PHYSICAL THERAPY AGGREGATE	1,120		1,120	177,200	6	511	26	11
12										12
13	69	ELECTROCARDIOLOGY AGGREGATE	320,412	282,412	38,000	165,600	224	17,834	892	13
14	69.01	CARDIAC CATH LAB AGGREGATE	39,700		39,700	165,600	200	15,923	796	14
15										15
16	69.02	CARDIAC REHABILITATI AGGREGATE	36,275		36,275	165,600	290	23,088	1,154	16
17	74	RENAL DIALYSIS AGGREGATE	6,780		6,780	177,200	54	4,600	230	17
18										18
19	91	EMERGENCY AGGREGATE	546,177		546,177	177,200	11,100	945,635	47,282	19
20										20
21	69	ELECTROCARDIOLOGY AGGREGATE	29,540		29,540	165,600	174	13,853	693	21
22	69	ELECTROCARDIOLOGY AGGREGATE	53,120		53,120	165,600	340	27,069	1,353	22
200		TOTAL	3,847,342	2,552,579	1,294,763		16,963	1,503,773	75,189	200

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATIO N	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT - ICE INSURANC E	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	4	EMPLOYEE BENEFITS DE AGGREGATE							26,649	1
2	5	ADMINISTRATIVE & GEN AGGREGATE					19,424	18,073	18,073	2
3										3
4	30	ADULTS & PEDIATRICS AGGREGATE							1,129,513	4
5	31	INTENSIVE CARE UNIT AGGREGATE					33,120	7,625	824,880	5
6										6
7	50	OPERATING ROOM AGGREGATE					159,400		296,750	7
8	54	RADIOLOGY-DIAGNOSTIC AGGREGATE					22,638	15,400	15,400	8
9										9
10	60	LABORATORY AGGREGATE					220,678	88,522	88,522	10
11	66	PHYSICAL THERAPY AGGREGATE					511	609	609	11
12										12
13	69	ELECTROCARDIOLOGY AGGREGATE					17,834	20,166	302,578	13
14	69.01	CARDIAC CATH LAB AGGREGATE					15,923	23,777	23,777	14
15										15
16	69.02	CARDIAC REHABILITATI AGGREGATE					23,088	13,187	13,187	16
17	74	RENAL DIALYSIS AGGREGATE					4,600	2,180	2,180	17
18										18
19	91	EMERGENCY AGGREGATE					945,635			19
20										20
21	69	ELECTROCARDIOLOGY AGGREGATE					13,853	15,687	15,687	21
22	69	ELECTROCARDIOLOGY AGGREGATE					27,069	26,051	26,051	22
200		TOTAL					1,503,773	231,277	2,783,856	200

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	32,009,302	32,009,302					1
2	CAP REL COSTS-MVBLE EQUIP	14,568,938		14,568,938				2
4	EMPLOYEE BENEFITS DEPARTMENT	37,728,192	471,569	34,202	38,233,963			4
5	ADMINISTRATIVE & GENERAL	56,794,374	7,407,952	7,033,347	6,031,219	77,266,892	77,266,892	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	11,726,553	4,346,094	118,009	897,408	17,088,064	4,116,378	7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING	6,654,948		27,535	754,353	7,436,836	1,791,474	9
10	DIETARY	2,913,690	384,035	57,871	340,900	3,696,496	890,456	10
11	CAFETERIA	869,402	252,549	50,280	296,154	1,468,385	353,722	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	9,588,089	313,519	5,413	1,928,647	11,835,668	2,851,118	13
14	CENTRAL SERVICES & SUPPLY	2,051,073	572,386	207,171	322,381	3,153,011	759,535	14
15	PHARMACY	4,502,889	228,244	82,522	906,923	5,720,578	1,378,041	15
16	MEDICAL RECORDS & LIBRARY	5,097,163	194,254	52,640	539,512	5,883,569	1,417,305	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)	-45,203	22,322	114	41,168	18,401	4,433	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	25,733,948	4,755,541	467,666	5,440,086	36,397,241	8,767,742	30
31	INTENSIVE CARE UNIT	8,971,928	1,184,942	193,707	1,864,428	12,215,005	2,942,497	31
35	NEONATAL INTENSIVE CARE UNIT	2,636,236	91,870	210,493	521,227	3,459,826	833,444	35
40	SUBPROVIDER - IPF	4,045,968	784,166	35,649	821,072	5,686,855	1,369,918	40
43	NURSERY	921,808	186,276	45,324	181,131	1,334,539	321,480	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	15,426,394	2,889,510	2,640,103	2,656,213	23,612,220	5,687,995	50
52	DELIVERY ROOM & LABOR ROOM	6,063,364	432,091	76,611	1,081,397	7,653,463	1,843,658	52
53	ANESTHESIOLOGY	147,247	24,074	1,104	26,227	198,652	47,854	53
54	RADIOLOGY-DIAGNOSTIC	19,259,530	1,577,740	1,347,117	2,864,740	25,049,127	6,034,134	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	3,186,331		418,369	377,485	3,982,185	959,277	54.01
56.01	ONCOLOGY	1,330,896	782,367	39,787	266,764	2,419,814	582,914	56.01
60	LABORATORY	11,351,757	622,149	340,068	1,212,175	13,526,149	3,258,341	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,524,021	42,891	21,545	121,281	2,709,738	652,754	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,529,516	145,875	43,926	500,447	3,219,764	775,615	65
66	PHYSICAL THERAPY	7,091,384	452,799	63,485	1,307,836	8,915,504	2,147,674	66
69	ELECTROCARDIOLOGY	2,946,903	247,753	163,942	526,953	3,885,551	935,998	69
69.01	CARDIAC CATH LAB	2,564,471	110,087	306,447	397,160	3,378,165	813,773	69.01
69.02	CARDIAC REHABILITATION	876,661	406,403	3,427	160,931	1,447,422	348,672	69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,091,808				22,091,808	5,321,740	71
72	IMPL. DEV. CHARGED TO PATIENTS	15,167,532				15,167,532	3,653,737	72
73	DRUGS CHARGED TO PATIENTS	15,732,949				15,732,949	3,789,942	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	114,052				114,052	27,474	73.01
74	RENAL DIALYSIS	766,845		3,657		770,502	185,608	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	5,880,036	996,222	73,969	1,001,077	7,951,304	1,915,406	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1,341,335	223,863	16,102	264,985	1,846,285	444,755	90.02
91	EMERGENCY	14,415,457	723,519	324,046	2,727,520	18,190,542	4,381,956	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	5,948,499	238,713	30,760	1,153,486	7,371,458	1,775,725	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	383,526,286	31,111,775	14,536,408	37,533,286	381,895,552	73,382,545	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	384,974	261,266	2,837	32,152	681,229	164,103	190
192	PHYSICIANS' PRIVATE OFFICES	1,308,141		2,442		1,310,583	315,709	192

KPMG LLP COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER	531,661		5,105	102,887	639,653	154,087	192.02
192.03	MOBILE DENTAL CLINIC	303,546		2,423	50,453	356,422	85,859	192.03
192.04	EMS CONTINUING EDUCATION	494,246			93,145	587,391	141,498	192.04
194	CORPORATE HEALTH	177,896	125,491	6,259	25,000	334,646	80,614	194
194.01	MARKETING/COMMUNICATION	2,311,834	92,976	753	113,907	2,519,470	606,920	194.01
194.02	FOUNDATION		41,461	545		42,006	10,119	194.02
194.03	OTHER NRCC	8,981,813	376,333	12,166	283,133	9,653,445	2,325,438	194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	398,020,397	32,009,302	14,568,938	38,233,963	398,020,397	77,266,892	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		7	9	10	11	13	14	
	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	21,204,442						7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING		9,228,310					9
10	DIETARY	411,614	179,137	5,177,703				10
11	CAFETERIA	270,686	117,804		2,210,597			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	336,034	146,244		118,758	15,287,822		13
14	CENTRAL SERVICES & SUPPLY	613,492	266,996		52,126		4,845,160	14
15	PHARMACY	244,635	106,467		55,959	547,663		15
16	MEDICAL RECORDS & LIBRARY	208,205	90,612		58,112			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)	23,925	10,412		2,292	22,435		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,097,061	2,218,273	3,972,378	480,940	4,706,859		30
31	INTENSIVE CARE UNIT	1,270,038	552,729	290,724	131,136	1,283,406		31
35	NEONATAL INTENSIVE CARE UNIT	98,467	42,854		35,710	349,487		35
40	SUBPROVIDER - IPF	840,480	365,782	612,481	66,071	646,626		40
43	NURSERY	199,653	86,890		28,158	275,576		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	3,097,019	1,347,843		209,956	2,054,795		50
52	DELIVERY ROOM & LABOR ROOM	463,122	201,554		47,592	465,775		52
53	ANESTHESIOLOGY	25,803	11,230		3,451	33,777		53
54	RADIOLOGY-DIAGNOSTIC	1,691,044	735,953		217,890			54
54.01	OFFSITE-DIAGNOSTIC SERVICES							54.01
56.01	ONCOLOGY	838,552	364,943		18,275	178,857		56.01
60	LABORATORY	666,828	290,208		131,926			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	45,971	20,007		10,596			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	156,351	68,045		42,192			65
66	PHYSICAL THERAPY	485,316	211,213		106,328			66
69	ELECTROCARDIOLOGY	265,545	115,567		42,116	412,181		69
69.01	CARDIAC CATH LAB	117,992	51,351		26,833	262,614		69.01
69.02	CARDIAC REHABILITATION	435,589	189,571		12,251	119,903		69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						2,872,789	71
72	IMPL. DEV. CHARGED TO PATIENTS						1,972,371	72
73	DRUGS CHARGED TO PATIENTS							73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	1,067,765	464,698			517,002		90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	239,939	104,423		23,943	234,321		90.02
91	EMERGENCY	775,478	337,493		244,698	2,394,810		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	255,856	111,350			781,735		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	20,242,460	8,809,649	4,875,583	2,167,309	15,287,822	4,845,160	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	280,028	121,870		5,069			190
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	DAY SURGERY CENTER							192.01

