KPMG LLP Compu-Max 2552-10

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S**
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 02/27/2017 Time: 18:14 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 NORTHWEST COMMUNITY HOSPITAL (14-0252) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 10/01/2015 and ending 09/30/2016, 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		2,839,355	799,617		-631,601	1
2	SUBPROVIDER - IPF		122,498			-1,891,515	2
3	SUBPROVIDER - IRF		619				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		2,962,472	799,617		-2,523,116	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.
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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 800 WEST CENTRAL ROAD	P.O. Box:			1
2	City: ARLINGTON HEIGHTS	State: IL	ZIP Code: 60005	County: COOK	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	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	NORTHWEST COMMUNITY HOSPITAL	14-0252	16974	1	07 / 01 / 1966	N	P	O	3
4	Subprovider - IPF	NWCH PSYCHIATRIC UNIT	14-S252	16974	4	11 / 01 / 1985	N	P	O	4
5	Subprovider - IRF	NWC REHAB	14-T252	16974	5	10 / 01 / 2015	N	P	O	5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	NORTHWEST COMMUNITY HOME CARE SERVIC	14-7094	16974		07 / 01 / 1966	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 10 / 01 / 2015	To: 09 / 30 / 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.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	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.	6,069	3,845					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
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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	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.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete 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)	Y			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

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

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

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	Y			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)	N	N		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.			N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1		118
			Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:		5,164,975			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)	N		140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on 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	N	N	156
157	Subprovider - IRF	N	N	N	N	157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N	N	N	160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (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.	N		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)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			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 in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	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)	N			3

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

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	Y		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for 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	01/19/2017	Y	01/19/2017	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 services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: CAROLYN	Last name: CEKAL	Title: DIR. CORPORATE REIMB	41
42	Employer: NORTHWEST COMMUN ITY HOSPITAL			42
43	Phone number: 847-618-4604	E-mail Address: CCEKAL@NHN.ORG		43

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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	268	98,088			29,198	2,671	61,096
2	HMO and other (see instructions)						4,988	3,845	
3	HMO IPF Subprovider						181	873	
4	HMO IRF Subprovider						236		
5	Hospital Adults & Peds. Swing Bed SNF								
6	Hospital Adults & Peds. Swing Bed NF								
7	Total Adults & Peds. (exclude observation beds) (see instructions)		268	98,088			29,198	2,671	61,096
8	Intensive Care Unit	31	60	21,960			3,767	460	7,537
9	Coronary Care Unit	32							
10	Burn Intensive Care Unit	33							
11	Surgical Intensive Care Unit	34							
12	NEONATAL INTENSIVE CARE UNIT	35	12	4,392				354	3,282
13	Nursery	43						294	5,491
14	Total (see instructions)		340	124,440			32,965	3,779	77,406
15	CAH Visits								
16	Subprovider - IPF	40	32	11,712			1,547	640	11,205
17	Subprovider - IRF	41	20	7,320			2,734		4,325
18	Subprovider I	42							
19	Skilled Nursing Facility	44							
20	Nursing Facility	45							
21	Other Long Term Care	46							
22	Home Health Agency	101					23,438		38,236
23	ASC (Distinct Part)	115							
24	Hospice (Distinct Part)	116							
24.10	Hospice (non-distinct part)	30							
25	CMHC	99							
26	RHC	88							
27	Total (sum of lines 14-26)		392						
28	Observation Bed Days								10,497
29	Ambulance Trips								
30	Employee discount days (see instructions)								
31	Employee discount days-IRF								
32	Labor & delivery (see instructions)								646
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								
33	LTCH non-covered days								

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					7,409	1,947	17,557	1
2	HMO and other (see instructions)					1,095	1		2
3	HMO IPF Subprovider						146		3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	NEONATAL INTENSIVE CARE UNIT								12
13	Nursery								13
14	Total (see instructions)		2,409.32			7,409	1,947	17,557	14
15	CAH Visits								15
16	Subprovider - IPF		58.21			203	109	1,728	16
17	Subprovider - IRF		23.42			187		301	17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		58.22						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		2,549.17						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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	180,365,019		180,365,019	5,318,167.00	33.91	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						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		13,996,857	1,531,902	15,528,759	394,324.00	39.38	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		3,079,660		3,079,660	52,460.00	58.70	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		2,794,327		2,794,327	27,857.00	100.31	13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries							14.01
14.02	Related organization salaries							14.02
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)		44,490,099		44,490,099			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		3,233,745		3,233,745			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related							25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		2,534,437		2,534,437	28,157.00	90.01	26
27	Administrative & General		28,591,870		28,591,870	715,272.00	39.97	27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		2,563,387		2,563,387	76,488.00	33.51	30
31	Laundry & Linen Service							31
32	Housekeeping		3,220,697		3,220,697	225,951.00	14.25	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		2,791,784	-1,423,526	1,368,258	76,879.00	17.80	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			1,423,526	1,423,526	92,883.00	15.33	36
37	Maintenance of Personnel							37
38	Nursing Administration		9,230,717		9,230,717	228,171.00	40.46	38
39	Central Services and Supply		1,573,300		1,573,300	82,083.00	19.17	39
40	Pharmacy		3,989,008		3,989,008	95,767.00	41.65	40
41	Medical Records & Medical Records Library		2,307,288		2,307,288	93,593.00	24.65	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	180,365,019		180,365,019	5,318,167.00	33.91	1
2	Excluded area salaries (see instructions)	13,996,857	1,531,902	15,528,759	394,324.00	39.38	2
3	Subtotal salarles (line 1 minus line 2)	166,368,162	-1,531,902	164,836,260	4,923,843.00	33.48	3
4	Subtotal other wages & related costs (see instructions)	5,873,987		5,873,987	80,317.00	73.14	4
5	Subtotal wage-related costs (see instructions)	44,490,099		44,490,099		26.99%	5
6	Total (sum of lines 3 through 5)	216,732,248	-1,531,902	215,200,346	5,004,160.00	43.00	6
7	Total overhead cost (see instructions)	56,802,488		56,802,488	1,715,244.00	33.12	7

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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	5,995,995	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)	8,044,524	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)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	17,414,738	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	416,469	10
11	Life Insurance (If employee is owner or beneficiary)	178,999	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	618,082	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	1,231,751	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	12,758,371	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	322,525	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	742,389	23
24	Total Wage Related cost (Sum of lines 1-23)	47,723,843	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA **HHA CCN: 14-7094** **WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA County: COOK

