NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

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: 01/27/2017 Time: 13:33 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 certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by NORTHWESTERN LAKE FOREST HOSPITAL (14-0130) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 09/01/2015 and ending 08/31/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and 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		928,325	195,943	32,271		1
2	SUBPROVIDER - IPF						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		928,325	195,943	32,271		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 resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control
number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions,
search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions
for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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PARTS I, II & III

Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence
not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions
or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2**
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 660 WESTMORELAND ROAD	P.O. Box:		1
2	City: LAKE FOREST	State: IL	ZIP Code: 60045	County: LAKE	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	NORTHWESTERN LAKE FOREST HOSPITAL	14-0130	29404	1	07 / 01 / 1966	N	P	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF	NORTHWESTERN LAKE FOREST HOSPITAL	14-5216	29404		07 / 01 / 1970	N	P	N	9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	NORTHWESTERN LAKE FOREST HOME HEALTH	14-7045	29404		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: 09 / 01 / 2015	To: 08 / 31 / 2016	20
21	Type of control (see instructions)	2		21

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,456	905			262		24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	Y	Y	40

		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 payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

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

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in 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 nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

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

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

Inpatient Psychiatric Faciltiy 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.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers		1	2	
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108

		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
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	360,577	66,521	1,262,061	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
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	HB0640	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: NORTHWESTERN MEMORIAL HEALTHCA	Contractor's Name: NGS		Contractor's Number: 06101	141
142	Street: 251 E HURON ST	P.O. Box:			142
143	City: CHICAGO	State: IL	ZIP Code: 60611		143

144	Are provider based physicians' costs included in Worksheet A?	N		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N	N	N	159
160	HHA	N	N	N	N	160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)		166

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)			168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)	0.25		169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	09 / 01 / 2015	08 / 31 / 2016	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N	171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accnountant? 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	11/30/2016	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	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	11/30/2016	Y	11/30/2016	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 Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE **WORKSHEET S-2 PART II**

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

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

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.		29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render servcies to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: JOHN	Last name: VANDER LAAN	Title: MANAGER	41
42	Employer: NORTHWESTERN MEMORIAL HEALTHCARE			42
43	Phone number: (312) 926-6618	E-mail Address: JVANDERL@NMH.ORG		43

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A 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	107	39,162			8,021	789	18,652	1
2	HMO and other (see instructions)						817	1,079		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)		107	39,162			8,021	789	18,652	7
8	Intensive Care Unit	31	10	3,660			1,284	111	2,541	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						214	3,760	13
14	Total (see instructions)		117	42,822			9,305	1,114	24,953	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44	30	10,980			6,995		8,858	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101							11,272	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)		147							27
28	Observation Bed Days								5,669	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)								260	30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)		8	2,928				430	774	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					2,349	334	6,887	1
2	HMO and other (see instructions)					193	474		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)	9.46	1,060.61			2,349	334	6,887	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		33.26						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		34.08						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)	9.46	1,127.95						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

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	84,944,531		84,944,531	2,403,674.00	35.34	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest 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		509,453	509,453	19,674.00	25.89	7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office personnel							8
9	SNF	44	1,939,299		1,939,299	66,181.00	29.30	9
10	Excluded area salaries (see instructions)		5,175,842	11,399	5,187,241	162,869.00	31.85	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		810,524		810,524	11,072.00	73.20	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs		27,388,839		27,388,839	525,391.00	52.13	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)		23,151,362		23,151,362			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		2,334,446		2,334,446			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)		85,639		85,639			25
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		166,361		166,361	4,464.00	37.27	26
27	Administrative & General		11,986,762	1,924	11,988,686	174,938.00	68.53	27
28	Administrative & General under contract (see instructions)		1,266,029		1,266,029	25,857.00	48.96	28
29	Maintenance & Repairs							29
30	Operation of Plant		3,049,545		3,049,545	113,681.00	26.83	30
31	Laundry & Linen Service		282,340		282,340	18,906.00	14.93	31
32	Housekeeping		1,476,747	-20,986	1,455,761	96,842.00	15.03	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		9,584		9,584	159.00	60.28	34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel		27,704		27,704	1,150.00	24.09	37
38	Nursing Administration		4,982,926		4,982,926	104,568.00	47.65	38
39	Central Services and Supply		776,849		776,849	30,654.00	25.34	39
40	Pharmacy		2,130,634		2,130,634	47,173.00	45.17	40
41	Medical Records & Medical Records Library		598,202		598,202	23,044.00	25.96	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	86,210,560	-509,453	85,701,107	2,409,857.00	35.56	1
2	Excluded area salaries (see instructions)	7,115,141	11,399	7,126,540	229,050.00	31.11	2
3	Subtotal salarles (line 1 minus line 2)	79,095,419	-520,852	78,574,567	2,180,807.00	36.03	3
4	Subtotal other wages & related costs (see instructions)	28,199,363		28,199,363	536,463.00	52.57	4
5	Subtotal wage-related costs (see instructions)	23,151,362		23,151,362		29.46%	5
6	Total (sum of lines 3 through 5)	130,446,144	-520,852	129,925,292	2,717,270.00	47.81	6
7	Total overhead cost (see instructions)	26,753,683	-19,062	26,734,621	641,436.00	41.68	7

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	4,542,654	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	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)	11,290,483	8
9	Prescription Drug Plan	1,838,786	9
10	Dental, Hearing and Vision Plan	275,523	10
11	Life Insurance (If employee is owner or beneficiary)	67,096	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	538,684	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	766,821	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	5,969,659	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	26,959	19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement	213,668	23
24	Total Wage Related cost (Sum of lines 1-23)	25,530,333	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)	42,531	25

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

HOSPITAL CONTRACT LABOR AND BENEFIT COST **WORKSHEET S-3 PART V**

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

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

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA **HHA CCN: 14-7045** **WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA County: LAKE

		Title V	Title XVIII	Title XIX	Other	Total	
	Description	1	2	3	4	5	
1	Home Health Aide Hours						1
2	Unduplicated Census Count (see instructions)						2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)	7.57		7.57	3
4	Director(s) and Assistant Director(s)				4
5	Other Administrative Personnel				5
6	Direct Nursing Service	22.03		22.03	6
7	Nursing Supervisor				7
8	Physical Therapy Service	7.28		7.28	8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service	1.76		1.76	10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service				12
13	Speech Pathology Supervisor				13
14	Medical Social Service	0.55		0.55	14
15	Medical Social Service Supervisor				15
16	Home Health Aide	1.92		1.92	16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.	2	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).	16974	20
20.01		29404	20.01

PPS ACTIVITY

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		1	2	3	4	5	
21	Skilled Nursing Visits	5,578	186	179		5,943	21
22	Skilled Nursing Visit Charges						22
23	Physical Therapy Visits	3,590	37	118		3,745	23
24	Physical Therapy Visit Charges						24
25	Occupational Therapy Visits	820	4	16		840	25
26	Occupational Therapy Visit Charges						26
27	Speech Pathology Visits						27
28	Speech Pathology Visit Charges						28
29	Medical Social Service Visits	198	2	8		208	29
30	Medical Social Service Visit Charges						30
31	Home Health Aide Visits	521		15		536	31
32	Home Health Aide Visit Charges						32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	10,707	229	336		11,272	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)						35
36	Total Number of Episodes (standard/non-outlier)						36
37	Total Number of Ourlier Episodes						37
38	Total Non-Routine Medical Supply Charges						38

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA **WORKSHEET S-5**

RENAL DIALYSIS STATISTICS

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

ESRD PPS

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

TRANSPLANT INFORMATION

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

EPOETIN

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

ARANESP

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

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

21	MCP	INITIAL METHOD	

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

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N	/ /	2

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC	555		555	12
13	RUB	1,145		1,145	13
14	RUA	437		437	14
15	RVC	1,107		1,107	15
16	RVB	1,719		1,719	16
17	RVA	531		531	17
18	RHC	349		349	18
19	RHB	315		315	19
20	RHA	114		114	20
21	RMC	109		109	21
22	RMB	50		50	22
23	RMA	49		49	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2	13		13	29
30	HE1				30
31	HD2				31
32	HD1	3		3	32
33	HC2				33
34	HC1	1		1	34
35	HB2	8		8	35
36	HB1	30		30	36
37	LE2				37
38	LE1	171		171	38
39	LD2				39
40	LD1	25		25	40
41	LC2				41
42	LC1	39		39	42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1	5		5	46
47	CD2				47
48	CD1	10		10	48
49	CC2				49
50	CC1	59		59	50
51	CB2				51
52	CB1	38		38	52
53	CA2				53
54	CA1	29		29	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
65	BB2				65
66	BB1	2		2	66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1	1		1	70
71	PD2				71
72	PD1	15		15	72
73	PC2				73
74	PC1	27		27	74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1	2		2	78
199	AAA	37		37	199
200	TOTAL	6,995		6,995	200

SNF SERVICES

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

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

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing			Y	202
203	Recruitment				203
204	Retention of employees				204
205	Training			Y	205
206	Other (OTHER (STAFF MEETINGS))			Y	206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	10,133,552			207

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)	0.219965	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	3,052,192	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges	98,576,785	6
7	Medicaid cost (line 1 times line 6)	21,683,443	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.	18,631,251	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig 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)	18,631,251	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	31,990,908	1,336,287	33,327,195	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	7,036,880	293,936	7,330,816	21
22	Partial payment by patients approved for charity care	46,179	15,784	61,963	22
23	Cost of charity care (line 21 minus line 22)	6,990,701	278,152	7,268,853	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)	27,011,000	26
27	Medicare bad debts for the entire hospital complex (see instructions)	201,696	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	26,809,304	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	5,897,109	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	13,165,962	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	31,797,213	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		13,038,588	13,038,588	249,908	13,288,496	-3,829,192	9,459,304	1
2	00200	Cap Rel Costs-Mvble Equip		5,304,519	5,304,519	119,373	5,423,892	-23,975	5,399,917	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	166,361	-2,071,085	-1,904,724		-1,904,724	-35,954	-1,940,678	4
5	00500	Administrative & General	11,986,762	48,934,442	60,921,204	-243,924	60,677,280	14,261,674	74,938,954	5
7	00700	Operation of Plant	3,049,545	9,120,025	12,169,570		12,169,570	-29,721	12,139,849	7
8	00800	Laundry & Linen Service	282,340	259,776	542,116		542,116		542,116	8
9	00900	Housekeeping	1,476,747	1,817,627	3,294,374	-20,986	3,273,388		3,273,388	9
10	01000	Dietary	9,584	5,112,970	5,122,554	-2,685,054	2,437,500	-605,117	1,832,383	10
11	01100	Cafeteria				2,010,312	2,010,312	-933,155	1,077,157	11
12	01200	Maintenance of Personnel	27,704	42,789	70,493		70,493	-70,493		12
13	01300	Nursing Administration	4,982,926	1,910,488	6,893,414		6,893,414	58,047	6,951,461	13
14	01400	Central Services & Supply	776,849	1,152,416	1,929,265	-34,433	1,894,832		1,894,832	14
15	01500	Pharmacy	2,130,634	21,279,856	23,410,490	-20,225,370	3,185,120	-46,620	3,138,500	15
16	01600	Medical Records & Library	598,202	376,517	974,719		974,719		974,719	16
17	01700	Social Service								17
21	02100	I&R Services-Salary & Fringes Apprvd				595,092	595,092		595,092	21
22	02200	I&R Services-Other Prgm Costs Apprvd	73,981	1,171,758	1,245,739	-798,785	446,954		446,954	22
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	10,760,598	3,654,659	14,415,257	-584,453	13,830,804	-150	13,830,654	30
31	03100	Intensive Care Unit	2,372,515	984,568	3,357,083	-1,365	3,355,718		3,355,718	31
43	04300	Nursery	707,754	201,465	909,219	575,320	1,484,539		1,484,539	43
44	04400	Skilled Nursing Facility	1,939,299	743,466	2,682,765		2,682,765		2,682,765	44
45	04500	Nursing Facility	1,732,813	1,127,153	2,859,966	695,728	3,555,694	-88,298	3,467,396	45
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	8,058,289	14,915,417	22,973,706	-10,658,602	12,315,104	-1,180	12,313,924	50
52	05200	Delivery Room & Labor Room	2,453,193	983,585	3,436,778	-14,736	3,422,042	-1,365	3,420,677	52
54	05400	Radiology-Diagnostic	6,661,271	5,137,418	11,798,689	-433,998	11,364,691	-40,330	11,324,361	54
55	05500	Radiology-Therapeutic	835,983	831,776	1,667,759	-38	1,667,721		1,667,721	55
57	05700	CT Scan	720,980	379,315	1,100,295	-108,111	992,184		992,184	57
58	05800	MRI	1,873,457	770,370	2,643,827	-88,443	2,555,384		2,555,384	58
59	05900	Cardiac Catheterization	697,556	1,633,793	2,331,349	-1,433,777	897,572		897,572	59
60	06000	Laboratory	3,154,884	5,274,984	8,429,868	33,560	8,463,428		8,463,428	60
65	06500	Respiratory Therapy	906,116	434,658	1,340,774	-36,613	1,304,161		1,304,161	65
66	06600	Physical Therapy	3,308,586	821,738	4,130,324		4,130,324	-31,694	4,098,630	66
68	06800	Speech Pathology	949,763	609,838	1,559,601	-88,407	1,471,194	-18,349	1,452,845	68
69	06900	Electrocardiology	705,817	206,628	912,445		912,445		912,445	69
70	07000	Electroencephalography	174,128	84,103	258,231		258,231		258,231	70
71	07100	Medical Supplies Charged to Patients		-586,386	-586,386	6,492,075	5,905,689		5,905,689	71
72	07200	Impl. Dev. Charged to Patients				6,196,078	6,196,078		6,196,078	72
73	07300	Drugs Charged to Patients				20,873,400	20,873,400		20,873,400	73
76.97	07697	CARDIAC REHABILITATION	543,487	171,535	715,022		715,022	-91,148	623,874	76.97
		OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	951,331	440,649	1,391,980	-6,844	1,385,136	-483,025	902,111	90.01
90.02	09002	WOUND CLINIC	399,248	826,358	1,225,606	-11,638	1,213,968		1,213,968	90.02
91	09100	Emergency	4,842,751	2,053,765	6,896,516	-159,963	6,736,553		6,736,553	91
92	09200	Observation Beds (Non-Distinct Part)								92
92.01	09201	OBSERVATION BEDS-DISTINCT	1,190,048	391,481	1,581,529	-281	1,581,248		1,581,248	92.01
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	2,798,544	1,296,444	4,094,988		4,094,988	-2,247,549	1,847,439	101
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	84,300,046	150,839,466	235,139,512	205,025	235,344,537	5,742,406	241,086,943	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	136,215	76,451	212,666		212,666	-58,403	154,263	190
192	19200	Physicians' Private Offices	175,539	2,797,915	2,973,454	-205,025	2,768,429	-6,706,388	-3,937,959	192
194	07950	HEALTH & FITNESS CENTER	332,731	719,080	1,051,811		1,051,811	-1,051,811		194
194.01	07951	OCCUPATIONAL HEALTH		5,748	5,748		5,748		5,748	194.01
200		TOTAL (sum of lines 118-199)	84,944,531	154,438,660	239,383,191		239,383,191	-2,074,196	237,308,995	200