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COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		7	9	10	11	13	14	
192.02	RESIDENTIAL TREATMENT CENTER			302,120	11,602			192.02
192.03	MOBILE DENTAL CLINIC							192.03
192.04	EMS CONTINUING EDUCATION							192.04
194	CORPORATE HEALTH	134,503	58,536		2,101			194
194.01	MARKETING/COMMUNICATION	99,653	43,370		11,093			194.01
194.02	FOUNDATION	44,439	19,340					194.02
194.03	OTHER NRCC	403,359	175,545		13,423			194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	21,204,442	9,228,310	5,177,703	2,210,597	15,287,822	4,845,160	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	PARAMED EDUCATION EMS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	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	8,053,343						15
16	MEDICAL RECORDS & LIBRARY		7,657,803					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)	15		81,913				23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	43,784	521,588		62,205,866		62,205,866	30
31	INTENSIVE CARE UNIT	2,942	165,121		18,853,598		18,853,598	31
35	NEONATAL INTENSIVE CARE UNIT	1,010	51,910		4,872,708		4,872,708	35
40	SUBPROVIDER - IPF	61	107,644		9,695,918		9,695,918	40
43	NURSERY	1,303	35,455		2,283,054		2,283,054	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	49,599	664,901		36,724,328		36,724,328	50
52	DELIVERY ROOM & LABOR ROOM	2,202	59,928		10,737,294		10,737,294	52
53	ANESTHESIOLOGY	8,568	67,432		396,767		396,767	53
54	RADIOLOGY-DIAGNOSTIC	8,718	1,923,981		35,660,847		35,660,847	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	2,358	217,637		5,161,457		5,161,457	54.01
56.01	ONCOLOGY	495	19,959		4,423,809		4,423,809	56.01
60	LABORATORY	114	1,057,688		18,931,254		18,931,254	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		70,798		3,509,864		3,509,864	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	540	104,198		4,366,705		4,366,705	65
66	PHYSICAL THERAPY	1,681	142,615		12,010,331		12,010,331	66
69	ELECTROCARDIOLOGY	9,155	224,782		5,890,895		5,890,895	69
69.01	CARDIAC CATH LAB	3,849	208,123		4,862,700		4,862,700	69.01
69.02	CARDIAC REHABILITATION	29	10,411		2,563,848		2,563,848	69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		684,019		30,970,356		30,970,356	71
72	IMPL. DEV. CHARGED TO PATIENTS		292,331		21,085,971		21,085,971	72
73	DRUGS CHARGED TO PATIENTS	7,760,934	356,561		27,640,386		27,640,386	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	56,261	999		198,786		198,786	73.01
74	RENAL DIALYSIS		21,147		977,257		977,257	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	70,481	63,292		12,049,948		12,049,948	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM		13,504		2,907,170		2,907,170	90.02
91	EMERGENCY	27,569	571,779	81,913	27,006,238		27,006,238	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	1,675			10,297,799		10,297,799	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	8,053,343	7,657,803	81,913	376,285,154		376,285,154	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				1,252,299		1,252,299	190
192	PHYSICIANS' PRIVATE OFFICES				1,626,292		1,626,292	192
192.01	DAY SURGERY CENTER							192.01

KPMG LLP COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	PARAMED EDUCATION EMS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	24	25	26	
192.02	RESIDENTIAL TREATMENT CENTER				1,107,462		1,107,462	192.02
192.03	MOBILE DENTAL CLINIC				442,281		442,281	192.03
192.04	EMS CONTINUING EDUCATION				728,889		728,889	192.04
194	CORPORATE HEALTH				610,400		610,400	194
194.01	MARKETING/COMMUNICATION				3,280,506		3,280,506	194.01
194.02	FOUNDATION				115,904		115,904	194.02
194.03	OTHER NRCC				12,571,210		12,571,210	194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	8,053,343	7,657,803	81,913	398,020,397		398,020,397	202

KPMG LLP

COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & 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	3,972	471,569	34,202	509,743	509,743		4
5	ADMINISTRATIVE & GENERAL	752,205	7,407,952	7,033,347	15,193,504	80,388	15,273,892	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	57,253	4,346,094	118,009	4,521,356	11,965	813,717	7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING	2,200		27,535	29,735	10,058	354,135	9
10	DIETARY	2,209	384,035	57,871	444,115	4,545	176,023	10
11	CAFETERIA	2,542	252,549	50,280	305,371	3,949	69,923	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	268	313,519	5,413	319,200	25,714	563,603	13
14	CENTRAL SERVICES & SUPPLY	82,454	572,386	207,171	862,011	4,298	150,143	14
15	PHARMACY	-11,133	228,244	82,522	299,633	12,092	272,408	15
16	MEDICAL RECORDS & LIBRARY		194,254	52,640	246,894	7,193	280,170	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)		22,322	114	22,436	549	876	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	20,099	4,755,541	467,666	5,243,306	72,532	1,733,133	30
31	INTENSIVE CARE UNIT	1,302	1,184,942	193,707	1,379,951	24,858	581,666	31
35	NEONATAL INTENSIVE CARE UNIT	927	91,870	210,493	303,290	6,949	164,753	35
40	SUBPROVIDER - IPF	643	784,166	35,649	820,458	10,947	270,802	40
43	NURSERY	426	186,276	45,324	232,026	2,415	63,549	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	125,825	2,889,510	2,640,103	5,655,438	35,415	1,124,390	50
52	DELIVERY ROOM & LABOR ROOM	721	432,091	76,611	509,423	14,418	364,450	52
53	ANESTHESIOLOGY		24,074	1,104	25,178	350	9,460	53
54	RADIOLOGY-DIAGNOSTIC	688,036	1,577,740	1,347,117	3,612,893	38,195	1,192,814	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	376,492		418,369	794,861	5,033	189,628	54.01
56.01	ONCOLOGY	78	782,367	39,787	822,232	3,557	115,229	56.01
60	LABORATORY	63,909	622,149	340,068	1,026,126	16,162	644,102	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		42,891	21,545	64,436	1,617	129,035	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	7,670	145,875	43,926	197,471	6,672	153,322	65
66	PHYSICAL THERAPY	713,841	452,799	63,485	1,230,125	17,437	424,547	66
69	ELECTROCARDIOLOGY	25,263	247,753	163,942	436,958	7,026	185,026	69
69.01	CARDIAC CATH LAB		110,087	306,447	416,534	5,295	160,865	69.01
69.02	CARDIAC REHABILITATION	154,400	406,403	3,427	564,230	2,146	68,925	69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						1,051,990	71
72	IMPL. DEV. CHARGED TO PATIENTS						722,263	72
73	DRUGS CHARGED TO PATIENTS						749,187	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS						5,431	73.01
74	RENAL DIALYSIS			3,657	3,657		36,691	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	275,730	996,222	73,969	1,345,921	13,347	378,633	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	28	223,863	16,102	239,993	3,533	87,918	90.02
91	EMERGENCY	6,463	723,519	324,046	1,054,028	36,366	866,215	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		238,713	30,760	269,473	15,379	351,021	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,353,823	31,111,775	14,536,408	49,002,006	500,400	14,506,043	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		261,266	2,837	264,103	429	32,439	190
192	PHYSICIANS' PRIVATE OFFICES			2,442	2,442		62,409	192

KPMG LLP COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER			5,105	5,105	1,372	30,460	192.02
192.03	MOBILE DENTAL CLINIC			2,423	2,423	673	16,972	192.03
192.04	EMS CONTINUING EDUCATION					1,242	27,971	192.04
194	CORPORATE HEALTH		125,491	6,259	131,750	333	15,936	194
194.01	MARKETING/COMMUNICATION		92,976	753	93,729	1,519	119,975	194.01
194.02	FOUNDATION		41,461	545	42,006		2,000	194.02
194.03	OTHER NRCC		376,333	12,166	388,499	3,775	459,687	194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	3,353,823	32,009,302	14,568,938	49,932,063	509,743	15,273,892	202