		Title V	Title XVIII	Title XIX	Other	Total	
	Description	1	2	3	4	5	
1	Home Health Aide Hours		2,435		1,061	3,496	1
2	Unduplicated Census Count (see instructions)		1,888.00		617.00	2,505.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)	1.00		1.00	3
4	Director(s) and Assistant Director(s)				4
5	Other Administrative Personnel	22.13		22.13	5
6	Direct Nursing Service	20.94		20.94	6
7	Nursing Supervisor				7
8	Physical Therapy Service	15.04		15.04	8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service	2.28		2.28	10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service	0.28		0.28	12
13	Speech Pathology Supervisor				13
14	Medical Social Service	1.24		1.24	14
15	Medical Social Service Supervisor				15
16	Home Health Aide	1.56		1.56	16
17	Home Health Aide Supervisor				17
18	CONTINUUM PERSONNEL				18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.	3	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).	11340	20
20.01		16974	20.01
20.02		20994	20.02

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	10,769	311	383	184	11,647	21
22	Skilled Nursing Visit Charges	2,003,220	57,846	69,564	34,224	2,164,854	22
23	Physical Therapy Visits	8,594	76	92	146	8,908	23
24	Physical Therapy Visit Charges	2,303,192	20,368	24,656	39,128	2,387,344	24
25	Occupational Therapy Visits	1,478	14	8	22	1,522	25
26	Occupational Therapy Visit Charges	396,104	3,752	2,144	5,896	407,896	26
27	Speech Pathology Visits	129		2	1	132	27
28	Speech Pathology Visit Charges	34,572		536	268	35,376	28
29	Medical Social Service Visits	228	24	1	4	257	29
30	Medical Social Service Visit Charges	55,404	5,832	243	972	62,451	30
31	Home Health Aide Visits	870	78	3	21	972	31
32	Home Health Aide Visit Charges	117,450	10,530	405	2,835	131,220	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	22,068	503	489	378	23,438	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	4,909,942	98,328	97,548	83,323	5,189,141	35
36	Total Number of Episodes (standard/non-outlier)	1,485		170	33	1,688	36
37	Total Number of Ourlier Episodes		15			15	37
38	Total Non-Routine Medical Supply Charges	248,362	27,117	10,632	351	286,462	38

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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)	0.241814	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	9,232,835	2
3	Did you receive DSH or supplemental payments from Medicaid?	N	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges	140,453,672	6
7	Medicaid cost (line 1 times line 6)	33,963,664	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.	24,730,829	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)	24,730,829	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	32,050,321	5,399,288	37,449,609	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	7,750,216	1,305,623	9,055,839	21
22	Partial payment by patients approved for charity care	108,252		108,252	22
23	Cost of charity care (line 21 minus line 22)	7,641,964	1,305,623	8,947,587	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)	9,232,632	26
27	Medicare bad debts for the entire hospital complex (see instructions)	2,261,413	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	6,971,219	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,685,738	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	10,633,325	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	35,364,154	31

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		59,496,441	59,496,441	-34,570,859	24,925,582	4,654,513	29,580,095	1
2	00200	Cap Rel Costs-Mvble Equip				21,361,291	21,361,291	193,629	21,554,920	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	2,534,437	26,968,813	29,503,250		29,503,250		29,503,250	4
5	00500	Administrative & General	28,591,870	39,662,007	68,253,877	13,246,101	81,499,978	-18,192,049	63,307,929	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	2,563,387	11,672,691	14,236,078	126,641	14,362,719	-5,269	14,357,450	7
8	00800	Laundry & Linen Service								8
9	00900	Housekeeping	3,220,697	3,725,840	6,946,537	45,595	6,992,132		6,992,132	9
10	01000	Dietary	2,791,784	3,022,761	5,814,545	-2,964,827	2,849,718		2,849,718	10
11	01100	Cafeteria				2,964,827	2,964,827	-1,875,474	1,089,353	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	9,230,717	1,134,109	10,364,826		10,364,826	-77,570	10,287,256	13
14	01400	Central Services & Supply	1,573,300	1,356,078	2,929,378	-297,919	2,631,459		2,631,459	14
15	01500	Pharmacy	3,989,008	17,989,488	21,978,496	-15,892,094	6,086,402	-7,583	6,078,819	15
16	01600	Medical Records & Library	2,307,288	2,921,181	5,228,469	-56	5,228,413		5,228,413	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	PARAMED ED PRGM-(SPECIFY)				1,153,255	1,153,255	-261,289	891,966	23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	31,555,253	6,333,359	37,888,612	-7,605,983	30,282,629	-872,116	29,410,513	30
31	03100	Intensive Care Unit	7,988,820	2,520,162	10,508,982	-962,713	9,546,269	-835,800	8,710,469	31
35	02060	NEONATAL INTENSIVE CARE UNIT	2,223,633	769,200	2,992,833	-1,369,886	1,622,947		1,622,947	35
40	04000	Subprovider - IPF	3,854,159	1,039,895	4,894,054	-45,095	4,848,959	-105,117	4,743,842	40
41	04100	Subprovider - IRF	1,425,200	1,800,437	3,225,637	-86	3,225,551		3,225,551	41
43	04300	Nursery				1,240,185	1,240,185		1,240,185	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	12,380,447	29,208,878	41,589,325	-28,505,330	13,083,995	-188,103	12,895,892	50
52	05200	Delivery Room & Labor Room				4,987,785	4,987,785		4,987,785	52
53	05300	Anesthesiology	153,515	779,276	932,791	-72,206	860,585		860,585	53
54	05400	Radiology-Diagnostic	12,926,792	8,764,663	21,691,455	-2,830,530	18,860,925	-29,318	18,831,607	54
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	1,735,802	1,318,824	3,054,626	-41,688	3,012,938		3,012,938	54.01
56.01	03480	ONCOLOGY	1,244,337	287,750	1,532,087	-74,349	1,457,738	71	1,457,809	56.01
60	06000	Laboratory	6,178,249	7,022,336	13,200,585	-90,857	13,109,728	-64,609	13,045,119	60
62	06200	Whole Blood & Packed Red Blood Cells	502,221	1,753,640	2,255,861	-745	2,255,116		2,255,116	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	2,290,608	617,541	2,908,149	-110,649	2,797,500		2,797,500	65
66	06600	Physical Therapy	6,656,836	1,797,050	8,453,886	-282,348	8,171,538	-272,012	7,899,526	66
69	06900	Electrocardiology	4,039,210	2,867,741	6,906,951	-296,805	6,610,146	-1,530,001	5,080,145	69
69.01	03630	CARDIAC CATH LAB	1,922,849	7,355,892	9,278,741	-6,573,935	2,704,806		2,704,806	69.01
69.02	03160	CARDIAC REHABILITATION	780,222	279,803	1,060,025	-6,322	1,053,703	-91,634	962,069	69.02
71	07100	Medical Supplies Charged to Patients				28,660,062	28,660,062		28,660,062	71
72	07200	Impl. Dev. Charged to Patients				15,523,040	15,523,040		15,523,040	72
73	07300	Drugs Charged to Patients				16,111,064	16,111,064		16,111,064	73
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS								73.01
74	07400	Renal Dialysis		1,054,441	1,054,441	-10,874	1,043,567		1,043,567	74
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT TREATMENT CENTERS	1,766,524	1,934,230	3,700,754	-198,951	3,501,803	-374	3,501,429	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	2,224,913	248,826	2,473,739	-9,075	2,464,664		2,464,664	90.02
91	09100	Emergency	12,995,443	4,767,346	17,762,789	-3,140,194	14,622,595		14,622,595	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
101	10100	Home Health Agency	5,020,524	956,708	5,977,232	569	5,977,801		5,977,801	101
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	176,668,045	251,427,407	428,095,452	-533,961	427,561,491	-19,560,105	408,001,386	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	144,931	236,400	381,331		381,331		381,331	190
192	19200	Physicians' Private Offices		1,306,115	1,306,115		1,306,115		1,306,115	192
192.01	19201	DAY SURGERY CENTER								192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	604,115	114,738	718,853		718,853		718,853	192.02
192.03	19203	MOBILE DENTAL CLINIC	211,235	92,752	303,987		303,987		303,987	192.03