			INCREASES			
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	IMPLANT RECLASS	A	Impl. Dev. Charged to Patient	72		6,196,078	1
2	IMPLANT RECLASS	A					2
3	IMPLANT RECLASS	A					3
4							4
500	Total reclassifications					6,196,078	500
	Code Letter - A						
1	MED SUPPLY	B	Medical Supplies Charged to P	71		6,492,075	1
2	MED SUPPLY	B					2
3	MED SUPPLY	B					3
4	MED SUPPLY	B					4
5	MED SUPPLY	B					5
6	MED SUPPLY	B					6
7	MED SUPPLY	B					7
8	MED SUPPLY	B					8
9	MED SUPPLY	B					9
10	MED SUPPLY	B					10
11	MED SUPPLY	B					11
12	MED SUPPLY	B					12
13	MED SUPPLY	B					13
14	MED SUPPLY	B					14
15	MED SUPPLY	B					15
500	Total reclassifications					6,492,075	500
	Code Letter - B						
1	DRUG RECLASS	C	Drugs Charged to Patients	73		20,749,118	1
2	DRUG RECLASS	C					2
3	DRUG RECLASS	C					3
4	DRUG RECLASS	C					4
5	DRUG RECLASS	C					5
6	DRUG RECLASS	C					6
7	DRUG RECLASS	C					7
8	DRUG RECLASS	C					8
9	DRUG RECLASS	C					9
10	DRUG RECLASS	C					10
500	Total reclassifications					20,749,118	500
	Code Letter - C						
1	HOUSEKEEPING	D	Nursing Facility	45	20,986		1
500	Total reclassifications				20,986		500
	Code Letter - D						
1	INTEREST RECLASS	E	Cap Rel Costs-Bldg & Fixt	1		249,908	1
2	INTEREST RECLASS	E	Cap Rel Costs-Mvble Equip	2		119,373	2
500	Total reclassifications					369,281	500
	Code Letter - E						
1	RAD PHARM RECLASS	F	Drugs Charged to Patients	73		124,282	1
2							2
3							3
500	Total reclassifications					124,282	500
	Code Letter - F						
1	MOB	G	Administrative & General	5	1,924	123,433	1
2	MOB	G	Laboratory	60	3,283	40,744	2
3	MOB	G	Speech Pathology	68	1,837	31,256	3
4	MOB	G	Cardiac Catheterization	59	2,543	5	4
500	Total reclassifications				9,587	195,438	500
	Code Letter - G						
1	NURSERY RECLASS	H	Nursery	43	426,524	150,891	1
500	Total reclassifications				426,524	150,891	500
	Code Letter - H						
1	RECL NON RESIDENT EXPENSES TO LN 22	I	I&R Services-Salary & Fringes	21	509,453	85,639	1
2	RECL RESIDENT STIPENDS TO ER	I	Emergency	91		172,983	2
3	RECL RESIDENT FRINGE TO ER	I	Emergency	91		30,710	3
500	Total reclassifications				509,453	289,332	500
	Code Letter - I						

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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	DIETARY RECLASS	J	Cafeteria	11		2,010,312	1
2			Nursing Facility	45		674,742	2
500	Total reclassifications					2,685,054	500
	Code Letter - J						
	GRAND TOTAL (Increases)				966,550	37,251,549	

(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.

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	IMPLANT RECLASS	A	Operating Room	50		5,490,097		1
2	IMPLANT RECLASS	A	Radiology-Diagnostic	54		48,491		2
3	IMPLANT RECLASS	A	Cardiac Catheterization	59		653,803		3
4			WOUND CLINIC	90.02		3,687		4
500	Total reclassifications					6,196,078		500
	Code letter - A							
1	MED SUPPLY	B	Central Services & Supply	14		34,433		1
2	MED SUPPLY	B	Pharmacy	15		13,550		2
3	MED SUPPLY	B	Adults & Pediatrics	30		7,038		3
4	MED SUPPLY	B	Intensive Care Unit	31		1,365		4
5	MED SUPPLY	B	Nursery	43		2,095		5
6	MED SUPPLY	B	Operating Room	50		5,118,483		6
7	MED SUPPLY	B	Delivery Room & Labor Room	52		14,736		7
8	MED SUPPLY	B	Radiology-Diagnostic	54		199,406		8
9	MED SUPPLY	B	CT Scan	57		667		9
10	MED SUPPLY	B	MRI	58		32		10
11	MED SUPPLY	B	Cardiac Catheterization	59		766,927		11
12	MED SUPPLY	B	Respiratory Therapy	65		36,613		12
13	MED SUPPLY	B	Speech Pathology	68		121,500		13
14	MED SUPPLY	B	OBSERVATION BEDS-DISTINCT	92.01		281		14
15	MED SUPPLY	B	Emergency	91		174,949		15
500	Total reclassifications					6,492,075		500
	Code letter - B							
1	DRUG RECLASS	C	Pharmacy	15		20,211,820		1
2	DRUG RECLASS	C	Operating Room	50		50,022		2
3	DRUG RECLASS	C	Radiology-Diagnostic	54		62,265		3
4	DRUG RECLASS	C	CT Scan	57		107,444		4
5	DRUG RECLASS	C	MRI	58		88,003		5
6	DRUG RECLASS	C	Cardiac Catheterization	59		15,595		6
7	DRUG RECLASS	C	Laboratory	60		10,467		7
8	DRUG RECLASS	C	OP PEDS ONC CLINIC	90.01		6,844		8
9	DRUG RECLASS	C	WOUND CLINIC	90.02		7,951		9
10	DRUG RECLASS	C	Emergency	91		188,707		10
500	Total reclassifications					20,749,118		500
	Code letter - C							
1	HOUSEKEEPING	D	Housekeeping	9	20,986			1
500	Total reclassifications				20,986			500
	Code letter - D							
1	INTEREST RECLASS	E	Administrative & General	5		369,281	14	1
2	INTEREST RECLASS	E					14	2
500	Total reclassifications					369,281		500
	Code letter - E							
1	RAD PHARM RECLASS	F	Radiology-Diagnostic	54		123,836		1
2			Radiology-Therapeutic	55		38		2
3			MRI	58		408		3
500	Total reclassifications					124,282		500
	Code letter - F							
1	MOB	G	Physicians' Private Offices	192	9,587	195,438		1
2	MOB	G						2
3	MOB	G						3
4	MOB	G						4
500	Total reclassifications				9,587	195,438		500
	Code letter - G							
1	NURSERY RECLASS	H	Adults & Pediatrics	30	426,524	150,891		1
500	Total reclassifications				426,524	150,891		500
	Code letter - H							
1	RECL NON RESIDENT EXPENSES TO LN 22	I	I&R Services-Other Prgm Costs	22	509,453	85,639		1
2	RECL RESIDENT STIPENDS TO ER	I	I&R Services-Other Prgm Costs	22		172,983		2
3	RECL RESIDENT FRINGE TO ER	I	I&R Services-Other Prgm Costs	22		30,710		3
500	Total reclassifications				509,453	289,332		500
	Code letter - I							

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	DIETARY RECLASS	J	Dietary	10		2,685,054		1
2								2
500	Total reclassifications					2,685,054		500
	Code letter - J							
	GRAND TOTAL (Decreases)				966,550	37,251,549		

(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.

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 Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	53,223,598				1,200,000	52,023,598		1
2	Land Improvements								2
3	Buildings and Fixtures	170,082,802	9,727,404		9,727,404	5,898,659	173,911,547		3
4	Building Improvements								4
5	Fixed Equipment	42,970,665	7,904,214		7,904,214	1,437,190	49,437,689		5
6	Movable Equipment								6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	266,277,065	17,631,618		17,631,618	8,535,849	275,372,834		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	266,277,065	17,631,618		17,631,618	8,535,849	275,372,834		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	13,038,588						13,038,588	1
2	Cap Rel Costs-Mvble Equip	5,304,519						5,304,519	2
3	Total (sum of lines 1-2)	18,343,107						18,343,107	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	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	173,911,547		173,911,547	0.778653					1
2	Cap Rel Costs-Mvble Equ	49,437,689		49,437,689	0.221347					2
3	Total (sum of lines 1-2)	223,349,236		223,349,236	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	9,209,396					249,908	9,459,304	1
2	Cap Rel Costs-Mvble Equip	5,280,544					119,373	5,399,917	2
3	Total (sum of lines 1-2)	14,489,940					369,281	14,859,221	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.)

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2					10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	25,819,228				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests						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	A	-332,103	Cap Rel Costs-Bldg & Fixt	1	9	26
27	Depreciation--movable equipment	A	-23,975	Cap Rel Costs-Mvble Equip	2	9	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	FOOD INCOME & MISC ADJ	B	-318,976	Dietary	10		33
33.03	FOOD INCOME & MISC ADJ	B	-933,155	Cafeteria	11		33.03
33.04	FOOD INCOME & MISC ADJ	B	-88,298	Nursing Facility	45		33.04
34	OTHER INCOME	B	-666,333	Administrative & General	5		34
34.01	OTHER INCOME	B	-29,721	Operation of Plant	7		34.01
34.02	OTHER INCOME	B	-286,141	Dietary	10		34.02
34.03	OTHER INCOME	B	-11,022	Maintenance of Personnel	12		34.03
34.04	OTHER INCOME	B	58,047	Nursing Administration	13		34.04
34.05	OTHER INCOME	B	-46,620	Pharmacy	15		34.05
34.06	OTHER INCOME	B	-150	Adults & Pediatrics	30		34.06
34.07	OTHER INCOME	B	-580	Operating Room	50		34.07
34.08	OTHER INCOME	B	-1,365	Delivery Room & Labor Room	52		34.08
34.09	OTHER INCOME	B	-40,330	Radiology-Diagnostic	54		34.09
34.10	OTHER INCOME	B	-31,694	Physical Therapy	66		34.10
34.11	OTHER INCOME	B	-10,292	Speech Pathology	68		34.11
34.12	OTHER INCOME	B	-91,148	CARDIAC REHABILITATION	76.97		34.12
34.13	OTHER INCOME	B	-483,025	OP PEDS ONC CLINIC	90.01		34.13
34.14	OTHER INCOME	B	-58,403	Gift, Flower, Coffee Shop & Canteen	190		34.14
34.15	OTHER INCOME	B	-24,735	Physicians' Private Offices	192		34.15
34.16	OTHER INCOME	B	-2,138,527	Home Health Agency	101		34.16
35							35
36	RENTAL INCOME	B	-598,802	Maintenance of Personnel	12		36
36.01	RENTAL INCOME	B	-600	Operating Room	50		36.01
36.02	RENTAL INCOME	B	-25	Speech Pathology	68		36.02
36.03	RENTAL INCOME	B	-109,022	Home Health Agency	101		36.03

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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	
36.04	RENTAL INCOME	B	-5,473,945	Physicians' Private Offices	192		36.04
36.05	RENTAL INCOME CAPPED AT EXPENSE	A	550,561	Maintenance of Personnel	12		36.05
37							37
38	HAP EXCLUDED	A	-3,300,766	Administrative & General	5		38
39	REAL ESTATE TAX	A	-35,954	Employee Benefits Department	4		39
39.01	REAL ESTATE TAX	A	-11,230	Maintenance of Personnel	12		39.01
39.02	REAL ESTATE TAX	A	-1,207,708	Physicians' Private Offices	192		39.02
40							40
40.01	UNALLOWABLE EXPENSE	A	-5,962	Administrative & General	5		40.01
41	PHYSICIAN NO HOURS	A	-5,396,283	Administrative & General	5		41
41.02	PHYSICIAN NO HOURS	A	-40,912	Administrative & General	5		41.02
41.03	PHYSICIAN NO HOURS	A	-8,032	Speech Pathology	68		41.03
42							42
43	CAPITAL BUILDING TO MEDICARE BASIS	A	-3,497,089	Cap Rel Costs-Bldg & Fixt	1	9	43
44							44
45	EXCLUDE HEALTH AND FITNESS	A	-1,051,811	HEALTH & FITNESS CENTER	194		45
46							46
47	EXCLUDE INTEREST	A	-2,147,298	Administrative & General	5		47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-2,074,196				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.