KPMG LLP

COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		7	9	10	11	13	14	
	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	5,347,038						7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING		393,928					9
10	DIETARY	103,795	7,647	736,125				10
11	CAFETERIA	68,258	5,029		452,530			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	84,736	6,243		24,311	1,023,807		13
14	CENTRAL SERVICES & SUPPLY	154,702	11,397		10,671		1,193,222	14
15	PHARMACY	61,689	4,545		11,455	36,676		15
16	MEDICAL RECORDS & LIBRARY	52,502	3,868		11,896			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)	6,033	444		469	1,502		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,285,305	94,691	564,761	98,453	315,213		30
31	INTENSIVE CARE UNIT	320,260	23,594	41,333	26,845	85,948		31
35	NEONATAL INTENSIVE CARE UNIT	24,830	1,829		7,310	23,405		35
40	SUBPROVIDER - IPF	211,940	15,614	87,078	13,525	43,304		40
43	NURSERY	50,346	3,709		5,764	18,455		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	780,963	57,535		42,980	137,607		50
52	DELIVERY ROOM & LABOR ROOM	116,784	8,604		9,743	31,192		52
53	ANESTHESIOLOGY	6,507	479		707	2,262		53
54	RADIOLOGY-DIAGNOSTIC	426,424	31,416		44,604			54
54.01	OFFSITE-DIAGNOSTIC SERVICES							54.01
56.01	ONCOLOGY	211,454	15,578		3,741	11,978		56.01
60	LABORATORY	168,151	12,388		27,006			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	11,592	854		2,169			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	39,426	2,905		8,637			65
66	PHYSICAL THERAPY	122,380	9,016		21,766			66
69	ELECTROCARDIOLOGY	66,961	4,933		8,622	27,603		69
69.01	CARDIAC CATH LAB	29,754	2,192		5,493	17,587		69.01
69.02	CARDIAC REHABILITATION	109,841	8,092		2,508	8,030		69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						707,482	71
72	IMPL. DEV. CHARGED TO PATIENTS						485,740	72
73	DRUGS CHARGED TO PATIENTS							73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	269,254	19,837			34,623		90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	60,505	4,458		4,901	15,692		90.02
91	EMERGENCY	195,549	14,407		50,092	160,378		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	64,518	4,753			52,352		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,104,459	376,057	693,172	443,668	1,023,807	1,193,222	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	70,614	5,202		1,038			190
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	DAY SURGERY CENTER							192.01

KPMG LLP COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		7	9	10	11	13	14	
192.02	RESIDENTIAL TREATMENT CENTER			42,953	2,375			192.02
192.03	MOBILE DENTAL CLINIC							192.03
192.04	EMS CONTINUING EDUCATION							192.04
194	CORPORATE HEALTH	33,917	2,499		430			194
194.01	MARKETING/COMMUNICATION	25,129	1,851		2,271			194.01
194.02	FOUNDATION	11,206	826					194.02
194.03	OTHER NRCC	101,713	7,493		2,748			194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	5,347,038	393,928	736,125	452,530	1,023,807	1,193,222	202

KPMG LLP

COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	PARAMED EDUCATION EMS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	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	698,498						15
16	MEDICAL RECORDS & LIBRARY		602,523					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)	1		20,820				23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	3,798	41,055		9,452,247		9,452,247	30
31	INTENSIVE CARE UNIT	255	12,997		2,497,707		2,497,707	31
35	NEONATAL INTENSIVE CARE UNIT	88	4,086		536,540		536,540	35
40	SUBPROVIDER - IPF	5	8,473		1,482,146		1,482,146	40
43	NURSERY	113	2,791		379,168		379,168	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	4,302	52,335		7,890,965		7,890,965	50
52	DELIVERY ROOM & LABOR ROOM	191	4,717		1,059,522		1,059,522	52
53	ANESTHESIOLOGY	743	5,308		50,994		50,994	53
54	RADIOLOGY-DIAGNOSTIC	756	151,205		5,498,307		5,498,307	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	205	17,130		1,006,857		1,006,857	54.01
56.01	ONCOLOGY	43	1,571		1,185,383		1,185,383	56.01
60	LABORATORY	10	83,252		1,977,197		1,977,197	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		5,573		215,276		215,276	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	47	8,202		416,682		416,682	65
66	PHYSICAL THERAPY	146	11,225		1,836,642		1,836,642	66
69	ELECTROCARDIOLOGY	794	17,693		755,616		755,616	69
69.01	CARDIAC CATH LAB	334	16,382		654,436		654,436	69.01
69.02	CARDIAC REHABILITATION	3	819		764,594		764,594	69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		53,840		1,813,312		1,813,312	71
72	IMPL. DEV. CHARGED TO PATIENTS		23,010		1,231,013		1,231,013	72
73	DRUGS CHARGED TO PATIENTS	673,135	28,065		1,450,387		1,450,387	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	4,880	79		10,390		10,390	73.01
74	RENAL DIALYSIS		1,665		42,013		42,013	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	6,113	4,982		2,072,710		2,072,710	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM		1,063		418,063		418,063	90.02
91	EMERGENCY	2,391	45,005		2,424,431		2,424,431	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	145			757,641		757,641	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	698,498	602,523		47,880,239		47,880,239	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				373,825		373,825	190
192	PHYSICIANS' PRIVATE OFFICES				64,851		64,851	192
192.01	DAY SURGERY CENTER							192.01

KPMG LLP COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	PARAMED EDUCATION EMS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	24	25	26	
192.02	RESIDENTIAL TREATMENT CENTER				82,265		82,265	192.02
192.03	MOBILE DENTAL CLINIC				20,068		20,068	192.03
192.04	EMS CONTINUING EDUCATION				29,213		29,213	192.04
194	CORPORATE HEALTH				184,865		184,865	194
194.01	MARKETING/COMMUNICATION				244,474		244,474	194.01
194.02	FOUNDATION				56,038		56,038	194.02
194.03	OTHER NRCC				963,915		963,915	194.03
200	CROSS FOOT ADJUSTMENTS			20,820	20,820		20,820	200
201	NEGATIVE COST CENTER			11,490	11,490		11,490	201
202	TOTAL (sum of lines 118-201)	698,498	602,523	32,310	49,932,063		49,932,063	202

KPMG LLP

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	694,055						1
2	CAP REL COSTS-MVBLE EQUIP		14,310,845					2
4	EMPLOYEE BENEFITS DEPARTMENT	10,225	33,596	168,240,588				4
5	ADMINISTRATIVE & GENERAL	160,626	6,908,754	26,539,336	-77,266,892	320,753,505		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	94,236	115,918	3,948,850		17,088,064	428,968	7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING		27,047	3,319,367		7,436,836		9
10	DIETARY	8,327	56,846	1,500,057		3,696,496	8,327	10
11	CAFETERIA	5,476	49,389	1,303,161		1,468,385	5,476	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	6,798	5,317	8,486,595		11,835,668	6,798	13
14	CENTRAL SERVICES & SUPPLY	12,411	203,501	1,418,567		3,153,011	12,411	14
15	PHARMACY	4,949	81,060	3,990,719		5,720,578	4,949	15
16	MEDICAL RECORDS & LIBRARY	4,212	51,707	2,374,005		5,883,569	4,212	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)	484	112	181,151		18,401	484	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	103,114	459,381	23,937,930		36,397,241	103,114	30
31	INTENSIVE CARE UNIT	25,693	190,275	8,204,016		12,215,005	25,693	31
35	NEONATAL INTENSIVE CARE UNIT	1,992	206,764	2,293,548		3,459,826	1,992	35
40	SUBPROVIDER - IPF	17,003	35,017	3,612,949		5,686,855	17,003	40
43	NURSERY	4,039	44,521	797,026		1,334,539	4,039	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	62,653	2,593,332	11,688,096		23,612,220	62,653	50
52	DELIVERY ROOM & LABOR ROOM	9,369	75,254	4,758,455		7,653,463	9,369	52
53	ANESTHESIOLOGY	522	1,084	115,405		198,652	522	53
54	RADIOLOGY-DIAGNOSTIC	34,210	1,323,252	12,605,674		25,049,127	34,210	54
54.01	OFFSITE-DIAGNOSTIC SERVICES		410,957	1,661,043		3,982,185		54.01
56.01	ONCOLOGY	16,964	39,082	1,173,838		2,419,814	16,964	56.01
60	LABORATORY	13,490	334,044	5,333,915		13,526,149	13,490	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	930	21,163	533,671		2,709,738	930	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,163	43,148	2,202,110		3,219,764	3,163	65
66	PHYSICAL THERAPY	9,818	62,360	5,754,852		8,915,504	9,818	66
69	ELECTROCARDIOLOGY	5,372	161,038	2,318,743		3,885,551	5,372	69
69.01	CARDIAC CATH LAB	2,387	301,018	1,747,618		3,378,165	2,387	69.01
69.02	CARDIAC REHABILITATION	8,812	3,366	708,143		1,447,422	8,812	69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					22,091,808		71
72	IMPL. DEV. CHARGED TO PATIENTS					15,167,532		72
73	DRUGS CHARGED TO PATIENTS					15,732,949		73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS					114,052		73.01
74	RENAL DIALYSIS		3,592			770,502		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	21,601	72,659	4,405,025		7,951,304	21,601	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	4,854	15,817	1,166,008		1,846,285	4,854	90.02
91	EMERGENCY	15,688	318,305	12,001,867		18,190,542	15,688	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	5,176	30,215	5,075,666		7,371,458	5,176	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	674,594	14,278,891	165,157,406	-77,266,892	304,628,660	409,507	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,665	2,787	141,476		681,229	5,665	190
192	PHYSICIANS' PRIVATE OFFICES		2,399			1,310,583		192