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	
192.04	19204	EMS CONTINUING EDUCATION				533,961	533,961		533,961	192.04
194	07950	CORPORATE HEALTH	128,712	34,012	162,724		162,724		162,724	194
194.01	07951	MARKETING/COMMUNICATION	904,748	2,311,351	3,216,099		3,216,099		3,216,099	194.01
194.02	07952	FOUNDATION								194.02
194.03	07953	OTHER NRCC	1,703,233	2,076,514	3,779,747		3,779,747		3,779,747	194.03
200		TOTAL (sum of lines 118-199)	180,365,019	257,599,289	437,964,308		437,964,308	-19,560,105	418,404,203	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES			
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	SHARED EXPENSES	A	Cafeteria	11	1,423,526	1,541,301	1
500	Total reclassifications				1,423,526	1,541,301	500
	Code Letter - A						
1	FLOAT POOL	B	Intensive Care Unit	31	28,194	59	1
2			Subprovider - IPF	40	9,272	19	2
3			NEONATAL INTENSIVE CARE UNIT	35	2,460	5	3
4			Operating Room	50	568	1	4
5			Emergency	91	2,838	6	5
6			Home Health Agency	101	568	1	6
500	Total reclassifications				43,900	91	500
	Code Letter - B						
1	TREATMENT CENTER LEASE EXP	C	Cap Rel Costs-Bldg & Fixt	1		190,900	1
500	Total reclassifications					190,900	500
	Code Letter - C						
1	COST OF MEDICAL SUPPLIES SOLD	D	Medical Supplies Charged to P	71		28,660,062	1
2			Impl. Dev. Charged to Patient	72		15,523,040	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
500	Total reclassifications					44,183,102	500
	Code Letter - D						
1	COST OF DRUGS SOLD	E	Drugs Charged to Patients	73		16,111,064	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
500	Total reclassifications					16,111,064	500
	Code Letter - E						
1	PARAMEDICAL EDUCATION	F	PARAMED ED PRGM-(SPECIFY)	23	161,552	33,407	1
2			EMS CONTINUING EDUCATION	192.04	442,466	91,495	2
500	Total reclassifications				604,018	124,902	500
	Code Letter - F						
1	NON DEPT ITEMS-COST ALLOCATION	G	Cap Rel Costs-Mvble Equip	2		21,361,291	1
2			Administrative & General	5		13,671,194	2
500	Total reclassifications					35,032,485	500
	Code Letter - G						
1	SALT CREEK OCCUPANCY COSTS	H	Cap Rel Costs-Bldg & Fixt	1		27,520	1
2			Operation of Plant	7		126,641	2
3			Housekeeping	9		45,595	3
500	Total reclassifications					199,756	500
	Code Letter - H						

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	FLU VACCINES	I	OUTPATIENT TREATMENT CENTERS	90.01	26,736	102,858	1
2							2
3							3
4							4
5							5
6							6
500	Total reclassifications				26,736	102,858	500
	Code Letter - I						
1	PROPERTY INSURANCE	J	Cap Rel Costs-Bldg & Fixt	1		243,206	1
2							2
3							3
500	Total reclassifications					243,206	500
	Code Letter - J						
1	LDR COST ALLOCATION	K	Nursery	43	921,440	318,745	1
2			Delivery Room & Labor Room	52	3,583,488	1,454,064	2
500	Total reclassifications				4,504,928	1,772,809	500
	Code Letter - K						
1	EMT CLINICAL EDUCAORS	L	PARAMED ED PRGM-(SPECIFY)	23	958,296		1
2							2
3							3
4							4
5							5
6							6
500	Total reclassifications				958,296		500
	Code Letter - L						
	GRAND TOTAL (Increases)				7,561,404	99,502,474	