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

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	4	Employee Benefits Department	VARIOUS NMG	23,091	23,091			1
2	4	Employee Benefits Department	VARIOUS HFI	103,560	103,560			2
3	5	Administrative & General	VARIOUS NMHC	51,014,356	25,195,128	25,819,228		3
3.01	5	Administrative & General	VARIOUS NMHC	5,842,813	5,842,813			3.01
3.02	5	Administrative & General	VARIOUS NMH	61,500	61,500			3.02
3.03	5	Administrative & General	VARIOUS NMG	12,478,163	12,478,163			3.03
3.04	5	Administrative & General	VARIOUS HFI	364,630	364,630			3.04
3.05	21	I&R Services-Salary & Fringes Apprvd	VARIOUS NMG	271,150	271,150			3.05
3.06	54	Radiology-Diagnostic	VARIOUS NMH	206,618	206,618			3.06
3.07	54	Radiology-Diagnostic	VARIOUS NMG	410,739	410,739			3.07
3.08	55	Radiology-Therapeutic	VARIOUS NMH	229,998	229,998			3.08
3.09	58	MRI	VARIOUS NMH	24,186	24,186			3.09
3.10	60	Laboratory	VARIOUS NMH	1,100,613	1,100,613			3.10
3.11	60	Laboratory	VAROUS NMG	931	931			3.11
3.12	68	Speech Pathology	VARIOUS NMG	8,032	8,032			3.12
3.13	70	Electroencephalography	VARIOUS NMG	21,999	21,999			3.13
3.14	76.97	CARDIAC REHABILITATION	VARIOUS NMG	87	87			3.14
3.15	90.01	OP PEDS ONC CLINIC	VARIOUS NMG	22,464	22,464			3.15
3.16	192	Physicians' Private Offices	VARIOUS NMHC	691,142	691,142			3.16
3.17	192	Physicians' Private Offices	VARIOUS NMG	110,297	110,297			3.17
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			72,986,369	47,167,141	25,819,228		5

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

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

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B			NM HEALTHCARE		HEALTHCARE	6
7	B			NM HOSPITAL		HEALTHCARE	7
8	B			NM FOUNDATION		HEALTHCARE	8
9	B			NM MEDICAL GROUP		HEALTHCARE	9
9.01	B			LF HEALTH AND FITNESS INSTITUT		HEALTHCARE	9.01
10							10

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

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

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL								200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL								200

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	9,459,304	9,459,304					1
2	Cap Rel Costs-Mvble Equip	5,399,917		5,399,917				2
4	Employee Benefits Department	-1,940,678	84,493		-1,856,185			4
5	Administrative & General	74,938,954	647,604	98,375		75,684,933	75,684,933	5
7	Operation of Plant	12,139,849	1,969,684	82,860		14,192,393	6,536,122	7
8	Laundry & Linen Service	542,116	24,040	13,355		579,511	266,886	8
9	Housekeeping	3,273,388	98,394	3,999		3,375,781	1,554,672	9
10	Dietary	1,832,383	65,365			1,897,748	873,983	10
11	Cafeteria	1,077,157	19,402			1,096,559	505,006	11
12	Maintenance of Personnel		88,338			88,338	40,683	12
13	Nursing Administration	6,951,461	16,372	6,278		6,974,111	3,211,836	13
14	Central Services & Supply	1,894,832	156,351	104,112		2,155,295	992,593	14
15	Pharmacy	3,138,500	32,436	93,568		3,264,504	1,503,425	15
16	Medical Records & Library	974,719	36,003			1,010,722	465,475	16
17	Social Service							17
21	I&R Services-Salary & Fringes Apprvd	595,092				595,092	274,062	21
22	I&R Services-Other Prgm Costs Apprvd	446,954		15,767		462,721	213,100	22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	13,830,654	232,509	41,822		14,104,985	6,495,867	30
31	Intensive Care Unit	3,355,718	41,798	16,911		3,414,427	1,572,470	31
43	Nursery	1,484,539	4,948	3,684		1,493,171	687,660	43
44	Skilled Nursing Facility	2,682,765	139,308	9,196		2,831,269	1,303,904	44
45	Nursing Facility	3,467,396	233,143	2,252		3,702,791	1,705,272	45
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,313,924	729,088	1,742,416		14,785,428	6,809,237	50
52	Delivery Room & Labor Room	3,420,677	77,204	62,800		3,560,681	1,639,825	52
54	Radiology-Diagnostic	11,324,361	245,710	1,615,268		13,185,339	6,072,336	54
55	Radiology-Therapeutic	1,667,721	141,615	683,627		2,492,963	1,148,102	55
57	CT Scan	992,184	9,941	32,906		1,035,031	476,670	57
58	MRI	2,555,384	208,582	240,497		3,004,463	1,383,666	58
59	Cardiac Catheterization	897,572	29,262	74,608		1,001,442	461,201	59
60	Laboratory	8,463,428	136,073	142,099		8,741,600	4,025,830	60
65	Respiratory Therapy	1,304,161	1,888	39,166		1,345,215	619,521	65
66	Physical Therapy	4,098,630	181,155	1,892		4,281,677	1,971,871	66
68	Speech Pathology	1,452,845	179,227	10,009		1,642,081	756,239	68
69	Electrocardiology	912,445	63,377	120,492		1,096,314	504,893	69
70	Electroencephalography	258,231	31,085	20,799		310,115	142,819	70
71	Medical Supplies Charged to Patients	5,905,689				5,905,689	2,719,788	71
72	Impl. Dev. Charged to Patients	6,196,078				6,196,078	2,853,523	72
73	Drugs Charged to Patients	20,873,400				20,873,400	9,612,961	73
76.97	CARDIAC REHABILITATION	623,874	8,456	1,766		634,096	292,025	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC	902,111	92,950	2,824		997,885	459,563	90.01
90.02	WOUND CLINIC	1,213,968	12,236	9,086		1,235,290	568,897	90.02
91	Emergency	6,736,553	218,009	72,253		7,026,815	3,236,108	91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT	1,581,248	78,928	31,567		1,691,743	779,110	92.01
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,847,439	20,821	3,289		1,871,549	861,918	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	241,086,943	6,355,795	5,399,543		239,839,245	75,599,119	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	154,263	8,158	374		162,795	74,973	190
192	Physicians' Private Offices	-3,937,959	3,077,559			-860,400		192
194	HEALTH & FITNESS CENTER							194
194.01	OCCUPATIONAL HEALTH	5,748	17,792			23,540	10,841	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers				-1,856,185	-1,856,185		201
202	TOTAL (sum of lines 118-201)	237,308,995	9,459,304	5,399,917	-1,856,185	237,308,995	75,684,933	202

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant	20,728,515						7
8	Laundry & Linen Service		846,397					8
9	Housekeeping	359,740	423,199	5,713,392				9
10	Dietary	176,906		87,095	3,035,732			10
11	Cafeteria	625,827		23,226		2,250,618		11
12	Maintenance of Personnel	74,517		11,612			215,150	12
13	Nursing Administration	845,737				1,301		13
14	Central Services & Supply	156,730		58,062		61,327		14
15	Pharmacy	557,914		34,838		44,369		15
16	Medical Records & Library	161,254		127,738		48,419		16
17	Social Service	344,712				29,694		17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,226,040	231,460	3,263,136	1,589,917	398,195		30
31	Intensive Care Unit	400,196	25,624	261,284	218,051	69,671		31
43	Nursery	47,373	58,738	81,288		58,824		43
44	Skilled Nursing Facility	1,333,762	6,233	185,801	748,643	81,622		44
45	Nursing Facility	2,232,124	37,772			78,996		45
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,211,034	14,460	603,854		302,070		50
52	Delivery Room & Labor Room	739,136	17,454			80,935		52
54	Radiology-Diagnostic	1,223,209		139,351		196,963		54
55	Radiology-Therapeutic	506,069				23,780		55
57	CT Scan	95,161				25,007		57
58	MRI	417,356				51,781		58
59	Cardiac Catheterization	280,179				17,571		59
60	Laboratory	792,021		174,189		136,421	53,787	60
65	Respiratory Therapy	18,096		52,257		30,700		65
66	Physical Therapy	1,117,024	3,587	63,869		98,580	53,787	66
68	Speech Pathology	485,113				33,547		68
69	Electrocardiology	147,994				21,080		69
70	Electroencephalography	297,599				4,957		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION	80,965	1,743			16,835		76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC	336,652		272,896		22,676		90.01
90.02	WOUND CLINIC	117,157	26,127			13,497		90.02
91	Emergency	1,188,577		226,446		174,459	107,576	91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT	127,973			479,121	25,130		92.01
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	4,368				83,634		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	20,728,515	846,397	5,666,942	3,035,732	2,232,041	215,150	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			46,450		13,497		190
192	Physicians' Private Offices					5,080		192
194	HEALTH & FITNESS CENTER							194
194.01	OCCUPATIONAL HEALTH							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	20,728,515	846,397	5,713,392	3,035,732	2,250,618	215,150	202

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

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	I&R SALARY & FRINGES	
		13	14	15	16	17	21	
	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
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	11,032,985						13
14	Central Services & Supply		3,424,007					14
15	Pharmacy			5,405,050				15
16	Medical Records & Library				1,813,608			16
17	Social Service					374,406		17
21	I&R Services-Salary & Fringes Apprvd						869,154	21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,639,627	144,844	469,887	106,665	374,406	869,154	30
31	Intensive Care Unit	792,621	41,377	127,022	26,325			31
43	Nursery	304,026	8,295	1,402	9,369			43
44	Skilled Nursing Facility	649,783	26,122	28,564	16,974			44
45	Nursing Facility	158,925	24,395	1,577	5,987			45
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,794,347	1,680,681	1,746,443	254,365			50
52	Delivery Room & Labor Room	800,781	66,228	261,254	27,092			52
54	Radiology-Diagnostic	169,143	429,419	479,525	202,662			54
55	Radiology-Therapeutic	45,234	2,384		64,433			55
57	CT Scan		36,417	2,528	89,127			57
58	MRI		58,237	46,788	128,766			58
59	Cardiac Catheterization	86,463	225,179	45,011	27,054			59
60	Laboratory		315,076	532,947	209,835			60
65	Respiratory Therapy		39,760	19,451	23,565			65
66	Physical Therapy		4,684		39,856			66
68	Speech Pathology		70,891		7,200			68
69	Electrocardiology		4,625	19,902	56,966			69
70	Electroencephalography		1,510		2,738			70
71	Medical Supplies Charged to Patients		24		80,853			71
72	Impl. Dev. Charged to Patients				33,349			72
73	Drugs Charged to Patients				153,154			73
76.97	CARDIAC REHABILITATION	69,416	2,128		2,877			76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC	196,288	28,129	106,995	18,370			90.01
90.02	WOUND CLINIC	39,356	42,002	215,592	9,807			90.02
91	Emergency	1,527,842	149,663	1,203,156	192,139			91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT	315,558	11,248	79,758	13,828			92.01
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	409,715	10,517	17,248	10,252			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,999,125	3,423,835	5,405,050	1,813,608	374,406	869,154	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	33,860	59					190
192	Physicians' Private Offices		113					192
194	HEALTH & FITNESS CENTER							194
194.01	OCCUPATIONAL HEALTH							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	11,032,985	3,424,007	5,405,050	1,813,608	374,406	869,154	202

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

	COST CENTER DESCRIPTIONS	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		22	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
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
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	675,821						22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	675,821	34,590,004	-1,544,975	33,045,029			30
31	Intensive Care Unit		6,949,068		6,949,068			31
43	Nursery		2,750,146		2,750,146			43
44	Skilled Nursing Facility		7,212,677		7,212,677			44
45	Nursing Facility		7,947,839		7,947,839			45
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		31,201,919		31,201,919			50
52	Delivery Room & Labor Room		7,193,386		7,193,386			52
54	Radiology-Diagnostic		22,097,947		22,097,947			54
55	Radiology-Therapeutic		4,282,965		4,282,965			55
57	CT Scan		1,759,941		1,759,941			57
58	MRI		5,091,057		5,091,057			58
59	Cardiac Catheterization		2,144,100		2,144,100			59
60	Laboratory		14,981,706		14,981,706			60
65	Respiratory Therapy		2,148,565		2,148,565			65
66	Physical Therapy		7,634,935		7,634,935			66
68	Speech Pathology		2,995,071		2,995,071			68
69	Electrocardiology		1,851,774		1,851,774			69
70	Electroencephalography		759,738		759,738			70
71	Medical Supplies Charged to Patients		8,706,354		8,706,354			71
72	Impl. Dev. Charged to Patients		9,082,950		9,082,950			72
73	Drugs Charged to Patients		30,639,515		30,639,515			73
76.97	CARDIAC REHABILITATION		1,100,085		1,100,085			76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC		2,439,454		2,439,454			90.01
90.02	WOUND CLINIC		2,267,725		2,267,725			90.02
91	Emergency		15,032,781		15,032,781			91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT		3,523,469		3,523,469			92.01
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		3,269,201		3,269,201			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	675,821	239,654,372	-1,544,975	238,109,397			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		331,634		331,634			190
192	Physicians' Private Offices		-855,207		-855,207			192
194	HEALTH & FITNESS CENTER							194
194.01	OCCUPATIONAL HEALTH		34,381		34,381			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers		-1,856,185		-1,856,185			201
202	TOTAL (sum of lines 118-201)	675,821	237,308,995	-1,544,975	235,764,020			202