KPMG LLP COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER		5,015	452,734		639,653		192.02
192.03	MOBILE DENTAL CLINIC		2,380	222,008		356,422		192.03
192.04	EMS CONTINUING EDUCATION			409,864		587,391		192.04
194	CORPORATE HEALTH	2,721	6,148	110,009		334,646	2,721	194
194.01	MARKETING/COMMUNICATION	2,016	740	501,223		2,519,470	2,016	194.01
194.02	FOUNDATION	899	535			42,006	899	194.02
194.03	OTHER NRCC	8,160	11,950	1,245,868		9,653,445	8,160	194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	32,009,302	14,568,938	38,233,963		77,266,892	21,204,442	202
203	UNIT COST MULT-WS B PT I	46.119259	1.018035	0.227258		0.240892	49.431291	203
204	COST TO BE ALLOC PER B PT II			509,743		15,273,892	5,347,038	204
205	UNIT COST MULT-WS B PT II			0.003030		0.047619	12.464888	205

KPMG LLP

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S SERVED	NURSING ADMINIS-TRATION FTE'S NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUISTION	
		9	10	11	13	14	15	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING	428,968						9
10	DIETARY	8,327	228,071					10
11	CAFETERIA	5,476		173,579				11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	6,798		9,325	122,657			13
14	CENTRAL SERVICES & SUPPLY	12,411		4,093		37,259,340		14
15	PHARMACY	4,949		4,394	4,394		16,325,717	15
16	MEDICAL RECORDS & LIBRARY	4,212		4,563				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)	484		180	180		30	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	103,114	174,978	37,764	37,764		88,759	30
31	INTENSIVE CARE UNIT	25,693	12,806	10,297	10,297		5,964	31
35	NEONATAL INTENSIVE CARE UNIT	1,992		2,804	2,804		2,048	35
40	SUBPROVIDER - IPF	17,003	26,979	5,188	5,188		124	40
43	NURSERY	4,039		2,211	2,211		2,641	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	62,653		16,486	16,486		100,547	50
52	DELIVERY ROOM & LABOR ROOM	9,369		3,737	3,737		4,464	52
53	ANESTHESIOLOGY	522		271	271		17,370	53
54	RADIOLOGY-DIAGNOSTIC	34,210		17,109			17,673	54
54.01	OFFSITE-DIAGNOSTIC SERVICES						4,781	54.01
56.01	ONCOLOGY	16,964		1,435	1,435		1,003	56.01
60	LABORATORY	13,490		10,359			231	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	930		832				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,163		3,313			1,094	65
66	PHYSICAL THERAPY	9,818		8,349			3,407	66
69	ELECTROCARDIOLOGY	5,372		3,307	3,307		18,558	69
69.01	CARDIAC CATH LAB	2,387		2,107	2,107		7,803	69.01
69.02	CARDIAC REHABILITATION	8,812		962	962		59	69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					22,091,808		71
72	IMPL. DEV. CHARGED TO PATIENTS					15,167,532		72
73	DRUGS CHARGED TO PATIENTS						15,732,949	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS						114,052	73.01
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	21,601			4,148		142,878	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	4,854		1,880	1,880			90.02
91	EMERGENCY	15,688		19,214	19,214		55,887	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	5,176			6,272		3,395	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	409,507	214,763	170,180	122,657	37,259,340	16,325,717	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,665		398				190
192	PHYSICIANS' PRIVATE OFFICES							192

KPMG LLP

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S SERVED	NURSING ADMINIS-TRATION FTE'S NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUISTION	
		9	10	11	13	14	15	
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER		13,308	911				192.02
192.03	MOBILE DENTAL CLINIC							192.03
192.04	EMS CONTINUING EDUCATION							192.04
194	CORPORATE HEALTH	2,721		165				194
194.01	MARKETING/COMMUNICATION	2,016		871				194.01
194.02	FOUNDATION	899						194.02
194.03	OTHER NRCC	8,160		1,054				194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	9,228,310	5,177,703	2,210,597	15,287,822	4,845,160	8,053,343	202
203	UNIT COST MULT-WS B PT I	21.512817	22.702154	12.735394	124.638806	0.130039	0.493292	203
204	COST TO BE ALLOC PER B PT II	393,928	736,125	452,530	1,023,807	1,193,222	698,498	204
205	UNIT COST MULT-WS B PT II	0.918316	3.227613	2.607055	8.346910	0.032025	0.042785	205

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY GROSS REVENUE	PARAMED EDUCATION EMS ASSIGNED TIME					
		16	23					
	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	1,561,456,148						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)		1,000					23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	106,359,771						30
31	INTENSIVE CARE UNIT	33,670,667						31
35	NEONATAL INTENSIVE CARE UNIT	10,585,181						35
40	SUBPROVIDER - IPF	21,950,188						40
43	NURSERY	7,229,766						43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	135,583,316						50
52	DELIVERY ROOM & LABOR ROOM	12,220,142						52
53	ANESTHESIOLOGY	13,750,319						53
54	RADIOLOGY-DIAGNOSTIC	392,243,338						54
54.01	OFFSITE-DIAGNOSTIC SERVICES	44,379,456						54.01
56.01	ONCOLOGY	4,069,924						56.01
60	LABORATORY	215,678,691						60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	14,436,712						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	21,247,480						65
66	PHYSICAL THERAPY	29,081,408						66
69	ELECTROCARDIOLOGY	45,836,528						69
69.01	CARDIAC CATH LAB	42,439,453						69.01
69.02	CARDIAC REHABILITATION	2,122,859						69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	139,481,859						71
72	IMPL. DEV. CHARGED TO PATIENTS	59,610,796						72
73	DRUGS CHARGED TO PATIENTS	72,708,104						73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	203,670						73.01
74	RENAL DIALYSIS	4,312,215						74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	12,906,245						90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	2,753,692						90.02
91	EMERGENCY	116,594,368	1,000					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							
118	SUBTOTALS (sum of lines 1-117)	1,561,456,148	1,000					118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190

KPMG LLP COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY GROSS REVENUE	PARAMED EDUCATION EMS ASSIGNED TIME					
		16	23					
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER							192.02
192.03	MOBILE DENTAL CLINIC							192.03
192.04	EMS CONTINUING EDUCATION							192.04
194	CORPORATE HEALTH							194
194.01	MARKETING/COMMUNICATION							194.01
194.02	FOUNDATION							194.02
194.03	OTHER NRCC							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	7,657,803	81,913					202
203	UNIT COST MULT-WS B PT I	0.004904	81.913000					203
204	COST TO BE ALLOC PER B PT II	602,523	20,820					204
205	UNIT COST MULT-WS B PT II	0.000386	20.820000					205

KPMG LLP COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 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	62,205,866		62,205,866		62,205,866	30
31	INTENSIVE CARE UNIT	18,853,598		18,853,598	7,625	18,861,223	31
35	NEONATAL INTENSIVE CARE UNIT	4,872,708		4,872,708		4,872,708	35
40	SUBPROVIDER - IPF	9,695,918		9,695,918		9,695,918	40
43	NURSERY	2,283,054		2,283,054		2,283,054	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	36,724,328		36,724,328		36,724,328	50
52	DELIVERY ROOM & LABOR ROOM	10,737,294		10,737,294		10,737,294	52
53	ANESTHESIOLOGY	396,767		396,767		396,767	53
54	RADIOLOGY-DIAGNOSTIC	35,660,847		35,660,847	15,400	35,676,247	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	5,161,457		5,161,457		5,161,457	54.01
56.01	ONCOLOGY	4,423,809		4,423,809		4,423,809	56.01
60	LABORATORY	18,931,254		18,931,254	88,522	19,019,776	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,509,864		3,509,864		3,509,864	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	4,366,705		4,366,705		4,366,705	65
66	PHYSICAL THERAPY	12,010,331		12,010,331	609	12,010,940	66
69	ELECTROCARDIOLOGY	5,890,895		5,890,895	61,904	5,952,799	69
69.01	CARDIAC CATH LAB	4,862,700		4,862,700	23,777	4,886,477	69.01
69.02	CARDIAC REHABILITATION	2,563,848		2,563,848	13,187	2,577,035	69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,970,356		30,970,356		30,970,356	71
72	IMPL. DEV. CHARGED TO PATIENTS	21,085,971		21,085,971		21,085,971	72
73	DRUGS CHARGED TO PATIENTS	27,640,386		27,640,386		27,640,386	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	198,786		198,786		198,786	73.01
74	RENAL DIALYSIS	977,257		977,257	2,180	979,437	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT CENTERS	12,049,948		12,049,948		12,049,948	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	2,907,170		2,907,170		2,907,170	90.02
91	EMERGENCY	27,006,238		27,006,238		27,006,238	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	5,363,059		5,363,059		5,363,059	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	10,297,799		10,297,799		10,297,799	101
200	SUBTOTAL (SEE INSTRUCTIONS)	381,648,213		381,648,213	213,204	381,861,417	200
201	LESS OBSERVATION BEDS	5,363,059		5,363,059		5,363,059	201
202	TOTAL (SEE INSTRUCTIONS)	376,285,154		376,285,154		376,498,358	202