(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	SHARED EXPENSES	A	Dietary	10	1,423,526	1,541,301		1
500	Total reclassifications				1,423,526	1,541,301		500
	Code letter - A							
1	FLOAT POOL	B	Adults & Pediatrics	30	43,900	91		1
2								2
3								3
4								4
5								5
6								6
500	Total reclassifications				43,900	91		500
	Code letter - B							
1	TREATMENT CENTER LEASE EXP	C	OUTPATIENT TREATMENT CENTERS	90.01		190,900	10	1
500	Total reclassifications					190,900		500
	Code letter - C							
1	COST OF MEDICAL SUPPLIES SOLD	D	Central Services & Supply	14		297,919		1
2			Pharmacy	15		30,475		2
3			Medical Records & Library	16		56		3
4			Adults & Pediatrics	30		2,415,267		4
5			Intensive Care Unit	31		947,614		5
6			NEONATAL INTENSIVE CARE UNIT	35		130,608		6
7			Subprovider - IPF	40		14,122		7
8			Operating Room	50		28,325,339		8
9			Anesthesiology	53		72,206		9
10			Radiology-Diagnostic	54		2,813,221		10
11			OFFSITE-DIAGNOSTIC SERVICES	54.01		41,688		11
12			ONCOLOGY	56.01		74,349		12
13			Laboratory	60		90,548		13
14			Whole Blood & Packed Red Bloo	62		745		14
15			Respiratory Therapy	65		110,649		15
16			Physical Therapy	66		281,895		16
17			Electrocardiology	69		104,176		17
18			CARDIAC CATH LAB	69.01		6,573,935		18
19			CARDIAC REHABILITATION	69.02		6,322		19
20			Renal Dialysis	74		10,874		20
21			OUTPATIENT TREATMENT CENTERS	90.01		120,192		21
22			PARTIAL HOSPITALIZATION PROGR	90.02		9,051		22
23			Emergency	91		1,711,851		23
500	Total reclassifications					44,183,102		500
	Code letter - D							
1	COST OF DRUGS SOLD	E	Pharmacy	15		15,758,761		1
2			Adults & Pediatrics	30		22,117		2
3			Intensive Care Unit	31		2,763		3
4			NEONATAL INTENSIVE CARE UNIT	35		497		4
5			Subprovider - IPF	40		12		5
6			Subprovider - IRF	41		86		6
7			Operating Room	50		99,840		7
8			Radiology-Diagnostic	54		10,952		8
9			Radiology-Diagnostic	54		6,357		9
10			Laboratory	60		309		10
11			Physical Therapy	66		37		11
12			Electrocardiology	69		192,629		12
13			PARTIAL HOSPITALIZATION PROGR	90.02		24		13
14			Emergency	91		16,680		14
500	Total reclassifications					16,111,064		500
	Code letter - E							
1	PARAMEDICAL EDUCATION	F	Emergency	91	604,018	124,902		1
2								2
500	Total reclassifications				604,018	124,902		500
	Code letter - F							
1	NON DEPT ITEMS-COST ALLOCATION	G	Cap Rel Costs-Bldg & Fixt	1		35,032,485	9	1
2								2
500	Total reclassifications					35,032,485		500
	Code letter - G							
1	SALT CREEK OCCUPANCY COSTS	H	Administrative & General	5		27,520	10	1
2			Administrative & General	5		126,641	14	2
3			Administrative & General	5		45,595		3
500	Total reclassifications					199,756		500
	Code letter - H							

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	FLU VACCINES	I	Pharmacy	15		102,858		1
2			Adults & Pediatrics	30	14,352			2
3			Intensive Care Unit	31	96			3
4			NEONATAL INTENSIVE CARE UNIT	35	1,061			4
5			Subprovider - IPF	40	11			5
6			Emergency	91	11,216			6
500	Total reclassifications				26,736	102,858		500
	Code letter - I							
1	PROPERTY INSURANCE	J	Administrative & General	5		225,337	12	1
2			Physical Therapy	66		416		2
3			OUTPATIENT TREATMENT CENTERS	90.01		17,453		3
500	Total reclassifications					243,206		500
	Code letter - J							
1	LDR COST ALLOCATION	K	NEONATAL INTENSIVE CARE UNIT	35	921,440	318,745		1
2			Adults & Pediatrics	30	3,583,488	1,454,064		2
500	Total reclassifications				4,504,928	1,772,809		500
	Code letter - K							
1	EMT CLINICAL EDUCAORS	L	Adults & Pediatrics	30	72,704			1
2			Intensive Care Unit	31	40,493			2
3			Subprovider - IPF	40	40,241			3
4			Operating Room	50	80,720			4
5			Delivery Room & Labor Room	52	49,767			5
6			Emergency	91	674,371			6
500	Total reclassifications				958,296			500
	Code letter - L							
	GRAND TOTAL (Decreases)				7,561,404	99,502,474		

(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	89,072					89,072		1
2	Land Improvements	14,234,310					14,234,310		2
3	Buildings and Fixtures	303,435,391	2,916,482		2,916,482	308,353	306,043,520		3
4	Building Improvements	1,317,195					1,317,195		4
5	Fixed Equipment	208,231,980	1,992,152		1,992,152		210,224,132		5
6	Movable Equipment	189,571,386	15,721,461		15,721,461	10,177,131	195,115,716		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	716,879,334	20,630,095		20,630,095	10,485,484	727,023,945		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	716,879,334	20,630,095		20,630,095	10,485,484	727,023,945		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	59,496,441						59,496,441	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	59,496,441						59,496,441	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	550,649,737		550,649,737	0.820988					1
2	Cap Rel Costs-Mvble Equ	120,066,007		120,066,007	0.179012					2
3	Total (sum of lines 1-2)	670,715,744		670,715,744	1.000000					3

		SUMMARY OF CAPITAL							
	Description	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	29,196,617	218,420	-78,148	243,206			29,580,095	1
2	Cap Rel Costs-Mvble Equip	21,554,920						21,554,920	2
3	Total (sum of lines 1-2)	50,751,537	218,420	-78,148	243,206			51,135,015	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.)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	B	-506,777	Cap Rel Costs-Bldg & Fixt	1	9	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-57,884	Administrative & General	5		7
8	Television and radio service (chapter 21)	A	-5,269	Operation of Plant	7		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-3,271,470				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-1,875,474	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34							34
35							35
36							36
37							37
38	LOBBYING PORTION OF DUES	A	-47,631	Administrative & General	5		38
39	PROVIDER ASSESSMENT REBATE	B	-16,407,485	Administrative & General	5		39
40							40
41							41
41.09	AMORT OF CAPITALIZED INT INCOME	B	-78,148	Cap Rel Costs-Bldg & Fixt	1	11	41.09
41.14	PARAMED EDUCATION TUITION INCOM	B	-261,289	PARAMED ED PRGM-(SPECIFY)	23		41.14
41.88	PIANO DEPRECTIATION	A	-1,371	Cap Rel Costs-Mvble Equip	2	9	41.88
42	WELLNESS CENTER RENT TO COST	A	-31,360	Physical Therapy	66		42
42.01	WELLNESS CENTER RENT TO COST	A	-90,224	CARDIAC REHABILITATION	69.02		42.01
43							43
44							44
45							45
45.01	MISC OPERATING INCOME	B	-1,621,751	Administrative & General	5		45.01
45.02	MISC OPERATING INCOME	B	-7,583	Pharmacy	15		45.02
45.03	MISC OPERATING INCOME	B	-77,570	Nursing Administration	13		45.03
45.05	MISC OPERATING INCOME	B	-68,196	Adults & Pediatrics	30		45.05
45.06	MISC OPERATING INCOME	B	-105,117	Subprovider - IPF	40		45.06
45.07	MISC OPERATING INCOME	B	-128,125	Operating Room	50		45.07
45.08	MISC OPERATING INCOME	B	-10,262	Radiology-Diagnostic	54		45.08
45.09	MISC OPERATING INCOME	B	-430	Laboratory	60		45.09
45.10	MISC OPERATING INCOME	B	-4,013	Physical Therapy	66		45.10
45.11	MISC OPERATING INCOME	B	-67,782	Electrocardiology	69		45.11
45.14	MISC OPERATING INCOME	B	71	ONCOLOGY	56.01		45.14
45.16	MISC OPERATING INCOME	B	-825	CARDIAC REHABILITATION	69.02		45.16
45.17	MISC OPERATING INCOME	B	-374	OUTPATIENT TREATMENT CENTERS	90.01		45.17
45.26	NON ALLOWABLE TRAVEL	A	-31,565	Administrative & General	5		45.26
45.32	CSM AND 901 DEPRECIATION	A	-1,718,816	Cap Rel Costs-Bldg & Fixt	1	9	45.32
45.33	AMORT OF DEPR EXP OF DEMOLISHED	A	68,111	Cap Rel Costs-Bldg & Fixt	1	9	45.33