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		84,493		84,493	84,493		4
5	Administrative & General	8,284,000	647,604	98,375	9,029,979		9,029,979	5
7	Operation of Plant	31,629	1,969,684	82,860	2,084,173		779,829	7
8	Laundry & Linen Service		24,040	13,355	37,395		31,842	8
9	Housekeeping		98,394	3,999	102,393		185,489	9
10	Dietary		65,365		65,365		104,276	10
11	Cafeteria		19,402		19,402		60,253	11
12	Maintenance of Personnel		88,338		88,338		4,854	12
13	Nursing Administration		16,372	6,278	22,650		383,206	13
14	Central Services & Supply	157,161	156,351	104,112	417,624		118,427	14
15	Pharmacy		32,436	93,568	126,004		179,375	15
16	Medical Records & Library		36,003		36,003		55,536	16
17	Social Service							17
21	I&R Services-Salary & Fringes Apprvd						32,699	21
22	I&R Services-Other Prgm Costs Apprvd			15,767	15,767		25,425	22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		232,509	41,822	274,331		775,027	30
31	Intensive Care Unit		41,798	16,911	58,709		187,613	31
43	Nursery		4,948	3,684	8,632		82,045	43
44	Skilled Nursing Facility	17,191	139,308	9,196	165,695		155,570	44
45	Nursing Facility		233,143	2,252	235,395		203,457	45
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	85,957	729,088	1,742,416	2,557,461		812,415	50
52	Delivery Room & Labor Room	696	77,204	62,800	140,700		195,649	52
54	Radiology-Diagnostic	583,533	245,710	1,615,268	2,444,511		724,495	54
55	Radiology-Therapeutic		141,615	683,627	825,242		136,981	55
57	CT Scan	750	9,941	32,906	43,597		56,872	57
58	MRI		208,582	240,497	449,079		165,086	58
59	Cardiac Catheterization		29,262	74,608	103,870		55,026	59
60	Laboratory	39,242	136,073	142,099	317,414		480,325	60
65	Respiratory Therapy		1,888	39,166	41,054		73,916	65
66	Physical Therapy	580	181,155	1,892	183,627		235,265	66
68	Speech Pathology		179,227	10,009	189,236		90,227	68
69	Electrocardiology		63,377	120,492	183,869		60,239	69
70	Electroencephalography		31,085	20,799	51,884		17,040	70
71	Medical Supplies Charged to Patients						324,500	71
72	Impl. Dev. Charged to Patients						340,456	72
73	Drugs Charged to Patients						1,146,884	73
76.97	CARDIAC REHABILITATION		8,456	1,766	10,222		34,842	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC		92,950	2,824	95,774		54,831	90.01
90.02	WOUND CLINIC		12,236	9,086	21,322		67,875	90.02
91	Emergency		218,009	72,253	290,262		386,102	91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT		78,928	31,567	110,495		92,956	92.01
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		20,821	3,289	24,110		102,836	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	9,200,739	6,355,795	5,399,543	20,956,077		9,019,741	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		8,158	374	8,532		8,945	190
192	Physicians' Private Offices	6,571	3,077,559		3,084,130			192
194	HEALTH & FITNESS CENTER							194
194.01	OCCUPATIONAL HEALTH		17,792		17,792		1,293	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers					84,493		201
202	TOTAL (sum of lines 118-201)	9,207,310	9,459,304	5,399,917	24,066,531	84,493	9,029,979	202

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant	2,864,002						7
8	Laundry & Linen Service		69,237					8
9	Housekeeping	49,704	34,618	372,204				9
10	Dietary	24,443		5,674	199,758			10
11	Cafeteria	86,469		1,513		167,637		11
12	Maintenance of Personnel	10,296		756			104,244	12
13	Nursing Administration	116,853				97		13
14	Central Services & Supply	21,655		3,783		4,568		14
15	Pharmacy	77,085		2,270		3,305		15
16	Medical Records & Library	22,280		8,322		3,606		16
17	Social Service	47,628				2,212		17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	307,566	18,934	212,578	104,621	29,660		30
31	Intensive Care Unit	55,294	2,096	17,022	14,348	5,189		31
43	Nursery	6,545	4,805	5,296		4,381		43
44	Skilled Nursing Facility	184,282	510	12,104	49,262	6,080		44
45	Nursing Facility	308,406	3,090			5,884		45
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	443,662	1,183	39,339		22,500		50
52	Delivery Room & Labor Room	102,124	1,428			6,028		52
54	Radiology-Diagnostic	169,007		9,078		14,671		54
55	Radiology-Therapeutic	69,922				1,771		55
57	CT Scan	13,148				1,863		57
58	MRI	57,665				3,857		58
59	Cardiac Catheterization	38,712				1,309		59
60	Laboratory	109,431		11,348		10,161	26,061	60
65	Respiratory Therapy	2,500		3,404		2,287		65
66	Physical Therapy	154,336	293	4,161		7,343	26,061	66
68	Speech Pathology	67,027				2,499		68
69	Electrocardiology	20,448				1,570		69
70	Electroencephalography	41,118				369		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION	11,187	143			1,254		76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC	46,514		17,778		1,689		90.01
90.02	WOUND CLINIC	16,187	2,137			1,005		90.02
91	Emergency	164,222		14,752		12,995	52,122	91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT	17,682			31,527	1,872		92.01
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	604				6,229		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,864,002	69,237	369,178	199,758	166,254	104,244	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			3,026		1,005		190
192	Physicians' Private Offices					378		192
194	HEALTH & FITNESS CENTER							194
194.01	OCCUPATIONAL HEALTH							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,864,002	69,237	372,204	199,758	167,637	104,244	202

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

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	I&R SALARY & FRINGES	
		13	14	15	16	17	21	
	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
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	522,806						13
14	Central Services & Supply		566,057					14
15	Pharmacy			388,039				15
16	Medical Records & Library				125,747			16
17	Social Service					49,840		17
21	I&R Services-Salary & Fringes Apprvd						32,699	21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	172,468	23,946	33,734	7,387	49,840		30
31	Intensive Care Unit	37,559	6,841	9,119	1,823			31
43	Nursery	14,406	1,371	101	649			43
44	Skilled Nursing Facility	30,790	4,319	2,051	1,175			44
45	Nursing Facility	7,531	4,033	113	415			45
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	85,026	277,846	125,381	17,764			50
52	Delivery Room & Labor Room	37,946	10,949	18,756	1,876			52
54	Radiology-Diagnostic	8,015	70,992	34,426	14,035			54
55	Radiology-Therapeutic	2,143	394		4,462			55
57	CT Scan		6,021	182	6,172			57
58	MRI		9,628	3,359	8,918			58
59	Cardiac Catheterization	4,097	37,227	3,231	1,874			59
60	Laboratory		52,088	38,261	14,532			60
65	Respiratory Therapy		6,573	1,396	1,632			65
66	Physical Therapy		774		2,760			66
68	Speech Pathology		11,720		499			68
69	Electrocardiology		765	1,429	3,945			69
70	Electroencephalography		250		190			70
71	Medical Supplies Charged to Patients		4		5,599			71
72	Impl. Dev. Charged to Patients				2,310			72
73	Drugs Charged to Patients				10,606			73
76.97	CARDIAC REHABILITATION	3,289	352		199			76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC	9,301	4,650	7,681	1,272			90.01
90.02	WOUND CLINIC	1,865	6,944	15,478	679			90.02
91	Emergency	72,398	24,742	86,377	13,306			91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT	14,953	1,860	5,726	958			92.01
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	19,415	1,739	1,238	710			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	521,202	566,028	388,039	125,747	49,840		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,604	10					190
192	Physicians' Private Offices		19					192
194	HEALTH & FITNESS CENTER							194
194.01	OCCUPATIONAL HEALTH							194.01
200	Cross Foot Adjustments						32,699	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	522,806	566,057	388,039	125,747	49,840	32,699	202

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

	COST CENTER DESCRIPTIONS	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		22	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
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
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	41,192						22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		2,010,092		2,010,092			30
31	Intensive Care Unit		395,613		395,613			31
43	Nursery		128,231		128,231			43
44	Skilled Nursing Facility		611,838		611,838			44
45	Nursing Facility		768,324		768,324			45
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		4,382,577		4,382,577			50
52	Delivery Room & Labor Room		515,456		515,456			52
54	Radiology-Diagnostic		3,489,230		3,489,230			54
55	Radiology-Therapeutic		1,040,915		1,040,915			55
57	CT Scan		127,855		127,855			57
58	MRI		697,592		697,592			58
59	Cardiac Catheterization		245,346		245,346			59
60	Laboratory		1,059,621		1,059,621			60
65	Respiratory Therapy		132,762		132,762			65
66	Physical Therapy		614,620		614,620			66
68	Speech Pathology		361,208		361,208			68
69	Electrocardiology		272,265		272,265			69
70	Electroencephalography		110,851		110,851			70
71	Medical Supplies Charged to Patients		330,103		330,103			71
72	Impl. Dev. Charged to Patients		342,766		342,766			72
73	Drugs Charged to Patients		1,157,490		1,157,490			73
76.97	CARDIAC REHABILITATION		61,488		61,488			76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC		239,490		239,490			90.01
90.02	WOUND CLINIC		133,492		133,492			90.02
91	Emergency		1,117,278		1,117,278			91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT		278,029		278,029			92.01
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		156,881		156,881			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		20,781,413		20,781,413			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		23,122		23,122			190
192	Physicians' Private Offices		3,084,527		3,084,527			192
194	HEALTH & FITNESS CENTER							194
194.01	OCCUPATIONAL HEALTH		19,085		19,085			194.01
200	Cross Foot Adjustments	41,192	73,891		73,891			200
201	Negative Cost Centers		84,493		84,493			201
202	TOTAL (sum of lines 118-201)	41,192	24,066,531		24,066,531			202

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

	COST CENTER DESCRIPTIONS	CAP BLDGS + FIXTURES DV 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	9,209,400						1
2	Cap Rel Costs-Mvble Equip		5,216,735					2
4	Employee Benefits Department	82,261		84,445,439				4
5	Administrative & General	630,495	95,038	11,986,762	-75,684,933	164,340,647		5
7	Operation of Plant	1,917,647	80,049	3,049,545		14,192,393	398,621	7
8	Laundry & Linen Service	23,405	12,902	282,340		579,511		8
9	Housekeeping	95,795	3,863	1,476,747		3,375,781	6,918	9
10	Dietary	63,638		9,584		1,897,748	3,402	10
11	Cafeteria	18,889				1,096,559	12,035	11
12	Maintenance of Personnel	86,004		27,704		88,338	1,433	12
13	Nursing Administration	15,939	6,065	4,982,926		6,974,111	16,264	13
14	Central Services & Supply	152,220	100,580	776,849		2,155,295	3,014	14
15	Pharmacy	31,579	90,394	2,130,634		3,264,504	10,729	15
16	Medical Records & Library	35,052		598,202		1,010,722	3,101	16
17	Social Service						6,629	17
21	I&R Services-Salary & Fringes Apprvd					595,092		21
22	I&R Services-Other Prgm Costs Apprvd		15,232	73,981		462,721		22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	226,366	40,403	10,760,598		14,104,985	42,808	30
31	Intensive Care Unit	40,694	16,337	2,372,515		3,414,427	7,696	31
43	Nursery	4,817	3,559	707,754		1,493,171	911	43
44	Skilled Nursing Facility	135,628	8,884	1,939,299		2,831,269	25,649	44
45	Nursing Facility	226,984	2,176	1,732,813		3,702,791	42,925	45
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	709,826	1,683,308	8,058,289		14,785,428	61,750	50
52	Delivery Room & Labor Room	75,164	60,670	2,453,193		3,560,681	14,214	52
54	Radiology-Diagnostic	239,219	1,560,474	6,661,271		13,185,339	23,523	54
55	Radiology-Therapeutic	137,874	660,436	835,983		2,492,963	9,732	55
57	CT Scan	9,678	31,790	720,980		1,035,031	1,830	57
58	MRI	203,071	232,339	1,873,457		3,004,463	8,026	58
59	Cardiac Catheterization	28,489	72,077	697,556		1,001,442	5,388	59
60	Laboratory	132,478	137,279	3,154,884		8,741,600	15,231	60
65	Respiratory Therapy	1,838	37,837	906,116		1,345,215	348	65
66	Physical Therapy	176,369	1,828	3,308,586		4,281,677	21,481	66
68	Speech Pathology	174,492	9,669	949,763		1,642,081	9,329	68
69	Electrocardiology	61,703	116,405	705,817		1,096,314	2,846	69
70	Electroencephalography	30,264	20,093	174,128		310,115	5,723	70
71	Medical Supplies Charged to Patients					5,905,689		71
72	Impl. Dev. Charged to Patients					6,196,078		72
73	Drugs Charged to Patients					20,873,400		73
76.97	CARDIAC REHABILITATION	8,233	1,706	543,487		634,096	1,557	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC	90,494	2,728	951,331		997,885	6,474	90.01
90.02	WOUND CLINIC	11,913	8,778	399,248		1,235,290	2,253	90.02
91	Emergency	212,249	69,802	4,842,751		7,026,815	22,857	91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT	76,843	30,496	1,190,048		1,691,743	2,461	92.01
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	20,271	3,177	2,798,544		1,871,549	84	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	6,187,881	5,216,374	84,133,685	-75,684,933	164,154,312	398,621	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	7,942	361	136,215		162,795		190
192	Physicians' Private Offices	2,996,255		175,539	860,400			192
194	HEALTH & FITNESS CENTER							194
194.01	OCCUPATIONAL HEALTH	17,322				23,540		194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	9,459,304	5,399,917			75,684,933	20,728,515	202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.027136	1.035114			0.460537	52.000559	203
204	Cost to be allocated (Per Wkst. B, Part II)					9,029,979	2,864,002	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.054947	7.184775	205