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 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	96,957,995		96,957,995				30
31	INTENSIVE CARE UNIT	33,670,667		33,670,667				31
35	NEONATAL INTENSIVE CARE UNIT	10,585,181		10,585,181				35
40	SUBPROVIDER - IPF	21,950,188		21,950,188				40
43	NURSERY	7,229,766		7,229,766				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	52,538,779	83,044,537	135,583,316	0.270862	0.270862	0.270862	50
52	DELIVERY ROOM & LABOR ROOM	11,783,837	436,305	12,220,142	0.878655	0.878655	0.878655	52
53	ANESTHESIOLOGY	6,601,097	7,149,222	13,750,319	0.028855	0.028855	0.028855	53
54	RADIOLOGY-DIAGNOSTIC	94,692,783	297,550,555	392,243,338	0.090915	0.090915	0.090954	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	200,000	44,179,456	44,379,456	0.116303	0.116303	0.116303	54.01
56.01	ONCOLOGY	527,239	3,542,685	4,069,924	1.086951	1.086951	1.086951	56.01
60	LABORATORY	82,678,661	133,000,030	215,678,691	0.087775	0.087775	0.088186	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,168,023	4,268,689	14,436,712	0.243121	0.243121	0.243121	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	18,997,311	2,250,169	21,247,480	0.205516	0.205516	0.205516	65
66	PHYSICAL THERAPY	6,717,266	22,364,142	29,081,408	0.412990	0.412990	0.413011	66
69	ELECTROCARDIOLOGY	11,467,530	34,368,998	45,836,528	0.128520	0.128520	0.129870	69
69.01	CARDIAC CATH LAB	18,175,605	24,263,848	42,439,453	0.114580	0.114580	0.115140	69.01
69.02	CARDIAC REHABILITATION	312	2,122,547	2,122,859	1.207734	1.207734	1.213945	69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	75,278,957	64,202,902	139,481,859	0.222039	0.222039	0.222039	71
72	IMPL. DEV. CHARGED TO PATIENTS	37,666,628	21,944,168	59,610,796	0.353727	0.353727	0.353727	72
73	DRUGS CHARGED TO PATIENTS	46,981,814	25,726,290	72,708,104	0.380156	0.380156	0.380156	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS		203,670	203,670	0.976020	0.976020	0.976020	73.01
74	RENAL DIALYSIS	4,043,604	268,611	4,312,215	0.226625	0.226625	0.227131	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	121,455	12,784,790	12,906,245	0.933653	0.933653	0.933653	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	100,000	2,653,692	2,753,692	1.055735	1.055735	1.055735	90.02
91	EMERGENCY	32,469,830	84,124,538	116,594,368	0.231626	0.231626	0.231626	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	4,575,202	4,826,574	9,401,776	0.570430	0.570430	0.570430	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	60	8,071,186	8,071,246				101
200	SUBTOTAL (SEE INSTRUCTIONS)	686,179,790	883,347,604	1,569,527,394				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	686,179,790	883,347,604	1,569,527,394				202

KPMG LLP COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		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)	9,452,247		9,452,247	63,829	148.09	29,847	4,420,042	30
31	INTENSIVE CARE UNIT	2,497,707		2,497,707	8,537	292.57	4,239	1,240,204	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	NEONATAL INTENSIVE CARE UNIT	536,540		536,540	923	581.30			35
40	SUBPROVIDER - IPF	1,482,146		1,482,146	8,993	164.81	1,548	255,126	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	379,168		379,168	8,440	44.93			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	14,347,808		14,347,808	90,722		35,634	5,915,372	200

(A) Worksheet A line numbers

KPMG LLP

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0252** **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	7,890,965	135,583,316	0.058200	26,631,965	1,549,980	50
52	DELIVERY ROOM & LABOR ROOM	1,059,522	12,220,142	0.086703			52
53	ANESTHESIOLOGY	50,994	13,750,319	0.003709	3,188,640	11,827	53
54	RADIOLOGY-DIAGNOSTIC	5,498,307	392,243,338	0.014018	51,170,926	717,314	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	1,006,857	44,379,456	0.022687	152,174	3,452	54.01
56.01	ONCOLOGY	1,185,383	4,069,924	0.291254	20,715	6,033	56.01
60	LABORATORY	1,977,197	215,678,691	0.009167	41,959,421	384,642	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	215,276	14,436,712	0.014912	4,912,025	73,248	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	416,682	21,247,480	0.019611	10,508,296	206,078	65
66	PHYSICAL THERAPY	1,836,642	29,081,408	0.063155	4,253,303	268,617	66
69	ELECTROCARDIOLOGY	755,616	45,836,528	0.016485	6,558,224	108,112	69
69.01	CARDIAC CATH LAB	654,436	42,439,453	0.015420	8,692,364	134,036	69.01
69.02	CARDIAC REHABILITATION	764,594	2,122,859	0.360172	312	112	69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,813,312	139,481,859	0.013000	36,848,322	479,028	71
72	IMPL. DEV. CHARGED TO PATIENTS	1,231,013	59,610,796	0.020651	21,327,459	440,433	72
73	DRUGS CHARGED TO PATIENTS	1,450,387	72,708,104	0.019948	22,412,406	447,083	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	10,390	203,670	0.051014			73.01
74	RENAL DIALYSIS	42,013	4,312,215	0.009743	2,852,800	27,795	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT CENTERS	2,072,710	12,906,245	0.160597	42,858	6,883	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	418,063	2,753,692	0.151819			90.02
91	EMERGENCY	2,424,431	116,594,368	0.020794	16,432,411	341,696	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	814,922	9,401,776	0.086677	2,496,454	216,385	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	33,589,712	1,391,062,351		260,461,075	5,422,754	200

(A) Worksheet A line numbers

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

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

		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	NEONATAL INTENSIVE CARE UNIT						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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		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)	63,829		29,847		30
31	INTENSIVE CARE UNIT	8,537		4,239		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	NEONATAL INTENSIVE CARE UNIT	923				35
40	SUBPROVIDER - IPF	8,993		1,548		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	8,440				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	90,722		35,634		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0252** **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
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	OFFSITE-DIAGNOSTIC SERVICES							54.01
56.01	ONCOLOGY							56.01
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
69.01	CARDIAC CATH LAB							69.01
69.02	CARDIAC REHABILITATION							69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM							90.02
91	EMERGENCY			81,913		81,913	81,913	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			81,913		81,913	81,913	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0252** | **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

		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	135,583,316			26,631,965		25,225,534		50
52	DELIVERY ROOM & LABOR ROOM	12,220,142							52
53	ANESTHESIOLOGY	13,750,319			3,188,640		5,221,220		53
54	RADIOLOGY-DIAGNOSTIC	392,243,338			51,170,926		126,960,467		54
54.01	OFFSITE-DIAGNOSTIC SERVICES	44,379,456			152,174		387,636		54.01
56.01	ONCOLOGY	4,069,924			20,715		574,718		56.01
60	LABORATORY	215,678,691			41,959,421		18,033,156		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	14,436,712			4,912,025		1,312,956		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	21,247,480			10,508,296		1,156,929		65
66	PHYSICAL THERAPY	29,081,408			4,253,303		569,603		66
69	ELECTROCARDIOLOGY	45,836,528			6,558,224		11,070,454		69
69.01	CARDIAC CATH LAB	42,439,453			8,692,364		12,073,644		69.01
69.02	CARDIAC REHABILITATION	2,122,859			312		994,651		69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	139,481,859			36,848,322		22,030,861		71
72	IMPL. DEV. CHARGED TO PATIENTS	59,610,796			21,327,459		12,770,424		72
73	DRUGS CHARGED TO PATIENTS	72,708,104			22,412,406		11,294,198		73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	203,670							73.01
74	RENAL DIALYSIS	4,312,215			2,852,800		123,080		74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT CENTERS	12,906,245			42,858		1,295,214		90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	2,753,692							90.02
91	EMERGENCY	116,594,368	0.000703	0.000703	16,432,411	11,552	21,195,308	14,900	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	9,401,776			2,496,454		4,539,369		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	1,391,062,351			260,461,075	11,552	276,829,422	14,900	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0252** **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	0.270862	25,225,534			6,832,639			50
52	DELIVERY ROOM & LABOR ROOM	0.878655							52
53	ANESTHESIOLOGY	0.028855	5,221,220			150,658			53
54	RADIOLOGY-DIAGNOSTIC	0.090915	126,960,467			11,542,611			54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.116303	387,636			45,083			54.01
56.01	ONCOLOGY	1.086951	574,718			624,690			56.01
60	LABORATORY	0.087775	18,033,156	5,833		1,582,860	512		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.243121	1,312,956			319,207			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.205516	1,156,929			237,767			65
66	PHYSICAL THERAPY	0.412990	569,603			235,240			66
69	ELECTROCARDIOLOGY	0.128520	11,070,454			1,422,775			69
69.01	CARDIAC CATH LAB	0.114580	12,073,644			1,383,398			69.01
69.02	CARDIAC REHABILITATION	1.207734	994,651			1,201,274			69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.222039	22,030,861			4,891,710			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.353727	12,770,424			4,517,244			72
73	DRUGS CHARGED TO PATIENTS	0.380156	11,294,198	1,172		4,293,557	446		73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	0.976020			94,057			91,802	73.01
74	RENAL DIALYSIS	0.226625	123,080			27,893			74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT CENTERS	0.933653	1,295,214			1,209,280			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.055735							90.02
91	EMERGENCY	0.231626	21,195,308	110,720		4,909,384	25,646		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.570430	4,539,369			2,589,392			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		276,829,422	117,725	94,057	48,016,662	26,604	91,802	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		276,829,422	117,725	94,057	48,016,662	26,604	91,802	202

(A) Worksheet A line numbers

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S252** **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