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
45.35	MED VS BOOK DEP DIFF	A	6,890,143	Cap Rel Costs-Bldg & Fixt	1	9	45.35
46	MAINFRAME SERVER EDITION-RECORD	A	195,000	Cap Rel Costs-Mvble Equip	2	9	46
47	PT B NON PHY COST	A	-236,639	Physical Therapy	66		47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-19,560,105				50

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

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

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

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							5

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

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

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

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

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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	5	Administrative & Gen AGGREGATE	38,512		38,512	177,200	150	12,779	639	2
3										3
4	30	Adults & Pediatrics AGGREGATE	803,920	803,920						4
5	31	Intensive Care Unit AGGREGATE	868,920	827,656	41,264	165,600	416	33,120	1,656	5
6										6
7	50	Operating Room AGGREGATE	189,978		189,978	208,000	1,300	130,000	6,500	7
8	54	Radiology-Diagnostic AGGREGATE	47,652		47,652	225,300	264	28,596	1,430	8
9										9
10	60	Laboratory AGGREGATE	286,723		286,723	215,700	2,146	222,544	11,127	10
11										11
12										12
13	69	Electrocardiology AGGREGATE	1,480,053	635,072	844,981	165,600	224	17,834	892	13
14										14
15										15
16	69.02	CARDIAC REHABILITATI AGGREGATE	1,620		1,620	165,600	13	1,035	52	16
17										17
18										18
19	91	Emergency AGGREGATE	1,343,597		1,343,597	177,200	23,344	1,988,729	99,436	19
20										20
200		TOTAL	5,060,975	2,266,648	2,794,327		27,857	2,434,637	121,732	200

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	5	Administrative & Gen AGGREGATE					12,779	25,733	25,733	2
3										3
4	30	Adults & Pediatrics AGGREGATE							803,920	4
5	31	Intensive Care Unit AGGREGATE					33,120	8,144	835,800	5
6										6
7	50	Operating Room AGGREGATE					130,000	59,978	59,978	7
8	54	Radiology-Diagnostic AGGREGATE					28,596	19,056	19,056	8
9										9
10	60	Laboratory AGGREGATE					222,544	64,179	64,179	10
11										11
12										12
13	69	Electrocardiology AGGREGATE					17,834	827,147	1,462,219	13
14										14
15										15
16	69.02	CARDIAC REHABILITATI AGGREGATE					1,035	585	585	16
17										17
18										18
19	91	Emergency AGGREGATE					1,988,729			19
20										20
200		TOTAL					2,434,637	1,004,822	3,271,470	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	29,580,095	29,580,095					1
2	Cap Rel Costs-Mvble Equip	21,554,920		21,554,920				2
4	Employee Benefits Department	29,503,250	435,782	19,532	29,958,564			4
5	Administrative & General	63,307,929	6,845,753	14,344,298	4,816,768	89,314,748	89,314,748	5
6	Maintenance & Repairs							6
7	Operation of Plant	14,357,450	4,016,267	114,652	431,846	18,920,215	5,134,946	7
8	Laundry & Linen Service							8
9	Housekeeping	6,992,132		23,133	542,581	7,557,846	2,051,199	9
10	Dietary	2,849,718	354,890	81,750	230,506	3,516,864	954,477	10
11	Cafeteria	1,089,353	233,383		239,817	1,562,553	424,077	11
12	Maintenance of Personnel							12
13	Nursing Administration	10,287,256	289,726	58,249	1,555,071	12,190,302	3,308,448	13
14	Central Services & Supply	2,631,459	528,947	312,576	265,049	3,738,031	1,014,502	14
15	Pharmacy	6,078,819	210,923	108,315	672,016	7,070,073	1,918,818	15
16	Medical Records & Library	5,228,413	179,512	49,872	388,702	5,846,499	1,586,740	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	891,966	20,628		188,657	1,101,251	298,880	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	29,410,513	3,883,508	505,234	4,690,258	38,489,513	10,445,925	30
31	Intensive Care Unit	8,710,469	1,095,016	176,107	1,343,764	11,325,356	3,073,702	31
35	NEONATAL INTENSIVE CARE UNIT	1,622,947	84,898	176,634	219,612	2,104,091	571,050	35
40	Subprovider - IPF	4,743,842	724,655	36,060	644,079	6,148,636	1,668,740	40
41	Subprovider - IRF	3,225,551	511,133	13,704	240,099	3,990,487	1,083,018	41
43	Nursery	1,240,185	172,139		155,232	1,567,556	425,435	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,895,892	2,670,223	2,421,582	2,072,194	20,059,891	5,444,254	50
52	Delivery Room & Labor Room	4,987,785	399,300		595,315	5,982,400	1,623,623	52
53	Anesthesiology	860,585	22,247		25,862	908,694	246,620	53
54	Radiology-Diagnostic	18,831,607	1,458,004	1,251,841	2,177,738	23,719,190	6,437,388	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	3,012,938		408,163	292,425	3,713,526	1,007,851	54.01
56.01	ONCOLOGY	1,457,809	722,993	31,784	209,630	2,422,216	657,389	56.01
60	Laboratory	13,045,119	574,934	269,346	1,040,831	14,930,230	4,052,064	60
62	Whole Blood & Packed Red Blood Cells	2,255,116	39,636	20,955	84,608	2,400,315	651,445	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,797,500	134,805	37,064	385,892	3,355,261	910,618	65
66	Physical Therapy	7,899,526	418,436	91,522	1,121,457	9,530,941	2,586,697	66
69	Electrocardiology	5,080,145	228,951	217,031	680,474	6,206,601	1,684,472	69
69.01	CARDIAC CATH LAB	2,704,806	101,732	417,923	323,937	3,548,398	963,035	69.01
69.02	CARDIAC REHABILITATION	962,069	375,561	21,793	131,442	1,490,865	404,621	69.02
71	Medical Supplies Charged to Patients	28,660,062				28,660,062	7,778,341	71
72	Impl. Dev. Charged to Patients	15,523,040				15,523,040	4,212,953	72
73	Drugs Charged to Patients	16,111,064				16,111,064	4,372,543	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis	1,043,567		2,073		1,045,640	283,787	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	3,501,429	920,618	71,490	302,105	4,795,642	1,301,537	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	2,464,664	206,874	36,448	374,824	3,082,810	836,675	90.02
91	Emergency	14,622,595	668,611	153,807	1,972,526	17,417,539	4,727,120	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	5,977,801	220,597	25,954	845,888	7,070,240	1,918,863	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	408,001,386	28,750,682	21,498,892	29,261,205	406,418,586	86,061,853	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	381,331	241,438	1,110	24,416	648,295	175,947	190
192	Physicians' Private Offices	1,306,115		3,975		1,310,090	355,558	192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER	718,853		12,599	101,773	833,225	226,137	192.02
192.03	MOBILE DENTAL CLINIC	303,987		27,202	35,586	366,775	99,543	192.03
192.04	EMS CONTINUING EDUCATION	533,961			74,541	608,502	165,147	192.04
194	CORPORATE HEALTH	162,724	115,967	10,506	21,684	310,881	84,373	194