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA FTES	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	
		8	9	10	11	12	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
8	Laundry & Linen Service	1,228,810						8
9	Housekeeping	614,405	4,498,489					9
10	Dietary		68,575	107,757				10
11	Cafeteria		18,287		91,710			11
12	Maintenance of Personnel		9,143			1,012,080		12
13	Nursing Administration				53		1,184,421	13
14	Central Services & Supply		45,716		2,499			14
15	Pharmacy		27,430		1,808			15
16	Medical Records & Library		100,576		1,973			16
17	Social Service				1,210			17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	336,037	2,569,258	56,436	16,226		390,724	30
31	Intensive Care Unit	37,201	205,724	7,740	2,839		85,090	31
43	Nursery	85,277	64,003		2,397		32,638	43
44	Skilled Nursing Facility	9,049	146,292	26,574	3,326		69,756	44
45	Nursing Facility	54,838			3,219		17,061	45
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	20,993	475,450		12,309		192,628	50
52	Delivery Room & Labor Room	25,340			3,298		85,966	52
54	Radiology-Diagnostic		109,719		8,026		18,158	54
55	Radiology-Therapeutic				969		4,856	55
57	CT Scan				1,019			57
58	MRI				2,110			58
59	Cardiac Catheterization				716		9,282	59
60	Laboratory		137,149		5,559	253,020		60
65	Respiratory Therapy		41,145		1,251			65
66	Physical Therapy	5,208	50,288		4,017	253,020		66
68	Speech Pathology				1,367			68
69	Electrocardiology				859			69
70	Electroencephalography				202			70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION	2,530			686		7,452	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC		214,867		924		21,072	90.01
90.02	WOUND CLINIC	37,932			550		4,225	90.02
91	Emergency		178,294		7,109	506,040	164,018	91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT			17,007	1,024		33,876	92.01
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency				3,408		43,984	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,228,810	4,461,916	107,757	90,953	1,012,080	1,180,786	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		36,573		550		3,635	190
192	Physicians' Private Offices				207			192
194	HEALTH & FITNESS CENTER							194
194.01	OCCUPATIONAL HEALTH							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	846,397	5,713,392	3,035,732	2,250,618	215,150	11,032,985	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.688794	1.270069	28.172017	24.540595	0.212582	9.315087	203
204	Cost to be allocated (Per Wkst. B, Part II)	69,237	372,204	199,758	167,637	104,244	522,806	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.056345	0.082740	1.853782	1.827903	0.103000	0.441402	205

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	
		14	15	16	17	21	22	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
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	16,603,809						14
15	Pharmacy		215,909					15
16	Medical Records & Library			1,082,485,649				16
17	Social Service				100			17
21	I&R Services-Salary & Fringes Apprvd					100		21
22	I&R Services-Other Prgm Costs Apprvd						100	22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	702,383	18,770	63,680,474	100	100	100	30
31	Intensive Care Unit	200,649	5,074	15,716,704				31
43	Nursery	40,225	56	5,593,718				43
44	Skilled Nursing Facility	126,672	1,141	10,133,552				44
45	Nursing Facility	118,297	63	3,574,030				45
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,150,003	69,763	151,592,601				50
52	Delivery Room & Labor Room	321,157	10,436	16,174,538				52
54	Radiology-Diagnostic	2,082,354	19,155	120,992,344				54
55	Radiology-Therapeutic	11,559		38,467,514				55
57	CT Scan	176,597	101	53,210,379				57
58	MRI	282,405	1,869	76,875,332				58
59	Cardiac Catheterization	1,091,946	1,798	16,151,618				59
60	Laboratory	1,527,878	21,289	125,274,815				60
65	Respiratory Therapy	192,805	777	14,068,869				65
66	Physical Therapy	22,715		23,794,526				66
68	Speech Pathology	343,768		4,298,210				68
69	Electrocardiology	22,428	795	34,009,735				69
70	Electroencephalography	7,322		1,634,725				70
71	Medical Supplies Charged to Patients	115		48,270,700				71
72	Impl. Dev. Charged to Patients			19,909,663				72
73	Drugs Charged to Patients			91,435,329				73
76.97	CARDIAC REHABILITATION	10,319		1,717,449				76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC	136,404	4,274	10,967,399				90.01
90.02	WOUND CLINIC	203,680	8,612	5,854,942				90.02
91	Emergency	725,751	48,061	114,710,116				91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT	54,545	3,186	8,255,716				92.01
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	50,999	689	6,120,651				101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	16,602,976	215,909	1,082,485,649	100	100	100	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	286						190
192	Physicians' Private Offices	547						192
194	HEALTH & FITNESS CENTER							194
194.01	OCCUPATIONAL HEALTH							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,424,007	5,405,050	1,813,608	374,406	869,154	675,821	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.206218	25.033926	0.001675	3,744.060000	8,691.540000	6,758.210000	203
204	Cost to be allocated (Per Wkst. B, Part II)	566,057	388,039	125,747	49,840	32,699	41,192	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.034092	1.797234	0.000116	498.400000	326.990000	411.920000	205

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

	COST CENTER DESCRIPTIONS							

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
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
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
43	Nursery							43
44	Skilled Nursing Facility							44
45	Nursing Facility							45
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
65	Respiratory Therapy							65
66	Physical Therapy							66
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC							90.01
90.02	WOUND CLINIC							90.02
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT							92.01
	OTHER REIMBURSABLE COST CENTERS							
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
194	HEALTH & FITNESS CENTER							194
194.01	OCCUPATIONAL HEALTH							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)							202
203	Unit Cost Multiplier (Wkst. B, Part I)							203
204	Cost to be allocated (Per Wkst. B, Part II)							204
205	Unit Cost Multiplier (Wkst. B, Part II)							205

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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 Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	33,045,029		33,045,029		33,045,029	30
31	Intensive Care Unit	6,949,068		6,949,068		6,949,068	31
43	Nursery	2,750,146		2,750,146		2,750,146	43
44	Skilled Nursing Facility	7,212,677		7,212,677		7,212,677	44
45	Nursing Facility	7,947,839		7,947,839		7,947,839	45
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	31,201,919		31,201,919		31,201,919	50
52	Delivery Room & Labor Room	7,193,386		7,193,386		7,193,386	52
54	Radiology-Diagnostic	22,097,947		22,097,947		22,097,947	54
55	Radiology-Therapeutic	4,282,965		4,282,965		4,282,965	55
57	CT Scan	1,759,941		1,759,941		1,759,941	57
58	MRI	5,091,057		5,091,057		5,091,057	58
59	Cardiac Catheterization	2,144,100		2,144,100		2,144,100	59
60	Laboratory	14,981,706		14,981,706		14,981,706	60
65	Respiratory Therapy	2,148,565		2,148,565		2,148,565	65
66	Physical Therapy	7,634,935		7,634,935		7,634,935	66
68	Speech Pathology	2,995,071		2,995,071		2,995,071	68
69	Electrocardiology	1,851,774		1,851,774		1,851,774	69
70	Electroencephalography	759,738		759,738		759,738	70
71	Medical Supplies Charged to Patients	8,706,354		8,706,354		8,706,354	71
72	Impl. Dev. Charged to Patients	9,082,950		9,082,950		9,082,950	72
73	Drugs Charged to Patients	30,639,515		30,639,515		30,639,515	73
76.97	CARDIAC REHABILITATION	1,100,085		1,100,085		1,100,085	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC	2,439,454		2,439,454		2,439,454	90.01
90.02	WOUND CLINIC	2,267,725		2,267,725		2,267,725	90.02
91	Emergency	15,032,781		15,032,781		15,032,781	91
92	Observation Beds (Non-Distinct Part)	7,702,470		7,702,470		7,702,470	92
92.01	OBSERVATION BEDS-DISTINCT	3,523,469		3,523,469		3,523,469	92.01
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	3,269,201		3,269,201		3,269,201	101
200	Subtotal (sum of lines 30 thru 199)	245,811,867		245,811,867		245,811,867	200
201	Less Observation Beds	7,702,470		7,702,470		7,702,470	201
202	Total (line 200 minus line 201)	238,109,397		238,109,397		238,109,397	202

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 SERVICE COST CENTERS							
30	Adults & Pediatrics	54,655,600		54,655,600				30
31	Intensive Care Unit	15,716,704		15,716,704				31
43	Nursery	5,593,718		5,593,718				43
44	Skilled Nursing Facility	10,133,552		10,133,552				44
45	Nursing Facility	3,574,030		3,574,030				45
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	41,751,482	109,841,119	151,592,601	0.205827	0.205827	0.205827	50
52	Delivery Room & Labor Room	15,236,725	937,813	16,174,538	0.444735	0.444735	0.444735	52
54	Radiology-Diagnostic	12,086,698	108,905,646	120,992,344	0.182639	0.182639	0.182639	54
55	Radiology-Therapeutic	437,815	38,029,699	38,467,514	0.111340	0.111340	0.111340	55
57	CT Scan	13,591,902	39,618,477	53,210,379	0.033075	0.033075	0.033075	57
58	MRI	8,094,290	68,781,042	76,875,332	0.066225	0.066225	0.066225	58
59	Cardiac Catheterization	8,039,188	8,112,430	16,151,618	0.132748	0.132748	0.132748	59
60	Laboratory	41,823,497	83,451,318	125,274,815	0.119591	0.119591	0.119591	60
65	Respiratory Therapy	11,417,386	2,651,483	14,068,869	0.152718	0.152718	0.152718	65
66	Physical Therapy	11,826,800	11,967,726	23,794,526	0.320869	0.320869	0.320869	66
68	Speech Pathology	727,525	3,570,685	4,298,210	0.696818	0.696818	0.696818	68
69	Electrocardiology	9,016,595	24,993,140	34,009,735	0.054448	0.054448	0.054448	69
70	Electroencephalography	182,133	1,452,592	1,634,725	0.464750	0.464750	0.464750	70
71	Medical Supplies Charged to Patients	19,946,362	28,324,338	48,270,700	0.180365	0.180365	0.180365	71
72	Impl. Dev. Charged to Patients	14,303,184	5,606,479	19,909,663	0.456208	0.456208	0.456208	72
73	Drugs Charged to Patients	17,312,379	74,122,950	91,435,329	0.335095	0.335095	0.335095	73
76.97	CARDIAC REHABILITATION	2,908	1,714,541	1,717,449	0.640534	0.640534	0.640534	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC	52,557	10,914,842	10,967,399	0.222428	0.222428	0.222428	90.01
90.02	WOUND CLINIC	45,869	5,809,073	5,854,942	0.387318	0.387318	0.387318	90.02
91	Emergency	15,867,785	98,842,331	114,710,116	0.131050	0.131050	0.131050	91
92	Observation Beds (Non-Distinct Part)	1,351,435	7,673,439	9,024,874	0.853471	0.853471	0.853471	92
92.01	OBSERVATION BEDS-DISTINCT	2,310,994	5,944,722	8,255,716	0.426791	0.426791	0.426791	92.01
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		6,120,651	6,120,651				101
200	Subtotal (sum of lines 30 thru 199)	335,099,113	747,386,536	1,082,485,649				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	335,099,113	747,386,536	1,082,485,649				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	2,010,092		2,010,092	24,321	82.65	8,021	662,936	30
31	Intensive Care Unit	395,613		395,613	2,541	155.69	1,284	199,906	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	128,231		128,231	3,760	34.10			43
44	Skilled Nursing Facility	611,838		611,838	8,858	69.07	6,995	483,145	44
45	Nursing Facility	768,324		768,324					45
200	Total (lines 30-199)	3,914,098		3,914,098	39,480		16,300	1,345,987	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0130** **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	4,382,577	151,592,601	0.028910	17,339,775	501,293	50
52	Delivery Room & Labor Room	515,456	16,174,538	0.031868	9,866	314	52
54	Radiology-Diagnostic	3,489,230	120,992,344	0.028838	6,016,392	173,501	54
55	Radiology-Therapeutic	1,040,915	38,467,514	0.027060	133,326	3,608	55
57	CT Scan	127,855	53,210,379	0.002403	6,464,257	15,534	57
58	MRI	697,592	76,875,332	0.009074	3,456,249	31,362	58
59	Cardiac Catheterization	245,346	16,151,618	0.015190	3,777,710	57,383	59
60	Laboratory	1,059,621	125,274,815	0.008458	17,702,201	149,725	60
65	Respiratory Therapy	132,762	14,068,869	0.009437	6,077,019	57,349	65
66	Physical Therapy	614,620	23,794,526	0.025830	2,497,892	64,521	66
68	Speech Pathology	361,208	4,298,210	0.084037	427,010	35,885	68
69	Electrocardiology	272,265	34,009,735	0.008006	4,848,692	38,819	69
70	Electroencephalography	110,851	1,634,725	0.067810	87,465	5,931	70
71	Medical Supplies Charged to Pat	330,103	48,270,700	0.006839	7,711,990	52,742	71
72	Impl. Dev. Charged to Patients	342,766	19,909,663	0.017216	6,407,727	110,315	72
73	Drugs Charged to Patients	1,157,490	91,435,329	0.012659	5,840,513	73,935	73
76.97	CARDIAC REHABILITATION	61,488	1,717,449	0.035802	963	34	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC	239,490	10,967,399	0.021837	29,960	654	90.01
90.02	WOUND CLINIC	133,492	5,854,942	0.022800	13,219	301	90.02
91	Emergency	1,117,278	114,710,116	0.009740	6,827,162	66,497	91
92	Observation Beds (Non-Distinct	468,534	9,024,874	0.051916	405,430	21,048	92
92.01	OBSERVATION BEDS-DISTINCT	278,029	8,255,716	0.033677	346,123	11,656	92.01
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	17,178,968	986,691,394		96,420,941	1,472,407	200

(A) Worksheet A line numbers

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

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

		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 SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

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

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	24,321		8,021		30
31	Intensive Care Unit	2,541		1,284		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	3,760				43
44	Skilled Nursing Facility	8,858		6,995		44
45	Nursing Facility					45
200	Total (lines 30-199)	39,480		16,300		200

(A) Worksheet A line numbers

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0130** **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
65	Respiratory Therapy							65
66	Physical Therapy							66
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC							90.01
90.02	WOUND CLINIC							90.02
91	Emergency							91
92	Observation Beds (Non-Distinct							92
92.01	OBSERVATION BEDS-DISTINCT							92.01
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0130** | **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/IID
[XX] PPS **[ ] TEFRA** **[ ] Other**