		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	7,890,965	135,583,316	0.058200	3,761	219	50
52	DELIVERY ROOM & LABOR ROOM	1,059,522	12,220,142	0.086703			52
53	ANESTHESIOLOGY	50,994	13,750,319	0.003709			53
54	RADIOLOGY-DIAGNOSTIC	5,498,307	392,243,338	0.014018	43,544	610	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	1,006,857	44,379,456	0.022687			54.01
56.01	ONCOLOGY	1,185,383	4,069,924	0.291254			56.01
60	LABORATORY	1,977,197	215,678,691	0.009167	301,290	2,762	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	215,276	14,436,712	0.014912			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	416,682	21,247,480	0.019611	1,163	23	65
66	PHYSICAL THERAPY	1,836,642	29,081,408	0.063155	7,345	464	66
69	ELECTROCARDIOLOGY	755,616	45,836,528	0.016485	57,543	949	69
69.01	CARDIAC CATH LAB	654,436	42,439,453	0.015420			69.01
69.02	CARDIAC REHABILITATION	764,594	2,122,859	0.360172			69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,813,312	139,481,859	0.013000	16,965	221	71
72	IMPL. DEV. CHARGED TO PATIENTS	1,231,013	59,610,796	0.020651			72
73	DRUGS CHARGED TO PATIENTS	1,450,387	72,708,104	0.019948	160,058	3,193	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	10,390	203,670	0.051014			73.01
74	RENAL DIALYSIS	42,013	4,312,215	0.009743			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT CENTERS	2,072,710	12,906,245	0.160597			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	418,063	2,753,692	0.151819			90.02
91	EMERGENCY	2,424,431	116,594,368	0.020794	296,678	6,169	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		9,401,776				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	32,774,790	1,391,062,351		888,347	14,610	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S252** **WORKSHEET D PART IV**

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

		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
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	OFFSITE-DIAGNOSTIC SERVICES							54.01
56.01	ONCOLOGY							56.01
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
69.01	CARDIAC CATH LAB							69.01
69.02	CARDIAC REHABILITATION							69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM							90.02
91	EMERGENCY			81,913		81,913	81,913	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			81,913		81,913	81,913	200

(A) Worksheet A line numbers

KPMG LLP

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S252** | **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

		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	135,583,316			3,761				50
52	DELIVERY ROOM & LABOR ROOM	12,220,142							52
53	ANESTHESIOLOGY	13,750,319							53
54	RADIOLOGY-DIAGNOSTIC	392,243,338			43,544				54
54.01	OFFSITE-DIAGNOSTIC SERVICES	44,379,456							54.01
56.01	ONCOLOGY	4,069,924							56.01
60	LABORATORY	215,678,691			301,290				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	14,436,712							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	21,247,480			1,163				65
66	PHYSICAL THERAPY	29,081,408			7,345				66
69	ELECTROCARDIOLOGY	45,836,528			57,543				69
69.01	CARDIAC CATH LAB	42,439,453							69.01
69.02	CARDIAC REHABILITATION	2,122,859							69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	139,481,859			16,965				71
72	IMPL. DEV. CHARGED TO PATIENTS	59,610,796							72
73	DRUGS CHARGED TO PATIENTS	72,708,104			160,058				73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	203,670							73.01
74	RENAL DIALYSIS	4,312,215							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT CENTERS	12,906,245							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	2,753,692							90.02
91	EMERGENCY	116,594,368	0.000703	0.000703	296,678	209			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	9,401,776							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	1,391,062,351			888,347	209			200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S252** **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	0.270862							50
52	DELIVERY ROOM & LABOR ROOM	0.878655							52
53	ANESTHESIOLOGY	0.028855							53
54	RADIOLOGY-DIAGNOSTIC	0.090915							54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.116303							54.01
56.01	ONCOLOGY	1.086951							56.01
60	LABORATORY	0.087775							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.243121							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.205516							65
66	PHYSICAL THERAPY	0.412990							66
69	ELECTROCARDIOLOGY	0.128520							69
69.01	CARDIAC CATH LAB	0.114580							69.01
69.02	CARDIAC REHABILITATION	1.207734							69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.222039							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.353727							72
73	DRUGS CHARGED TO PATIENTS	0.380156							73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	0.976020							73.01
74	RENAL DIALYSIS	0.226625							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT CENTERS	0.933653							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.055735							90.02
91	EMERGENCY	0.231626							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.570430							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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0252** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	63,829	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	63,829	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)	58,326	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)	29,847	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)	62,205,866	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	62,205,866	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)	62,205,866	37

KPMG LLP COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0252** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) | [XX] PPS [ ] TEFRA [ ] 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)					974.57	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					29,087,991	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)					29,087,991	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	18,861,223	8,537	2,209.35	4,239	9,365,435	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	NEONATAL INTENSIVE CARE UNIT	4,872,708	923	5,279.21			47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					52,827,952	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					91,281,378	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	5,660,246	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	5,434,306	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	11,094,552	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	80,186,826	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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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0252** **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)	5,503	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)	974.57	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)	5,363,059	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	9,452,247	62,205,866	0.151951	5,363,059	814,922	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S252** **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)	8,993	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	8,993	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)	8,993	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)	1,548	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)	9,695,918	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	9,695,918	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)	9,695,918	37

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COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S252** **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)	1,078.16	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	1,668,992	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	1,668,992	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	175,628	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	1,844,620	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	255,126	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	14,819	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	269,945	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	1,574,675	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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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0252** **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		49,071,557		30
31	INTENSIVE CARE UNIT		18,452,130		31
35	NEONATAL INTENSIVE CARE UNIT				35
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.270862	26,631,965	7,213,587	50
52	DELIVERY ROOM & LABOR ROOM	0.878655			52
53	ANESTHESIOLOGY	0.028855	3,188,640	92,008	53
54	RADIOLOGY-DIAGNOSTIC	0.090954	51,170,926	4,654,200	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.116303	152,174	17,698	54.01
56.01	ONCOLOGY	1.086951	20,715	22,516	56.01
60	LABORATORY	0.088186	41,959,421	3,700,234	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.243121	4,912,025	1,194,216	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.205516	10,508,296	2,159,623	65
66	PHYSICAL THERAPY	0.413011	4,253,303	1,756,661	66
69	ELECTROCARDIOLOGY	0.129870	6,558,224	851,717	69
69.01	CARDIAC CATH LAB	0.115140	8,692,364	1,000,839	69.01
69.02	CARDIAC REHABILITATION	1.213945	312	379	69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.222039	36,848,322	8,181,765	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.353727	21,327,459	7,544,098	72
73	DRUGS CHARGED TO PATIENTS	0.380156	22,412,406	8,520,211	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	0.976020			73.01
74	RENAL DIALYSIS	0.227131	2,852,800	647,959	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT TREATMENT CENTERS	0.933653	42,858	40,015	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.055735			90.02
91	EMERGENCY	0.231626	16,432,411	3,806,174	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.570430	2,496,454	1,424,052	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		260,461,075	52,827,952	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		260,461,075		202

(A) Worksheet A line numbers

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S252** **WORKSHEET D-3**

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

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
35	NEONATAL INTENSIVE CARE UNIT				35
40	SUBPROVIDER - IPF		3,761,256		40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.270862	3,761	1,019	50
52	DELIVERY ROOM & LABOR ROOM	0.878655			52
53	ANESTHESIOLOGY	0.028855			53
54	RADIOLOGY-DIAGNOSTIC	0.090954	43,544	3,961	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.116303			54.01
56.01	ONCOLOGY	1.086951			56.01
60	LABORATORY	0.088186	301,290	26,570	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.243121			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.205516	1,163	239	65
66	PHYSICAL THERAPY	0.413011	7,345	3,034	66
69	ELECTROCARDIOLOGY	0.129870	57,543	7,473	69
69.01	CARDIAC CATH LAB	0.115140			69.01
69.02	CARDIAC REHABILITATION	1.213945			69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.222039	16,965	3,767	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.353727			72
73	DRUGS CHARGED TO PATIENTS	0.380156	160,058	60,847	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	0.976020			73.01
74	RENAL DIALYSIS	0.227131			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT TREATMENT CENTERS	0.933653			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.055735			90.02
91	EMERGENCY	0.231626	296,678	68,718	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.570430			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		888,347	175,628	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		888,347		202

(A) Worksheet A line numbers

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	67,409,899			1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)				1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)				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)	1,330,111			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	6,025,989			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	320.92			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)				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				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)				9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)				12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR				13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				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				18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)				20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				21
22	IME PAYMENT ADJUSTMENT (see instructions)				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)				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)				29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0250			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)				31
32	SUM OF LINES 30 AND 31				32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)				33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)				34
		PRIOR TO	ON OR AFTER		
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
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)				35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)				35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)				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
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)	68,740,010			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)	68,740,010			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	5,853,276			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)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	4,858			53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES	8,172			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)	11,552			58
59	TOTAL (sum of amounts on lines 49 through 58)	74,617,868			59
60	PRIMARY PAYER PAYMENTS	16,853			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	74,601,015			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	6,839,744			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	124,304			63
64	ALLOWABLE BAD DEBTS (see instructions)	533,515			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	346,785			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	338,945			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	67,983,752			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (OTHER ADJ-ALLIED HEALTH A&G)	2,044			70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	6,671			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-471,923			70.94
71	AMOUNT DUE PROVIDER (see instructions)	67,520,544			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	1,350,411			71.01
72	INTERIM PAYMENTS	66,109,001			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	61,132			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	137,587			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