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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	
194.01	MARKETING/COMMUNICATION	3,216,099	85,920	588	152,420	3,455,027	937,694	194.01
194.02	FOUNDATION		38,315	48		38,363	10,412	194.02
194.03	OTHER NRCC	3,779,747	347,773		286,939	4,414,459	1,198,084	194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	418,404,203	29,580,095	21,554,920	29,958,564	418,404,203	89,314,748	202

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		7	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	24,055,161						7
8	Laundry & Linen Service							8
9	Housekeeping		9,609,045					9
10	Dietary	466,952	186,528	5,124,821				10
11	Cafeteria	307,077	122,664		2,416,371			11
12	Maintenance of Personnel							12
13	Nursing Administration	381,210	152,278		145,817	16,178,055		13
14	Central Services & Supply	695,969	278,011		52,366		5,778,879	14
15	Pharmacy	277,524	110,859		59,495	28,685		15
16	Medical Records & Library	236,196	94,350		48,256			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	27,141	10,842		31,781	335,301		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,109,777	2,041,146	4,093,408	555,243	5,858,063	4,150	30
31	Intensive Care Unit	1,440,782	575,533	264,527	130,699	1,378,916	447	31
35	NEONATAL INTENSIVE CARE UNIT	111,705	44,622		20,448	215,731	8	35
40	Subprovider - IPF	953,474	380,874	625,714	77,511	817,766	194	40
41	Subprovider - IRF	672,529	268,648		30,030			41
43	Nursery	226,494	90,475		14,414	152,068		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,513,381	1,403,451		216,811	2,287,436	155,942	50
52	Delivery Room & Labor Room	525,384	209,869		62,317	657,461		52
53	Anesthesiology	29,272	11,693		5,088	53,676	37	53
54	Radiology-Diagnostic	1,918,388	766,317		228,977		264,041	54
54.01	OFFSITE-DIAGNOSTIC SERVICES						15,479	54.01
56.01	ONCOLOGY	951,287	380,000		19,525	205,993	9	56.01
60	Laboratory	756,476	302,181		115,219		1	60
62	Whole Blood & Packed Red Blood Cells	52,151	20,832		10,117		3	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	177,371	70,852		45,552			65
66	Physical Therapy	550,562	219,927		83,190		97	66
69	Electrocardiology	301,245	120,335		65,775	693,947	19,290	69
69.01	CARDIAC CATH LAB	133,855	53,470		28,767	303,506	16,700	69.01
69.02	CARDIAC REHABILITATION	494,149	197,392		13,974	147,426	168	69.02
71	Medical Supplies Charged to Patients						3,178,657	71
72	Impl. Dev. Charged to Patients						2,111,752	72
73	Drugs Charged to Patients						5,400	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	1,211,315	483,871				825	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	272,197	108,731		44,879	473,487		90.02
91	Emergency	879,733	351,417		243,460	2,568,593	2,792	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	290,254	115,944				2,412	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	22,963,850	9,173,112	4,983,649	2,349,711	16,178,055	5,778,404	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	317,675	126,898		5,137			190
192	Physicians' Private Offices							192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER			141,172	11,341		140	192.02
192.03	MOBILE DENTAL CLINIC						81	192.03
192.04	EMS CONTINUING EDUCATION							192.04
194	CORPORATE HEALTH	152,585	60,951		2,641			194
194.01	MARKETING/COMMUNICATION	113,051	45,159		15,622			194.01
194.02	FOUNDATION	50,413	20,138					194.02

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		7	9	10	11	13	14	
194.03	OTHER NRCC	457,587	182,787		31,919		254	194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,055,161	9,609,045	5,124,821	2,416,371	16,178,055	5,778,879	202

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	PARAMED EDUCATION EMS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	24	25	26	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	9,465,454						15
16	Medical Records & Library		7,812,041					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	16		1,805,212				23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	30,353	576,878	131,630	67,336,086		67,336,086	30
31	Intensive Care Unit	2,856	168,903	75,217	18,436,938		18,436,938	31
35	NEONATAL INTENSIVE CARE UNIT	977	50,613		3,119,245		3,119,245	35
40	Subprovider - IPF	276	125,605	75,217	10,874,007		10,874,007	40
41	Subprovider - IRF	492	35,293		6,080,497		6,080,497	41
43	Nursery		35,789		2,512,231		2,512,231	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	103,366	654,788	150,434	33,989,754		33,989,754	50
52	Delivery Room & Labor Room		35,356	94,021	9,190,431		9,190,431	52
53	Anesthesiology	27,296	145,924		1,428,300		1,428,300	53
54	Radiology-Diagnostic	7,921	1,602,750		34,944,972		34,944,972	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	3,548	226,937		4,967,341		4,967,341	54.01
56.01	ONCOLOGY	253	375,557		5,012,229		5,012,229	56.01
60	Laboratory	234	947,194		21,103,599		21,103,599	60
62	Whole Blood & Packed Red Blood Cells		40,021		3,174,884		3,174,884	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	620	88,398		4,648,672		4,648,672	65
66	Physical Therapy	2,201	192,598		13,166,213		13,166,213	66
69	Electrocardiology	100,327	258,655		9,450,647		9,450,647	69
69.01	CARDIAC CATH LAB	329	212,716		5,260,776		5,260,776	69.01
69.02	CARDIAC REHABILITATION	204	9,765		2,758,564		2,758,564	69.02
71	Medical Supplies Charged to Patients	408	625,143		40,242,611		40,242,611	71
72	Impl. Dev. Charged to Patients		303,982		22,151,727		22,151,727	72
73	Drugs Charged to Patients	9,002,987	462,566		29,954,560		29,954,560	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis		28,135		1,357,562		1,357,562	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	115,927	73,005		7,982,122		7,982,122	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	247	13,131		4,832,157		4,832,157	90.02
91	Emergency	15,272	486,696	1,278,693	27,971,315		27,971,315	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	16,981	35,643		9,450,337		9,450,337	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	9,433,091	7,812,041	1,805,212	401,397,777		401,397,777	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				1,273,952		1,273,952	190
192	Physicians' Private Offices				1,665,648		1,665,648	192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER	56			1,212,071		1,212,071	192.02
192.03	MOBILE DENTAL CLINIC	699			467,098		467,098	192.03
192.04	EMS CONTINUING EDUCATION				773,649		773,649	192.04
194	CORPORATE HEALTH				611,431		611,431	194
194.01	MARKETING/COMMUNICATION				4,566,553		4,566,553	194.01
194.02	FOUNDATION				119,326		119,326	194.02