		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	151,592,601			17,339,775		23,458,499		50
52	Delivery Room & Labor Room	16,174,538			9,866		2,961		52
54	Radiology-Diagnostic	120,992,344			6,016,392		27,888,347		54
55	Radiology-Therapeutic	38,467,514			133,326		15,302,844		55
57	CT Scan	53,210,379			6,464,257		11,943,328		57
58	MRI	76,875,332			3,456,249		18,559,979		58
59	Cardiac Catheterization	16,151,618			3,777,710		3,513,890		59
60	Laboratory	125,274,815			17,702,201		15,471,385		60
65	Respiratory Therapy	14,068,869			6,077,019		742,192		65
66	Physical Therapy	23,794,526			2,497,892		419,855		66
68	Speech Pathology	4,298,210			427,010		364,497		68
69	Electrocardiology	34,009,735			4,848,692		8,187,937		69
70	Electroencephalography	1,634,725			87,465		476,668		70
71	Medical Supplies Charged to Pat	48,270,700			7,711,990		6,374,645		71
72	Impl. Dev. Charged to Patients	19,909,663			6,407,727		1,405,856		72
73	Drugs Charged to Patients	91,435,329			5,840,513		26,139,534		73
76.97	CARDIAC REHABILITATION	1,717,449			963		1,059,492		76.97
	OUTPATIENT SERVICE COST CENTERS								
90.01	OP PEDS ONC CLINIC	10,967,399			29,960		4,210,272		90.01
90.02	WOUND CLINIC	5,854,942			13,219		2,843,520		90.02
91	Emergency	114,710,116			6,827,162		14,242,425		91
92	Observation Beds (Non-Distinct	9,024,874			405,430		4,353,432		92
92.01	OBSERVATION BEDS-DISTINCT	8,255,716			346,123		2,063,378		92.01
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	986,691,394			96,420,941		189,024,936		200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0130** **WORKSHEET D PART V**

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

			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	0.205827	23,458,499			4,828,392			50
52	Delivery Room & Labor Room	0.444735	2,961			1,317			52
54	Radiology-Diagnostic	0.182639	27,888,347	600		5,093,500	110		54
55	Radiology-Therapeutic	0.111340	15,302,844			1,703,819			55
57	CT Scan	0.033075	11,943,328			395,026			57
58	MRI	0.066225	18,559,979			1,229,135			58
59	Cardiac Catheterization	0.132748	3,513,890			466,462			59
60	Laboratory	0.119591	15,471,385	13,507		1,850,238	1,615		60
65	Respiratory Therapy	0.152718	742,192			113,346			65
66	Physical Therapy	0.320869	419,855			134,718			66
68	Speech Pathology	0.696818	364,497			253,988			68
69	Electrocardiology	0.054448	8,187,937			445,817			69
70	Electroencephalography	0.464750	476,668			221,531			70
71	Medical Supplies Charged to Pat	0.180365	6,374,645			1,149,763			71
72	Impl. Dev. Charged to Patients	0.456208	1,405,856			641,363			72
73	Drugs Charged to Patients	0.335095	26,139,534	50,991		8,759,227	17,087		73
76.97	CARDIAC REHABILITATION	0.640534	1,059,492			678,641			76.97
	OUTPATIENT SERVICE COST CENTERS								
90.01	OP PEDS ONC CLINIC	0.222428	4,210,272			936,482			90.01
90.02	WOUND CLINIC	0.387318	2,843,520			1,101,346			90.02
91	Emergency	0.131050	14,242,425	280		1,866,470	37		91
92	Observation Beds (Non-Distinct	0.853471	4,353,432			3,715,528			92
92.01	OBSERVATION BEDS-DISTINCT	0.426791	2,063,378			880,631			92.01
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		189,024,936	65,378		36,466,740	18,849		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		189,024,936	65,378		36,466,740	18,849		202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-5216** **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
65	Respiratory Therapy							65
66	Physical Therapy							66
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC							90.01
90.02	WOUND CLINIC							90.02
91	Emergency							91
92	Observation Beds (Non-Distinct							92
92.01	OBSERVATION BEDS-DISTINCT							92.01
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-5216** **WORKSHEET D PART IV**

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

		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	151,592,601							50
52	Delivery Room & Labor Room	16,174,538							52
54	Radiology-Diagnostic	120,992,344			165,850				54
55	Radiology-Therapeutic	38,467,514							55
57	CT Scan	53,210,379			1,927				57
58	MRI	76,875,332			18,190				58
59	Cardiac Catheterization	16,151,618			242,053				59
60	Laboratory	125,274,815			1,250,418				60
65	Respiratory Therapy	14,068,869							65
66	Physical Therapy	23,794,526			5,833,621				66
68	Speech Pathology	4,298,210			133,407				68
69	Electrocardiology	34,009,735			8,525				69
70	Electroencephalography	1,634,725			3,030				70
71	Medical Supplies Charged to Pat	48,270,700			135,017				71
72	Impl. Dev. Charged to Patients	19,909,663							72
73	Drugs Charged to Patients	91,435,329			1,139,326				73
76.97	CARDIAC REHABILITATION	1,717,449							76.97
	OUTPATIENT SERVICE COST CENTERS								
90.01	OP PEDS ONC CLINIC	10,967,399							90.01
90.02	WOUND CLINIC	5,854,942							90.02
91	Emergency	114,710,116							91
92	Observation Beds (Non-Distinct	9,024,874							92
92.01	OBSERVATION BEDS-DISTINCT	8,255,716							92.01
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	986,691,394			8,931,364				200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-5216** **WORKSHEET D PART V**

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

			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	0.205827							50
52	Delivery Room & Labor Room	0.444735							52
54	Radiology-Diagnostic	0.182639							54
55	Radiology-Therapeutic	0.111340							55
57	CT Scan	0.033075							57
58	MRI	0.066225							58
59	Cardiac Catheterization	0.132748							59
60	Laboratory	0.119591							60
65	Respiratory Therapy	0.152718							65
66	Physical Therapy	0.320869							66
68	Speech Pathology	0.696818							68
69	Electrocardiology	0.054448							69
70	Electroencephalography	0.464750							70
71	Medical Supplies Charged to Pat	0.180365							71
72	Impl. Dev. Charged to Patients	0.456208							72
73	Drugs Charged to Patients	0.335095							73
76.97	CARDIAC REHABILITATION	0.640534							76.97
	OUTPATIENT SERVICE COST CENTERS								
90.01	OP PEDS ONC CLINIC	0.222428							90.01
90.02	WOUND CLINIC	0.387318							90.02
91	Emergency	0.131050							91
92	Observation Beds (Non-Distinct	0.853471							92
92.01	OBSERVATION BEDS-DISTINCT	0.426791							92.01
	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

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	2,010,092		2,010,092	24,321	82.65	789	65,211	30
31	Intensive Care Unit	395,613		395,613	2,541	155.69	111	17,282	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	128,231		128,231	3,760	34.10	214	7,297	43
44	Skilled Nursing Facility	611,838		611,838	8,858	69.07			44
45	Nursing Facility	768,324		768,324					45
200	Total (lines 30-199)	3,914,098		3,914,098	39,480		1,114	89,790	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0130** **WORKSHEET D PART II**

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	4,382,577	151,592,601	0.028910			50
52	Delivery Room & Labor Room	515,456	16,174,538	0.031868			52
54	Radiology-Diagnostic	3,489,230	120,992,344	0.028838			54
55	Radiology-Therapeutic	1,040,915	38,467,514	0.027060			55
57	CT Scan	127,855	53,210,379	0.002403			57
58	MRI	697,592	76,875,332	0.009074			58
59	Cardiac Catheterization	245,346	16,151,618	0.015190			59
60	Laboratory	1,059,621	125,274,815	0.008458			60
65	Respiratory Therapy	132,762	14,068,869	0.009437			65
66	Physical Therapy	614,620	23,794,526	0.025830			66
68	Speech Pathology	361,208	4,298,210	0.084037			68
69	Electrocardiology	272,265	34,009,735	0.008006			69
70	Electroencephalography	110,851	1,634,725	0.067810			70
71	Medical Supplies Charged to Pat	330,103	48,270,700	0.006839			71
72	Impl. Dev. Charged to Patients	342,766	19,909,663	0.017216			72
73	Drugs Charged to Patients	1,157,490	91,435,329	0.012659			73
76.97	CARDIAC REHABILITATION	61,488	1,717,449	0.035802			76.97
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC	239,490	10,967,399	0.021837			90.01
90.02	WOUND CLINIC	133,492	5,854,942	0.022800			90.02
91	Emergency	1,117,278	114,710,116	0.009740			91
92	Observation Beds (Non-Distinct	468,534	9,024,874	0.051916			92
92.01	OBSERVATION BEDS-DISTINCT	278,029	8,255,716	0.033677			92.01
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	17,178,968	986,691,394				200

(A) Worksheet A line numbers

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

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

		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 SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

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

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	24,321		789		30
31	Intensive Care Unit	2,541		111		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	3,760		214		43
44	Skilled Nursing Facility	8,858				44
45	Nursing Facility					45
200	Total (lines 30-199)	39,480		1,114		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0130** **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
65	Respiratory Therapy							65
66	Physical Therapy							66
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC							90.01
90.02	WOUND CLINIC							90.02
91	Emergency							91
92	Observation Beds (Non-Distinct							92
92.01	OBSERVATION BEDS-DISTINCT							92.01
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0130** | **WORKSHEET D PART IV**

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

		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	151,592,601							50
52	Delivery Room & Labor Room	16,174,538							52
54	Radiology-Diagnostic	120,992,344							54
55	Radiology-Therapeutic	38,467,514							55
57	CT Scan	53,210,379							57
58	MRI	76,875,332							58
59	Cardiac Catheterization	16,151,618							59
60	Laboratory	125,274,815							60
65	Respiratory Therapy	14,068,869							65
66	Physical Therapy	23,794,526							66
68	Speech Pathology	4,298,210							68
69	Electrocardiology	34,009,735							69
70	Electroencephalography	1,634,725							70
71	Medical Supplies Charged to Pat	48,270,700							71
72	Impl. Dev. Charged to Patients	19,909,663							72
73	Drugs Charged to Patients	91,435,329							73
76.97	CARDIAC REHABILITATION	1,717,449							76.97
	OUTPATIENT SERVICE COST CENTERS								
90.01	OP PEDS ONC CLINIC	10,967,399							90.01
90.02	WOUND CLINIC	5,854,942							90.02
91	Emergency	114,710,116							91
92	Observation Beds (Non-Distinct	9,024,874							92
92.01	OBSERVATION BEDS-DISTINCT	8,255,716							92.01
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	986,691,394							200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0130** **WORKSHEET D PART V**

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

			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	0.205827							50
52	Delivery Room & Labor Room	0.444735							52
54	Radiology-Diagnostic	0.182639							54
55	Radiology-Therapeutic	0.111340							55
57	CT Scan	0.033075							57
58	MRI	0.066225							58
59	Cardiac Catheterization	0.132748							59
60	Laboratory	0.119591							60
65	Respiratory Therapy	0.152718							65
66	Physical Therapy	0.320869							66
68	Speech Pathology	0.696818							68
69	Electrocardiology	0.054448							69
70	Electroencephalography	0.464750							70
71	Medical Supplies Charged to Pat	0.180365							71
72	Impl. Dev. Charged to Patients	0.456208							72
73	Drugs Charged to Patients	0.335095							73
76.97	CARDIAC REHABILITATION	0.640534							76.97
	OUTPATIENT SERVICE COST CENTERS								
90.01	OP PEDS ONC CLINIC	0.222428							90.01
90.02	WOUND CLINIC	0.387318							90.02
91	Emergency	0.131050							91
92	Observation Beds (Non-Distinct	0.853471							92
92.01	OBSERVATION BEDS-DISTINCT	0.426791							92.01
	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

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0130** **WORKSHEET D-1**
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	24,321	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	24,321	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)	18,652	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8,021	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	33,045,029	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	33,045,029	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	33,045,029	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0130** **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)					1,358.70	38
39	Program general inpatient routine service cost (line 9 x line 38)					10,898,133	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					10,898,133	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	6,949,068	2,541	2,734.78	1,284	3,511,458	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					17,752,224	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					32,161,815	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					862,842	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,472,407	51
52	Total Program excludable cost (sum of lines 50 and 51)					2,335,249	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					29,826,566	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 etner 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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					5,669	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,358.70	88
89	Observation bed cost (line 87 x line 88) (see instructions)					7,702,470	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	2,010,092	33,045,029	0.060829	7,702,470	468,534	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5216** **WORKSHEET D-1**
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,858	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,858	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)	8,858	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	6,995	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	7,212,677	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,212,677	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,212,677	37

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5216** **WORKSHEET D-1**
PARTS III & IV

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

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

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	7,212,677	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	814.26	71
72	Program routine service cost (line 9 x line 71)	5,695,749	72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)	5,695,749	74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)	5,695,749	83
84	Program inpatient ancillary services (see instructions)	2,586,025	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	8,281,774	86

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0130** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	24,321	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	24,321	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)	18,652	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	789	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	3,760	15
16	Nursery days (title V or XIX only)	214	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)	33,045,029	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	33,045,029	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	33,045,029	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0130** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,358.70	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,072,014	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)					1,072,014	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)	2,750,146	3,760	731.42	214	156,524	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	6,949,068	2,541	2,734.78	111	303,561	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					1,532,099	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					89,790	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)					89,790	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0130** **WORKSHEET D-1**
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					5,669	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0130** **WORKSHEET D-3**