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (see instructions)				96

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0252** **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)	118,406			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	48,001,762			2
3	PPS PAYMENTS	42,607,391			3
4	OUTLIER PAYMENT (see instructions)	55,827			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)	0.899			5
6	LINE 2 TIMES LINE 5	43,153,584			6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6	0.9886			7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200	14,900			9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	118,406			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	211,782			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)	211,782			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)	211,782			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	93,376			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)	118,406			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)	42,678,118			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	22,144			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	9,476,853			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	33,297,527			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)	33,297,527			30
31	PRIMARY PAYER PAYMENTS	2,253			31
32	SUBTOTAL (line 30 minus line 31)	33,295,274			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)	404,030			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	262,620			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	283,568			36
37	SUBTOTAL (see instructions)	33,557,894			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS ()				39
40	SUBTOTAL (see instructions)	33,557,894			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	671,158			40.01
41	INTERIM PAYMENTS	32,859,179			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	27,557			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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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S252** **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 ()				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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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0252** **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				66,109,001		32,859,179	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)				66,109,001		32,859,179	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		1,411,543		698,715	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				67,520,544		33,557,894	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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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-S252** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[ ] HOSPITAL [XX] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] 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				1,117,759			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)				1,117,759			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		59,943			6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				1,177,702			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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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 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	17,148	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	34,086	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3,021	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	67,786	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	1,569,527,394	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	54,789,935	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)	1,474,664	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	29,493	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	1,445,171	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,526,339	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-81,168	32

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S252** **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)	1,293,771	1
2	NET IPF PPS OUTLIER PAYMENT	7,395	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)	24.638356	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)	1,301,166	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)	1,301,166	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (line 16 less line 17)	1,301,166	18
19	DEDUCTIBLES	135,264	19
20	SUBTOTAL (line 18 minus line 19)	1,165,902	20
21	COINSURANCE	25,328	21
22	SUBTOTAL (line 20 minus line 21)	1,140,574	22
23	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	56,798	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	36,919	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	22,894	25
26	SUBTOTAL (sum of lines 22 and 24)	1,177,493	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)	209	28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	1,177,702	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	23,554	31.01
32	INTERIM PAYMENTS	1,117,759	32
33	TENTATIVE SETTLEMENT (for contractor use only)		33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)	36,389	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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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

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	12,711,783				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	59,326,075				4
5	OTHER RECEIVABLES	15,001,177				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE					6
7	INVENTORY	5,132,761				7
8	PREPAID EXPENSES	5,489,152				8
9	OTHER CURRENT ASSETS	48				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	97,660,996				11
	FIXED ASSETS					
12	LAND	1,789,072				12
13	LAND IMPROVEMENTS	14,250,270				13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	326,517,316				15
16	ACCUMULATED DEPRECIATION	-289,098,664				16
17	LEASEHOLD IMPROVEMENTS	1,317,195				17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	206,775,885				19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	120,066,006				23
24	ACCUMULATED DEPRECIATION					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)	381,617,080				30
	OTHER ASSETS					
31	INVESTMENTS	87,586,567				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	25,107,028				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	112,693,595				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	591,971,671				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	13,836,242				37
38	SALARIES, WAGES & FEES PAYABLE	31,655,849				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	6,741,738				40
41	DEFERRED INCOME	444,709				41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	59,130,758				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	111,809,296				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	294,992,332				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES					49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	294,992,332				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	406,801,628				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	185,170,043				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

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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	
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)	185,170,043				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	591,971,671				60

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

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		192,843,868			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		25,135,164			2
3	TOTAL (sun of line 1 and line 2)		217,979,032			3
4	ADDITIONS (credit adjustments)					4
5	RESTRICTED NET ASSETS TRANSFER					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)		217,979,032			11
12	DEDUCTIONS (debit adjustments)					12
13	RESTRICTED NET ASSETS TRANSFER	32,808,989				13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		32,808,989			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		185,170,043			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	RESTRICTED NET ASSETS TRANSFER					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	RESTRICTED NET ASSETS TRANSFER					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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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

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	129,659,842		129,659,842	1
2	SUBPROVIDER IPF	21,950,188		21,950,188	2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	151,610,030		151,610,030	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	34,719,442		34,719,442	11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	NEONATAL INTENSIVE CARE UNIT	11,391,367		11,391,367	15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)	46,110,809		46,110,809	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	197,720,839		197,720,839	17
18	ANCILLARY SERVICES	488,753,185	866,781,529	1,355,534,714	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY		8,071,185	8,071,185	22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	686,474,024	874,852,714	1,561,326,738	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		416,179,252	29
30	MISC WORKSHEET A-8 ADJUSTMENT	303,067		30
31				31
32				32
33				33
34				34
35	OTHER			35
36	TOTAL ADDITIONS (sum of lines 30-35)		303,067	36
37	PROVISION FOR BA DEBT - MISC RECEIP			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)		416,482,319	43

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

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

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	1,561,326,738	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	1,138,902,949	2
3	NET PATIENT REVENUES (line 1 minus line 2)	422,423,789	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	416,482,319	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	5,941,470	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	1,207,493	6
7	INCOME FROM INVESTMENTS	1,271,595	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	1,850,673	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	2,540,575	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (CAPITATION)	1,474,055	24
24.01	OTHER (OTHER REVENUE - ACCT 533990)	6,589,749	24.01
24.02	OTHER (RECONCILING OTHER INCOME)	877,386	24.02
24.03	OTHER (COMMUNICATIONS)	284,177	24.03
24.04	OTHER (MEANINGFUL USE)	2,548,553	24.04
24.05	OTHER (OTHER INCOME ACCT 539990)	549,438	24.05
25	TOTAL OTHER INCOME (sum of lines 6-24)	19,193,694	25
26	TOTAL (line 5 plus line 25)	25,135,164	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	25,135,164	29

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7094** **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	1,698,819	124,101				5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	1,709,268	126,802	72,113	11,389	137,486	6
7	PHYSICAL THERAPY	1,313,406	94,779	46,695	7,375	89,026	7
8	OCCUPATIONAL THERAPY	140,862	10,165	5,008	791	9,548	8
9	SPEECH PATHOLOGY	20,123	1,452	715	113	1,364	9
10	MEDICAL SOCIAL SERVICES	136,937	10,108	1,640	259	3,127	10
11	HOME HEALTH AIDE	55,251	3,548	4,301	678	8,198	11
12	SUPPLIES (see instructions)					101,991	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)	5,074,666	370,955	130,472	20,605	350,740	24

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7094** **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	1,822,920	1,061	1,823,981		1,823,981	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	2,057,058		2,057,058		2,057,058	6
7	PHYSICAL THERAPY	1,551,281		1,551,281		1,551,281	7
8	OCCUPATIONAL THERAPY	166,374		166,374		166,374	8
9	SPEECH PATHOLOGY	23,767		23,767		23,767	9
10	MEDICAL SOCIAL SERVICES	152,071		152,071		152,071	10
11	HOME HEALTH AIDE	71,976		71,976		71,976	11
12	SUPPLIES (see instructions)	101,991		101,991		101,991	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)	5,947,438	1,061	5,948,499		5,948,499	24

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

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7094** **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	1,823,981				5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE	2,057,058				6
7	PHYSICAL THERAPY	1,551,281				7
8	OCCUPATIONAL THERAPY	166,374				8
9	SPEECH PATHOLOGY	23,767				9
10	MEDICAL SOCIAL SERVICES	152,071				10
11	HOME HEALTH AIDE	71,976				11
12	SUPPLIES (see instructions)	101,991				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)	5,948,499				24

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7094** **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		1,823,981	1,823,981		5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE		2,057,058	890,084	2,947,142	6
7	PHYSICAL THERAPY		1,551,281	657,020	2,208,301	7
8	OCCUPATIONAL THERAPY		166,374	78,326	244,700	8
9	SPEECH PATHOLOGY		23,767	11,598	35,365	9
10	MEDICAL SOCIAL SERVICES		152,071	68,201	220,272	10
11	HOME HEALTH AIDE		71,976	28,863	100,839	11
12	SUPPLIES (see instructions)		101,991	20,053	122,044	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			69,836	69,836	23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)		5,948,499		5,948,499	24

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

COST ALLOCATION - HHA STATISTICAL BASIS **HHA CCN: 14-7094** **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					-1,823,981	9,277,061	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE					2,470,052	4,527,110	6
7	PHYSICAL THERAPY					1,790,428	3,341,709	7
8	OCCUPATIONAL THERAPY					232,007	398,381	8
9	SPEECH PATHOLOGY					35,220	58,987	9
10	MEDICAL SOCIAL SERVICES					194,812	346,883	10
11	HOME HEALTH AIDE					74,827	146,803	11
12	SUPPLIES (see instructions)						101,991	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					355,197	355,197	23
23.50	TELEMEDICINE							23.50
24	TOTAL (sum of lines 1-23)					3,328,562	9,277,061	24
25	COST TO BE ALLOC (per Worksheet H-1, Part I)						1,823,981	25
26	UNIT COST MULTIPLIER						0.196612	26