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	PARAMED EDUCATION EMS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	24	25	26	
194.03	OTHER NRCC	31,608			6,316,698		6,316,698	194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	9,465,454	7,812,041	1,805,212	418,404,203		418,404,203	202

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	3,210	435,782	19,532	458,524	458,524		4
5	Administrative & General	1,049,189	6,845,753	14,344,298	22,239,240	73,787	22,313,027	5
6	Maintenance & Repairs							6
7	Operation of Plant	71,712	4,016,267	114,652	4,202,631	6,608	1,282,828	7
8	Laundry & Linen Service							8
9	Housekeeping			23,133	23,133	8,303	512,437	9
10	Dietary	1,771	354,890	81,750	438,411	3,527	238,450	10
11	Cafeteria		233,383		233,383	3,670	105,944	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,245	289,726	58,249	349,220	23,797	826,527	13
14	Central Services & Supply	109,555	528,947	312,576	951,078	4,056	253,446	14
15	Pharmacy		210,923	108,315	319,238	10,284	479,365	15
16	Medical Records & Library		179,512	49,872	229,384	5,948	396,404	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)		20,628		20,628	2,887	74,667	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	21,896	3,883,508	505,234	4,410,638	71,774	2,609,772	30
31	Intensive Care Unit	1,371	1,095,016	176,107	1,272,494	20,563	767,882	31
35	NEONATAL INTENSIVE CARE UNIT	859	84,898	176,634	262,391	3,361	142,662	35
40	Subprovider - IPF	1,120	724,655	36,060	761,835	9,856	416,890	40
41	Subprovider - IRF		511,133	13,704	524,837	3,674	270,563	41
43	Nursery		172,139		172,139	2,375	106,283	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	116,286	2,670,223	2,421,582	5,208,091	31,710	1,360,101	50
52	Delivery Room & Labor Room		399,300		399,300	9,110	405,619	52
53	Anesthesiology		22,247		22,247	396	61,611	53
54	Radiology-Diagnostic	688,955	1,458,004	1,251,841	3,398,800	33,325	1,608,209	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	422,057		408,163	830,220	4,475	251,784	54.01
56.01	ONCOLOGY		722,993	31,784	754,777	3,208	164,231	56.01
60	Laboratory	56,540	574,934	269,346	900,820	15,928	1,012,299	60
62	Whole Blood & Packed Red Blood Cells		39,636	20,955	60,591	1,295	162,746	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	805	134,805	37,064	172,674	5,905	227,493	65
66	Physical Therapy	803,296	418,436	91,522	1,313,254	17,161	646,217	66
69	Electrocardiology	108,548	228,951	217,031	554,530	10,413	420,820	69
69.01	CARDIAC CATH LAB		101,732	417,923	519,655	4,957	240,588	69.01
69.02	CARDIAC REHABILITATION	154,400	375,561	21,793	551,754	2,011	101,084	69.02
71	Medical Supplies Charged to Patients						1,943,210	71
72	Impl. Dev. Charged to Patients						1,052,493	72
73	Drugs Charged to Patients						1,092,362	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis			2,073	2,073		70,896	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	431,514	920,618	71,490	1,423,622	4,623	325,154	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM		206,874	36,448	243,322	5,736	209,021	90.02
91	Emergency	2,050	668,611	153,807	824,468	30,185	1,180,944	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	3,230	220,597	25,954	249,781	12,944	479,376	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,049,609	28,750,682	21,498,892	54,299,183	447,852	21,500,378	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		241,438	1,110	242,548	374	43,956	190
192	Physicians' Private Offices			3,975	3,975		88,827	192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER			12,599	12,599	1,557	56,494	192.02
192.03	MOBILE DENTAL CLINIC			27,202	27,202	545	24,868	192.03
192.04	EMS CONTINUING EDUCATION					1,141	41,258	192.04
194	CORPORATE HEALTH		115,967	10,506	126,473	332	21,078	194
194.01	MARKETING/COMMUNICATION		85,920	588	86,508	2,332	234,258	194.01
194.02	FOUNDATION		38,315	48	38,363		2,601	194.02

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	
194.03	OTHER NRCC		347,773		347,773	4,391	299,309	194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,049,609	29,580,095	21,554,920	55,184,624	458,524	22,313,027	202