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

		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		23,388,595		30
31	Intensive Care Unit		7,955,288		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.205827	17,339,775	3,568,994	50
52	Delivery Room & Labor Room	0.444735	9,866	4,388	52
54	Radiology-Diagnostic	0.182639	6,016,392	1,098,828	54
55	Radiology-Therapeutic	0.111340	133,326	14,845	55
57	CT Scan	0.033075	6,464,257	213,805	57
58	MRI	0.066225	3,456,249	228,890	58
59	Cardiac Catheterization	0.132748	3,777,710	501,483	59
60	Laboratory	0.119591	17,702,201	2,117,024	60
65	Respiratory Therapy	0.152718	6,077,019	928,070	65
66	Physical Therapy	0.320869	2,497,892	801,496	66
68	Speech Pathology	0.696818	427,010	297,548	68
69	Electrocardiology	0.054448	4,848,692	264,002	69
70	Electroencephalography	0.464750	87,465	40,649	70
71	Medical Supplies Charged to Patients	0.180365	7,711,990	1,390,973	71
72	Impl. Dev. Charged to Patients	0.456208	6,407,727	2,923,256	72
73	Drugs Charged to Patients	0.335095	5,840,513	1,957,127	73
76.97	CARDIAC REHABILITATION	0.640534	963	617	76.97
	OUTPATIENT SERVICE COST CENTERS				
90.01	OP PEDS ONC CLINIC	0.222428	29,960	6,664	90.01
90.02	WOUND CLINIC	0.387318	13,219	5,120	90.02
91	Emergency	0.131050	6,827,162	894,700	91
92	Observation Beds (Non-Distinct Part)	0.853471	405,430	346,023	92
92.01	OBSERVATION BEDS-DISTINCT	0.426791	346,123	147,722	92.01
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		96,420,941	17,752,224	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		96,420,941		202

(A) Worksheet A line numbers

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-5216** **WORKSHEET D-3**

Check	**[ ] Title V**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[ ] IPF**	**[XX] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
Boxes:	**[ ] Title XIX**	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[ ] 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
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.205827			50
52	Delivery Room & Labor Room	0.444735			52
54	Radiology-Diagnostic	0.182639	165,850	30,291	54
55	Radiology-Therapeutic	0.111340			55
57	CT Scan	0.033075	1,927	64	57
58	MRI	0.066225	18,190	1,205	58
59	Cardiac Catheterization	0.132748	242,053	32,132	59
60	Laboratory	0.119591	1,250,418	149,539	60
65	Respiratory Therapy	0.152718			65
66	Physical Therapy	0.320869	5,833,621	1,871,828	66
68	Speech Pathology	0.696818	133,407	92,960	68
69	Electrocardiology	0.054448	8,525	464	69
70	Electroencephalography	0.464750	3,030	1,408	70
71	Medical Supplies Charged to Patients	0.180365	135,017	24,352	71
72	Impl. Dev. Charged to Patients	0.456208			72
73	Drugs Charged to Patients	0.335095	1,139,326	381,782	73
76.97	CARDIAC REHABILITATION	0.640534			76.97
	OUTPATIENT SERVICE COST CENTERS				
90.01	OP PEDS ONC CLINIC	0.222428			90.01
90.02	WOUND CLINIC	0.387318			90.02
91	Emergency	0.131050			91
92	Observation Beds (Non-Distinct Part)	0.853471			92
92.01	OBSERVATION BEDS-DISTINCT	0.426791			92.01
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		8,931,364	2,586,025	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		8,931,364		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0130** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[XX] 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
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.205827			50
52	Delivery Room & Labor Room	0.444735			52
54	Radiology-Diagnostic	0.182639			54
55	Radiology-Therapeutic	0.111340			55
57	CT Scan	0.033075			57
58	MRI	0.066225			58
59	Cardiac Catheterization	0.132748			59
60	Laboratory	0.119591			60
65	Respiratory Therapy	0.152718			65
66	Physical Therapy	0.320869			66
68	Speech Pathology	0.696818			68
69	Electrocardiology	0.054448			69
70	Electroencephalography	0.464750			70
71	Medical Supplies Charged to Patients	0.180365			71
72	Impl. Dev. Charged to Patients	0.456208			72
73	Drugs Charged to Patients	0.335095			73
76.97	CARDIAC REHABILITATION	0.640534			76.97
	OUTPATIENT SERVICE COST CENTERS				
90.01	OP PEDS ONC CLINIC	0.222428			90.01
90.02	WOUND CLINIC	0.387318			90.02
91	Emergency	0.131050			91
92	Observation Beds (Non-Distinct Part)	0.853471			92
92.01	OBSERVATION BEDS-DISTINCT	0.426791			92.01
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,684,388			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	18,528,278			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	764,381			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments	1,616,459			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	109.51			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) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records	9.56			10
11	FTE count for residents in dental 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	9.56			16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count	9.56			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.087298			19
20	Prior year resident to bed ratio (see instructions)	0.087298			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.087298			21
22	IME payment adjustment (see instructions)	940,799			22
22.01	IME payment adjustment - Managed Care (see instructions)	75,238			22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)	9.56			24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)	940,799			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	75,238			29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0244			30
31	Percentage of Medicaid patient days to total patient days (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 (1.00)**	**(1.01)**	**October 1 (2.00)**	
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 (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46
47	Subtotal (see instructions)	21,917,846			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	21,993,084			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,753,409			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)	192,430			52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies	2,071			54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	23,940,994			59
60	Primary payer payments	2,240			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	23,938,754			61
62	Deductibles billed to program beneficiaries	56,028			62
63	Coinsurance billed to program beneficiaries	2,253,440			63
64	Allowable bad debts (see instructions)	111,930			64
65	Adjusted reimbursable bad debts (see instructions)	72,755			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	60,330			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	21,702,041			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	-146,872			70.93
70.94	HRR adjustment amount (see instructions)	-61,101			70.94
70.99	HAC adjustment amount (see instructions)	235,405			70.99
71	Amount due provider (see instructions)	21,258,663			71
71.01	Sequestration adjustment (see instructions)	425,173			71.01
72	Interim payments	19,905,165			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	928,325			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	248,833			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96

	HSP Bonus Payment Amount	**Prior to 10/1**	**On or After 10/1**		
100	HSP bonus amount (see instructions)				100

	HVBP Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

	HRR Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCLUATION **EXHIBIT 5**

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to 10/1		On or after 10/1		Total (cols. 2 and 3)	
		(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments							1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1,684,388	1,684,388				1,684,388	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	18,528,278			18,528,278		18,528,278	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1							1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1							1.04
2	Outlier payments for discharges	764,381	63,698		700,683		764,381	2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments	1,616,459	134,705		1,481,754		1,616,459	4
	Indirect Medical Education Adjustment							
5	Amount from Worksheet E Part A, line 21	0.087298	0.087298		0.087298			5
6	IME payment adjustment	940,799	78,400		862,399		940,799	6
6.01	IME payment adjustment for managed care	75,238	6,270		68,968		75,238	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	IME payment adjustment factor							7
8	IME add-on adjustment amount							8
8.01	IME payment adjustment add-on for managed care							8.01
9	Total IME payment (sum of lines 6 and 8)	940,799	78,400		862,399		940,799	9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	75,238	6,270		68,968		75,238	9.01
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage							10
11	Disproportionate share adjustment							11
11.01	Uncompensated care payments							11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	21,917,846	1,826,486		20,091,360		21,917,846	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)							14
15	Total payment for inpatient operating costs SCH and MDH only	21,993,084	1,832,756		20,160,328		21,993,084	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	1,753,409	146,117		1,607,292		1,753,409	16
17	Special add-on payments for new technologies	2,071			2,071		2,071	17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)							17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG							17.02
18	Capital outlier reconciliation adjustment amount							18
19	**SUBTOTAL**		1,978,873		21,769,691		23,748,564	19
20	Capital DRG other than outlier	1,620,604	135,050		1,485,554		1,620,604	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	17,580	1,465		16,115		17,580	21
21.01	Model 4 BPCI Capital DRG outlier payments							21.01
22	Indirect medical education percentage	4.5400	4.5400		4.5400			22
23	Indirect medical education adjustment	73,575	6,131		67,444		73,575	23
24	Allowable disproportionate share percentage	0.0257	0.0257		0.0257			24
25	Disproportionate share adjustment	41,650	3,471		38,179		41,650	25
26	Total prospective capital payments	1,753,409	146,117		1,607,292		1,753,409	26
27								27
28	Low volume adjustment prior to October 1							28
29	Low volume adjustment on or after October 1							29
30	HVBP payment adjustment	-146,872	-12,239		-134,633		-146,872	30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment	-61,101	-5,092		-56,009		-61,101	31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment		19,615		215,790		235,405	32

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0130** **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)	18,849			1
2	Medical and other services reimbursed under OPPS (see instructions)	36,466,740			2
3	PPS payments	24,475,795			3
4	Outlier payment (see instructions)	99,588			4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	18,849			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	65,378			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	65,378			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)	65,378			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	46,529			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)	18,849			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	24,575,383			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	4,995,976			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	19,598,256			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	170,014			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	19,768,270			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	19,768,270			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)	198,371			34
35	Adjusted reimbursable bad debts (see instructions)	128,941			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	107,428			36
37	Subtotal (see instructions)	19,897,211			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	19,897,211			40
40.01	Sequestration adjustment (see instructions)	397,944			40.01
41	Interim payments	19,303,324			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	195,943			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	499,990			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

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-5216** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

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

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (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

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0130** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[XX] Hospital** **[ ] 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				15,872		12,231	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				20,211,204		19,220,031	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			08/30/2016	71,062	3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	04/08/2016	223,383			3.51
		Provider	.52	08/30/2016	98,528			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		-321,911		71,062	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)				19,905,165		19,303,324	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		928,325		195,943	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				20,833,490		19,499,267	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.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-5216** **WORKSHEET E-1 PART I**

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				2,964,450			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				2,964,450			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					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				2,964,450			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.

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 (Wkst. S-3, Pt. I, col. 15, line 14)	6,887	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	9,305	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	817	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	21,193	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	1,082,485,649	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	33,327,195	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	387,784	8
9	Sequestration adjustment amount (see instructions)	7,756	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	380,028	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	347,757	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	32,271	32

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

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3**
PART VI

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

	PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	Resource Utilization Group (RUGS) payment	3,440,941	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	3,440,941	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	Medical and other services. Do not use this line. (see instructions)		5
6	Deductibles		6
7	Coinsurance	415,992	7
8	Allowable bad debts (see instructions)		8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		9
10	Adjusted reimbursable bad debts (see instructions)		10
11	Utilization review		11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)	3,024,949	12
13	Inpatient primary payer payments		13
14	Other adjustments (specify) (see instructions)		14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		14.50
15	Subtotal (see instructions)	3,024,949	15
15.01	Sequestration adjustment (see instructions)	60,499	15.01
16	Interim payments	2,964,450	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 16 and 17)		18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0130** **WORKSHEET E-3 PART VII**

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	1,532,099		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	1,532,099		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	1,532,099		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	1,532,099		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	1,532,099		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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

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

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996				1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			9.56	6
7	Enter the lesser of line 5 or line 6				7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	9.56	0.00	9.56	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
11	Total weighted FTE count	0.00	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00		14
15	Adjustment for residents in initial years of new programs	9.56	0.00		15
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
17	Adjusted rolling average FTE count	9.56	0.00		17
18	Per resident amount	83,227.88	0.00		18
19	Approved amount for resident costs	795,659		795,659	19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)			9.56	21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)			795,659	25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	9,305	817		26
27	Total inpatient days (see instructions)	21,967	21,967		27
28	Ratio of inpatient days to total inpatient days	0.423590	0.037192		28
29	Program direct GME amount	337,033	29,592		29
30	Reduction for direct GME payments for Medicare Advantage		4,181		30
31	Net Program direct GME amount			362,444	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	Part A Reasonable Cost				
37	Reasonable cost (see instructions)			41,298,505	37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)			2,240	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			41,296,265	41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)			36,485,589	42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)			36,485,589	44
45	Total reasonable cost (sum of lines 41 and 44)			77,781,854	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.530924	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.469076	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			362,444	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			192,430	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			170,014	50

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

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

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996				1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)				6
7	Enter the lesser of line 5 or line 6				7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
11	Total weighted FTE count	0.00	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
17	Adjusted rolling average FTE count	0.00	0.00		17
18	Per resident amount	0.00	0.00		18
19	Approved amount for resident costs				19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)				25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	1,330	1,079		26
27	Total inpatient days (see instructions)	21,967	21,967		27
28	Ratio of inpatient days to total inpatient days	0.060545	0.049119		28
29	Program direct GME amount				29
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	Part A Reasonable Cost				
37	Reasonable cost (see instructions)				37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)				41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)				42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)				44
45	Total reasonable cost (sum of lines 41 and 44)				45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)				46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)				48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)				49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)				50

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	27,088	27,146,645	26,272,955		1
2	Temporary investments					2
3	Notes receivable	-7,307,884				3
4	Accounts receivable	51,735,928				4
5	Other receivables	1,466,140				5
6	Allowances for uncollectible notes and accounts receivable	-22,187,543				6
7	Inventory	6,334,374				7
8	Prepaid expenses	423,346				8
9	Other current assets	7,325,361				9
10	Due from other funds	-18,893,925				10
11	Total current assets (sum of lines 1-10)	18,922,885	27,146,645	26,272,955		11
	FIXED ASSETS					
12	Land	52,023,598				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	173,911,546				15
16	Accumulated depreciation	-80,486,849				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	49,437,689				19
20	Accumulated depreciation	-30,984,912				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment					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)	163,901,072				30
	OTHER ASSETS					
31	Investments	66,114,937	-3,822,755	500		31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	220,059,936				34
35	Total other assets (sum of lines 31-34)	286,174,873	-3,822,755	500		35
36	Total assets (sum of lines 11, 30 and 35)	468,998,830	23,323,890	26,273,455		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	31,500,507				37
38	Salaries, wages and fees payable	13,178,040				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	41,281,770				43
44	Other current liabilities	5,783,610				44
45	Total current liabilities (sum of lines 37 thru 44)	91,743,927				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	56,748,698				47
48	Unsecured loans					48
49	Other long term liabilities	29,085,729				49
50	Total long term liabilities (sum of lines 46 thru 49)	85,834,427				50
51	Total liabilities (sum of lines 45 and 50)	177,578,354				51
	CAPITAL ACCOUNTS					
52	General fund balance	291,420,476				52
53	Specific purpose fund		23,323,890			53
54	Donor created - endowment fund balance - restricted			26,273,455		54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56