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7094** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	ADMINISTRATIVE AND GENERAL		238,713	30,760	386,297	655,770	157,970	1
2	SKILLED NURSING CARE	2,947,142			388,446	3,335,588	803,516	2
3	PHYSICAL THERAPY	2,208,301			298,482	2,506,783	603,864	3
4	OCCUPATIONAL THERAPY	244,700			32,012	276,712	66,658	4
5	SPEECH PATHOLOGY	35,365			4,573	39,938	9,621	5
6	MEDICAL SOCIAL SERVICES	220,272			31,120	251,392	60,558	6
7	HOME HEALTH AIDE	100,839			12,556	113,395	27,316	7
8	SUPPLIES	122,044				122,044	29,399	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	69,836				69,836	16,823	19
20	TOTALS (sum of lines 1-19)(2)	5,948,499	238,713	30,760	1,153,486	7,371,458	1,775,725	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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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7094** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	ADMINISTRATIVE AND GENERAL		255,856		111,350			1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							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)		255,856		111,350			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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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7094** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	ADMINISTRATIVE AND GENERAL		781,735					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				1,675			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)		781,735		1,675			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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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7094** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION EMS	SUBTOTAL (sum of col.4A-23)	
		19	20	21	22	23	24	
1	ADMINISTRATIVE AND GENERAL						1,962,681	1
2	SKILLED NURSING CARE						4,139,104	2
3	PHYSICAL THERAPY						3,110,647	3
4	OCCUPATIONAL THERAPY						343,370	4
5	SPEECH PATHOLOGY						49,559	5
6	MEDICAL SOCIAL SERVICES						311,950	6
7	HOME HEALTH AIDE						140,711	7
8	SUPPLIES						151,443	8
9	DRUGS						1,675	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						86,659	19
20	TOTALS (sum of lines 1-19)(2)						10,297,799	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7094** **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		1,962,681					1
2	SKILLED NURSING CARE		4,139,104	974,642	5,113,746			2
3	PHYSICAL THERAPY		3,110,647	732,467	3,843,114			3
4	OCCUPATIONAL THERAPY		343,370	80,854	424,224			4
5	SPEECH PATHOLOGY		49,559	11,670	61,229			5
6	MEDICAL SOCIAL SERVICES		311,950	73,455	385,405			6
7	HOME HEALTH AIDE		140,711	33,133	173,844			7
8	SUPPLIES		151,443	35,660	187,103			8
9	DRUGS		1,675	394	2,069			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		86,659	20,406	107,065			19
20	TOTALS (sum of lines 1-19)(2)		10,297,799	1,962,681	10,297,799			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.			0.235471				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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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 14-7094 **WORKSHEET H-2 PART II**

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	
		1	2	4	4A	5	6	
1	ADMINISTRATIVE AND GENERAL	5,176	30,215	1,699,819		655,770		1
2	SKILLED NURSING CARE			1,709,268		3,335,588		2
3	PHYSICAL THERAPY			1,313,406		2,506,783		3
4	OCCUPATIONAL THERAPY			140,862		276,712		4
5	SPEECH PATHOLOGY			20,123		39,938		5
6	MEDICAL SOCIAL SERVICES			136,937		251,392		6
7	HOME HEALTH AIDE			55,251		113,395		7
8	SUPPLIES					122,044		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					69,836		19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)	5,176	30,215	5,075,666		7,371,458		20
21	TOTAL COST TO BE ALLOCATED	238,713	30,760	1,153,486		1,775,725		21
22	UNIT COST MULTIPLIER	46.119204		0.227258		0.240892		22
22	UNIT COST MULTIPLIER		1.018037					22

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 14-7094 **WORKSHEET H-2 PART II**

	HHA COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S SERVED	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	
		7	8	9	10	11	12	
1	ADMINISTRATIVE AND GENERAL	5,176		5,176				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)	5,176		5,176				20
21	TOTAL COST TO BE ALLOCATED	255,856		111,350				21
22	UNIT COST MULTIPLIER	49.431221		21.512751				22
22	UNIT COST MULTIPLIER							22

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 14-7094 **WORKSHEET H-2 PART II**

	HHA COST CENTER	NURSING ADMINIS-TRATION FTE'S NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUISTION	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	ADMINISTRATIVE AND GENERAL	6,272						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			3,395				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)	6,272		3,395				20
21	TOTAL COST TO BE ALLOCATED	781,735		1,675				21
22	UNIT COST MULTIPLIER	124.638871		0.493373				22
22	UNIT COST MULTIPLIER							22

KPMG LLP COMPU-MAX

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 14-7094 **WORKSHEET H-2 PART II**

	HHA COST CENTER	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION EMS 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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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7094** **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	5,113,746		5,113,746	24,500	208.72	1
2	PHYSICAL THERAPY	3	3,843,114		3,843,114	15,864	242.25	2
3	OCCUPATIONAL THERAPY	4	424,224		424,224	1,701	249.40	3
4	SPEECH PATHOLOGY	5	61,229		61,229	243	251.97	4
5	MEDICAL SOCIAL SERVICES	6	385,405		385,405	557	691.93	5
6	HOME HEALTH AIDE	7	173,844		173,844	1,461	118.99	6
7	TOTAL (sum of lines 1-6)		10,001,562		10,001,562	44,326		7

LIMITATION COST COMPUTATION			PROGRAM VISITS			
				PART B		
	PATIENT SERVICES	CBSA NO.	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	
		1	2	3	4	
8	SKILLED NURSING CARE	11340	615	15,300		8
9	PHYSICAL THERAPY	11340	415	10,289		9
10	OCCUPATIONAL THERAPY	11340	63	1,085		10
11	SPEECH PATHOLOGY	11340	6	158		11
12	MEDICAL SOCIAL SERVICES	11340	17	453		12
13	HOME HEALTH AIDE	11340	10	1,227		13
14	TOTAL (sum of lines 8-13)		1,126	28,512		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	187,103	58,680	245,783	264,276	0.930024	15
16	COST OF DRUGS	9	2,069		2,069			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	0.412990			col. 2, line 2	1
2	OCCUPATIONAL THERAPY	67				col. 2, line 3	2
3	SPEECH PATHOLOGY	68				col. 2, line 4	3
4	MEDICAL SUPPLIES CHARGED TO PAT	71	0.222039	264,276	58,680	col. 2, line 15	4
5	DRUGS CHARGED TO PATIENTS	73	0.380156			col. 2, line 16	5
5.01	FLU VACCINE DRUGS CHG TO PATIEN	73.01	0.976020			col. 2, line 16	5.01

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APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7094** **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	615	15,300		128,363	3,193,416		3,321,779	1
2	PHYSICAL THERAPY	415	10,289		100,534	2,492,510		2,593,044	2
3	OCCUPATIONAL THERAPY	63	1,085		15,712	270,599		286,311	3
4	SPEECH PATHOLOGY	6	158		1,512	39,811		41,323	4
5	MEDICAL SOCIAL SERVICES	17	453		11,763	313,444		325,207	5
6	HOME HEALTH AIDE	10	1,227		1,190	146,001		147,191	6
7	TOTAL (sum of lines 1-6)	1,126	28,512		259,074	6,455,781		6,714,855	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		176,699					16

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NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/26/2015 Run Time: 16:17 Version: 2014.10

CALCULATION OF HHA REIMBURSEMRNT SETTLEMENT **HHA CCN: 14-7094** **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	217,409	176,699		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)	217,409	176,699		6
7	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (complete only if line 6 exceeds line 1)	217,409	176,699		7
8	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 1 exceeds line 6)				8
9	PRIMARY PAYER PAYMENTS		8,718		9

COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		PART A SERVICES	PART B SERVICES	
	DESCRIPTION	1	2	
10	TOTAL REASONABLE COST (see instructions)		-8,718	10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	186,323	4,919,418	11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES	2,397	93,240	13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES	4,315	91,968	14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	909	967	15
16	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES	17	54	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)	193,961	5,096,929	22
23	EXCESS REASONABLE COST (from line 8)			23
24	SUBTOTAL (line 22 minus line 23)	193,961	5,096,929	24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (from your records)			25
26	NET COST (line 24 minus line 25)	193,961	5,096,929	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)	193,961	5,096,929	29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			30
31	SUBTOTAL (line 29 plus/minus line 30)	193,961	5,096,929	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	3,879	101,941	31.01
32	INTERIM PAYMENTS (see instructions)	190,082	4,994,988	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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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **HHA CCN: 14-7094** **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				190,082		4,994,988	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)				190,082		4,994,988	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		3,879		101,941	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				193,961		5,096,929	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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CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0252** **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	5,386,896	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	319,318	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)	185.72	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.0250	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.1077	8
9	SUM OF LINES 7 AND 8	0.1327	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0273	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	147,062	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	5,853,276	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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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
35	NEONATAL INTENSIVE CARE UNIT							35
40	SUBPROVIDER - IPF							40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	OFFSITE-DIAGNOSTIC SERVICES							54.01
56.01	ONCOLOGY							56.01
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
69.01	CARDIAC CATH LAB							69.01
69.02	CARDIAC REHABILITATION							69.02
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM							90.02
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							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	DAY SURGERY CENTER							192.01

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES **WORKSHEET L-1 PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
192.02	RESIDENTIAL TREATMENT CENTER							192.02
192.03	MOBILE DENTAL CLINIC							192.03
192.04	EMS CONTINUING EDUCATION							192.04
194	CORPORATE HEALTH							194
194.01	MARKETING/COMMUNICATION							194.01
194.02	FOUNDATION							194.02
194.03	OTHER NRCC							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202