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 thru 58)	291,420,476	23,323,890	26,273,455		59
60	Total liabilities and fund balances (sum of lines 51 and 59)	468,998,830	23,323,890	26,273,455		60

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

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		272,793,643		27,146,645	1
2	Net income (loss) (from Worksheet G-3, line 29)		21,471,925			2
3	Total (sum of line 1 and line 2)		294,265,568		27,146,645	3
4	Additions (credit adjustments) (specify)					4
5	CHNG IN VALUE OF SLPIT INT AGREEMNT			52,417		5
6	GIFTS, GRANTS & OTHER REVENUE			8,535,689		6
7	INVESTMENT INCOME - REALIZED GAINS			1,653,318		7
8	RECLASSIFICATION					8
9						9
10	Total additions (sum of lines 4-9)				10,241,424	10
11	Subtotal (line 3 plus line 10)		294,265,568		37,388,069	11
12	Deductions (debit adjustments) (specify)					12
13	OPERATING EXPENSES			1,259,761		13
14	PROPERTY ADDITIONS			12,790,325		14
15	PRIOR PERIOD ADJUSTMENT	2,845,092		14,093		15
16						16
17						17
18	Total deductions (sum of lines 12-17)		2,845,092		14,064,179	18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		291,420,476		23,323,890	19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period		26,272,955			1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)		26,272,955			3
4	Additions (credit adjustments) (specify)					4
5	CHNG IN VALUE OF SLPIT INT AGREEMNT					5
6	GIFTS, GRANTS & OTHER REVENUE	500				6
7	INVESTMENT INCOME - REALIZED GAINS					7
8	RECLASSIFICATION					8
9						9
10	Total additions (sum of lines 4-9)		500			10
11	Subtotal (line 3 plus line 10)		26,273,455			11
12	Deductions (debit adjustments) (specify)					12
13	OPERATING EXPENSES					13
14	PROPERTY ADDITIONS					14
15	PRIOR PERIOD ADJUSTMENT					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)		26,273,455			19

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

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	65,489,664		65,489,664	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	10,133,552		10,133,552	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	75,623,216		75,623,216	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	75,623,216		75,623,216	17
18	Ancillary services	252,812,113	769,619,978	1,022,432,091	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				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)	328,435,329	769,619,978	1,098,055,307	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		239,383,191	29
30	Add (specify)			30
31	BAD DEBT			31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		239,383,191	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	1,098,055,307	1
2	Less contractual allowances and discounts on patients' accounts	854,977,851	2
3	Net patient revenues (line 1 minus line 2)	243,077,456	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	239,383,191	4
5	Net income from service to patients (line 3 minus line 4)	3,694,265	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	1,458,003	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	625	12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	950,686	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	5,364,923	22
23	Governmental appropriations	544,334	23
24	Other (SHARED, TELECOM, OTHER)		24
24.01	Other (OTHER INCOME)	9,459,089	24.01
25	Total other income (sum of lines 6-24)	17,777,660	25
26	Total (line 5 plus line 25)	21,471,925	26
29	Net income (or loss) for the period (line 26 minus line 28)	21,471,925	29

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7045** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR-TATION (see ins-tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	517,948					5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,458,554					6
7	Physical Therapy	632,422					7
8	Occupational Therapy	131,722					8
9	Speech Pathology						9
10	Medical Social Services	43,965					10
11	Home Health Aide	75,194					11
12	Supplies (see instructions)						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)	2,859,805					24

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7045** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	517,948		517,948	-183,353	334,595	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,458,554		1,458,554	-516,326	942,228	6
7	Physical Therapy	632,422		632,422	-223,876	408,546	7
8	Occupational Therapy	131,722		131,722	-46,629	85,093	8
9	Speech Pathology						9
10	Medical Social Services	43,965		43,965	-15,564	28,401	10
11	Home Health Aide	75,194		75,194	-26,618	48,576	11
12	Supplies (see instructions)						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)	2,859,805		2,859,805	-1,012,366	1,847,439	24

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

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7045** **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 CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	334,595				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	942,228				6
7	Physical Therapy	408,546				7
8	Occupational Therapy	85,093				8
9	Speech Pathology					9
10	Medical Social Services	28,401				10
11	Home Health Aide	48,576				11
12	Supplies (see instructions)					12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	1,847,439				24

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7045** **WORKSHEET H-1 PART I**

		TRANSPORT-ATION	SUBTOTAL (cols. 0-4)	ADMINI-STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		334,595	334,595		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		942,228	208,392	1,150,620	6
7	Physical Therapy		408,546	90,358	498,904	7
8	Occupational Therapy		85,093	18,820	103,913	8
9	Speech Pathology					9
10	Medical Social Services		28,401	6,281	34,682	10
11	Home Health Aide		48,576	10,744	59,320	11
12	Supplies (see instructions)					12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		1,847,439		1,847,439	24

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

COST ALLOCATION - HHA STATISTICAL BASIS **HHA CCN: 14-7045** **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 CENTERS							
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-334,595	1,512,844	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						942,228	6
7	Physical Therapy						408,546	7
8	Occupational Therapy						85,093	8
9	Speech Pathology							9
10	Medical Social Services						28,401	10
11	Home Health Aide						48,576	11
12	Supplies (see instructions)							12
13	Drugs							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					-334,595	1,512,844	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						334,595	25
26	Unit Cost Multiplier						0.221170	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7045** **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		3,771			3,771	1,737	1
2	Skilled Nursing Care	1,150,620	10,620	3,289		1,164,529	536,309	2
3	Physical Therapy	498,904	4,605			503,509	231,885	3
4	Occupational Therapy	103,913	959			104,872	48,297	4
5	Speech Pathology							5
6	Medical Social Services	34,682	319			35,001	16,119	6
7	Home Health Aide	59,320	547			59,867	27,571	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)	1,847,439	20,821	3,289		1,871,549	861,918	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.

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7045** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
1	Administrative and General	780				15,141		1
2	Skilled Nursing Care	2,236				42,651		2
3	Physical Therapy	988				18,504		3
4	Occupational Therapy	208				3,853		4
5	Speech Pathology							5
6	Medical Social Services	52				1,276		6
7	Home Health Aide	104				2,209		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)	4,368				83,634		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.

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7045** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	I&R SALARY & FRINGES	
		13	14	15	16	17	21	
1	Administrative and General	171,696	1,905	3,129	1,857			1
2	Skilled Nursing Care	9	5,363	8,787	5,228			2
3	Physical Therapy	153,895	2,326	3,805	2,267			3
4	Occupational Therapy	67,050	484	801	472			4
5	Speech Pathology							5
6	Medical Social Services	6,297	162	275	158			6
7	Home Health Aide	10,768	277	451	270			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)	409,715	10,517	17,248	10,252			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.

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7045** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	I&R PROGRAM COSTS	SUBTOTAL (sum of col.4A-23)	I&R COST & POST STEP-DOWN ADJS	SUBTOTAL (cols 23 +/- 24)	ALLOCATED HHA A&G (see PtII)	TOTAL HHA COSTS	
		22	24	25	26	27	28	
1	Administrative and General		200,016		200,016			1
2	Skilled Nursing Care		1,765,112		1,765,112	115,030	1,880,142	2
3	Physical Therapy		917,179		917,179	59,772	976,951	3
4	Occupational Therapy		226,037		226,037	14,731	240,768	4
5	Speech Pathology							5
6	Medical Social Services		59,340		59,340	3,867	63,207	6
7	Home Health Aide		101,517		101,517	6,616	108,133	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)		3,269,201		3,269,201	200,016	3,269,201	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.					0.065169		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.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 14-7045 **WORKSHEET H-2 PART II**

	HHA COST CENTER	CAP BLDGS + FIXTURES DV 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	4A	5	7	
1	Administrative and General	3,671		506,853		3,771	15	1
2	Skilled Nursing Care	10,339	3,177	1,427,310		1,164,529	43	2
3	Physical Therapy	4,483		618,875		503,509	19	3
4	Occupational Therapy	934		128,900		104,872	4	4
5	Speech Pathology							5
6	Medical Social Services	311		43,023		35,001	1	6
7	Home Health Aide	533		73,583		59,867	2	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)	20,271	3,177	2,798,544		1,871,549	84	20
21	Total cost to be allocated	20,821	3,289			861,918	4,368	21
22	Unit Cost Multiplier	1.027132				0.460537		22
22	Unit Cost Multiplier		1.035253				52.000000	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 14-7045 **WORKSHEET H-2 PART II**

	HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA FTES	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	
		8	9	10	11	12	13	
1	Administrative and General				617		18,432	1
2	Skilled Nursing Care				1,738		1	2
3	Physical Therapy				754		16,521	3
4	Occupational Therapy				157		7,198	4
5	Speech Pathology							5
6	Medical Social Services				52		676	6
7	Home Health Aide				90		1,156	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)				3,408		43,984	20
21	Total cost to be allocated				83,634		409,715	21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier				24.540493		9.315092	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 14-7045 **WORKSHEET H-2 PART II**

	HHA COST CENTER	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	
		14	15	16	17	21	22	
1	Administrative and General	9,237	125	1,108,530				1
2	Skilled Nursing Care	26,010	351	3,121,646				2
3	Physical Therapy	11,278	152	1,353,531				3
4	Occupational Therapy	2,349	32	281,916				4
5	Speech Pathology							5
6	Medical Social Services	784	11	94,095				6
7	Home Health Aide	1,341	18	160,933				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)	50,999	689	6,120,651				20
21	Total cost to be allocated	10,517	17,248	10,252				21
22	Unit Cost Multiplier	0.206220		0.001675				22
22	Unit Cost Multiplier		25.033382					22

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 14-7045 **WORKSHEET H-2 PART II**

	HHA COST CENTER							
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

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7045** **WORKSHEET H-3 PARTS I & II**

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation

	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	Skilled Nursing Care	2	1,880,142		1,880,142	5,943	316.36	1
2	Physical Therapy	3	976,951		976,951	3,745	260.87	2
3	Occupational Therapy	4	240,768		240,768	840	286.63	3
4	Speech Pathology	5						4
5	Medical Social Services	6	63,207		63,207	208	303.88	5
6	Home Health Aide	7	108,133		108,133	536	201.74	6
7	Total (sum of lines 1-6)		3,269,201		3,269,201	11,272		7

Limitation Cost Comoputation

			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	16974		748		8
8.01	Skilled Nursing Care	29404		5,195		8.01
9	Physical Therapy	16974		413		9
9.01	Physical Therapy	29404		3,332		9.01
10	Occupational Therapy	16974		77		10
10.01	Occupational Therapy	29404		763		10.01
11	Speech Pathology	16974				11
11.01	Speech Pathology	29404				11.01
12	Medical Social Services	16974		30		12
12.01	Medical Social Services	29404		178		12.01
13	Home Health Aide	16974		29		13
13.01	Home Health Aide	29404		507		13.01
14	Total (sum of lines 8-13)			11,272		14

Supplies and Drugs Cost Computations

	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	Cost of Medical Supplies	8						15
16	Cost of Drugs	9						16

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

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	66	0.320869			col. 2, line 2	1
2	Occupational Therapy	67				col. 2, line 3	2
3	Speech Pathology	68	0.696818			col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.180365			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.335095			col. 2, line 16	5

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7045** **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		5,943			1,880,127		1,880,127	1
2	Physical Therapy		3,745			976,958		976,958	2
3	Occupational Therapy		840			240,769		240,769	3
4	Speech Pathology								4
5	Medical Social Services		208			63,207		63,207	5
6	Home Health Aide		536			108,133		108,133	6
7	Total (sum of lines 1-6)		11,272			3,269,194		3,269,194	7

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

CALCULATION OF HHA REIMBURSEMRNT SETTLEMENT **HHA CCN: 14-7045** **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				2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)				4
5	Ratio of line 3 to line 4 (not to excced 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		Part A Services	Part B Services	
	Description	1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers		1,919,749	11
12	Total PPS Reimbursement - Full Episodes with Outliers		44,055	12
13	Total PPS Reimbursement - LUPA Episodes		38,832	13
14	Total PPS Reimbursement - PEP Episodes		31,180	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		6,292	15
16	Total PPS Outlier Reimbursement - PSP Episodes			16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)		2,040,108	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		2,040,108	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		2,040,108	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		2,040,108	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		2,040,108	31
31.01	Sequestration adjustment (see instructions)			31.01
32	Interim payments (see instructions)		2,040,108	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **HHA CCN: 14-7045** **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						2,040,108	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)						2,040,108	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	Determine net settlement amount (balance due)		.01					6.01
	based on the cost report (see instructions)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)						2,040,108	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.

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form **CMS-2552-10**	Period : From: 09/01/2015 To: 08/31/2016	Run Date: 01/27/2017 Run Time: 13:33 Version: 2016.05 (06/27/2016)

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0130** **WORKSHEET L**

Check Applicable Boxes:
[ ] Title V **[XX] Hospital** **[XX] PPS**
[XX] Title XVIII, Part A **[ ] SUB (Other)** **[ ] Cost Method**
[ ] Title XIX

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	1,620,604	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	17,580	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)	60.73	3
4	Number of interns & residents (see instructions)	9.56	4
5	Indirect medical education percentage (see instructions)	4.54	5
6	Indirect medical education adjustment (see instructions)	73,575	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0244	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.1009	8
9	Sum of lines 7 and 8	0.1253	9
10	Allowable disproportionate share percentage (see instructions)	0.0257	10
11	Disproportionate share adjustment (see instructions)	41,650	11
12	Total prospective capital payments (see instructions)	1,753,409	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

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
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
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
43	Nursery							43
44	Skilled Nursing Facility							44
45	Nursing Facility							45
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
65	Respiratory Therapy							65
66	Physical Therapy							66
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC							90.01
90.02	WOUND CLINIC							90.02
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT							92.01
	OTHER REIMBURSABLE COST CENTERS							
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
194	HEALTH & FITNESS CENTER							194
194.01	OCCUPATIONAL HEALTH							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202