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		7	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	5,492,067						7
8	Laundry & Linen Service							8
9	Housekeeping		543,873					9
10	Dietary	106,610	10,558	797,556				10
11	Cafeteria	70,109	6,943		420,049			11
12	Maintenance of Personnel							12
13	Nursing Administration	87,035	8,619		25,348	1,320,546		13
14	Central Services & Supply	158,898	15,735		9,103		1,392,316	14
15	Pharmacy	63,362	6,275		10,342	2,341		15
16	Medical Records & Library	53,926	5,340		8,388			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	6,197	614		5,525	27,369		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,166,617	115,531	637,042	96,520	478,168	1,000	30
31	Intensive Care Unit	328,947	32,575	41,167	22,720	112,555	108	31
35	NEONATAL INTENSIVE CARE UNIT	25,504	2,526		3,555	17,609	2	35
40	Subprovider - IPF	217,689	21,557	97,377	13,474	66,751	47	40
41	Subprovider - IRF	153,546	15,205		5,220			41
43	Nursery	51,711	5,121		2,506	12,413		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	802,145	79,435		37,689	186,714	37,572	50
52	Delivery Room & Labor Room	119,951	11,879		10,833	53,666		52
53	Anesthesiology	6,683	662		884	4,381	9	53
54	Radiology-Diagnostic	437,990	43,374		39,804		63,616	54
54.01	OFFSITE-DIAGNOSTIC SERVICES						3,729	54.01
56.01	ONCOLOGY	217,190	21,508		3,394	16,814	2	56.01
60	Laboratory	172,712	17,103		20,029			60
62	Whole Blood & Packed Red Blood Cells	11,907	1,179		1,759		1	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	40,496	4,010		7,919			65
66	Physical Therapy	125,700	12,448		14,461		23	66
69	Electrocardiology	68,778	6,811		11,434	56,644	4,648	69
69.01	CARDIAC CATH LAB	30,561	3,026		5,001	24,774	4,024	69.01
69.02	CARDIAC REHABILITATION	112,820	11,172		2,429	12,034	40	69.02
71	Medical Supplies Charged to Patients						765,835	71
72	Impl. Dev. Charged to Patients						508,791	72
73	Drugs Charged to Patients						1,301	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	276,557	27,387				199	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	62,146	6,154		7,801	38,649		90.02
91	Emergency	200,853	19,890		42,322	209,664	673	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	66,268	6,562				581	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,242,908	519,199	775,586	408,460	1,320,546	1,392,201	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	72,529	7,182		893			190
192	Physicians' Private Offices							192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER			21,970	1,972		34	192.02
192.03	MOBILE DENTAL CLINIC						20	192.03
192.04	EMS CONTINUING EDUCATION							192.04
194	CORPORATE HEALTH	34,837	3,450		459			194
194.01	MARKETING/COMMUNICATION	25,811	2,556		2,716			194.01
194.02	FOUNDATION	11,510	1,140					194.02

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		7	9	10	11	13	14	
194.03	OTHER NRCC	104,472	10,346		5,549		61	194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,492,067	543,873	797,556	420,049	1,320,546	1,392,316	202

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

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	PARAMED EDUCATION EMS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	24	25	26	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	891,207						15
16	Medical Records & Library		699,390					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	1		137,888				23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,858	51,608		9,641,528		9,641,528	30
31	Intensive Care Unit	269	15,110		2,614,390		2,614,390	31
35	NEONATAL INTENSIVE CARE UNIT	92	4,528		462,230		462,230	35
40	Subprovider - IPF	26	11,237		1,616,739		1,616,739	40
41	Subprovider - IRF	46	3,157		976,248		976,248	41
43	Nursery		3,202		355,750		355,750	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	9,732	58,577		7,811,766		7,811,766	50
52	Delivery Room & Labor Room		3,163		1,013,521		1,013,521	52
53	Anesthesiology	2,570	13,054		112,497		112,497	53
54	Radiology-Diagnostic	746	143,906		5,769,770		5,769,770	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	334	20,302		1,110,844		1,110,844	54.01
56.01	ONCOLOGY	24	33,597		1,214,745		1,214,745	56.01
60	Laboratory	22	84,736		2,223,649		2,223,649	60
62	Whole Blood & Packed Red Blood Cells		3,580		243,058		243,058	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	58	7,908		466,463		466,463	65
66	Physical Therapy	207	17,230		2,146,701		2,146,701	66
69	Electrocardiology	9,446	23,139		1,166,663		1,166,663	69
69.01	CARDIAC CATH LAB	31	19,030		851,647		851,647	69.01
69.02	CARDIAC REHABILITATION	19	874		794,237		794,237	69.02
71	Medical Supplies Charged to Patients	38	55,925		2,765,008		2,765,008	71
72	Impl. Dev. Charged to Patients		27,194		1,588,478		1,588,478	72
73	Drugs Charged to Patients	847,666	41,381		1,982,710		1,982,710	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis		2,517		75,486		75,486	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	10,915	6,531		2,074,988		2,074,988	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	23	1,175		574,027		574,027	90.02
91	Emergency	1,438	43,540		2,553,977		2,553,977	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	1,599	3,189		820,300		820,300	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	888,160	699,390		53,027,420		53,027,420	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				367,482		367,482	190
192	Physicians' Private Offices				92,802		92,802	192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER	5			94,631		94,631	192.02
192.03	MOBILE DENTAL CLINIC	66			52,701		52,701	192.03
192.04	EMS CONTINUING EDUCATION				42,399		42,399	192.04
194	CORPORATE HEALTH				186,629		186,629	194
194.01	MARKETING/COMMUNICATION				354,181		354,181	194.01
194.02	FOUNDATION				53,614		53,614	194.02

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	PARAMED EDUCATION EMS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	24	25	26	
194.03	OTHER NRCC	2,976			774,877		774,877	194.03
200	Cross Foot Adjustments			137,888	137,888		137,888	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	891,207	699,390	137,888	55,184,624		55,184,624	202

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	694,055						1
2	Cap Rel Costs-Mvble Equip		21,295,303					2
4	Employee Benefits Department	10,225	19,297	177,830,582				4
5	Administrative & General	160,626	14,171,528	28,591,870	-89,314,748	329,089,455		5
6	Maintenance & Repairs							6
7	Operation of Plant	94,236	113,271	2,563,387		18,920,215	428,968	7
8	Laundry & Linen Service							8
9	Housekeeping		22,854	3,220,697		7,557,846		9
10	Dietary	8,327	80,765	1,368,258		3,516,864	8,327	10
11	Cafeteria	5,476		1,423,526		1,562,553	5,476	11
12	Maintenance of Personnel							12
13	Nursing Administration	6,798	57,547	9,230,717		12,190,302	6,798	13
14	Central Services & Supply	12,411	308,811	1,573,300		3,738,031	12,411	14
15	Pharmacy	4,949	107,010	3,989,008		7,070,073	4,949	15
16	Medical Records & Library	4,212	49,271	2,307,288		5,846,499	4,212	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	484		1,119,848		1,101,251	484	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	91,121	499,149	27,840,809		38,489,513	91,121	30
31	Intensive Care Unit	25,693	173,986	7,976,425		11,325,356	25,693	31
35	NEONATAL INTENSIVE CARE UNIT	1,992	174,507	1,303,592		2,104,091	1,992	35
40	Subprovider - IPF	17,003	35,626	3,823,179		6,148,636	17,003	40
41	Subprovider - IRF	11,993	13,539	1,425,200		3,990,487	11,993	41
43	Nursery	4,039		921,440		1,567,556	4,039	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	62,653	2,392,416	12,300,295		20,059,891	62,653	50
52	Delivery Room & Labor Room	9,369		3,533,721		5,982,400	9,369	52
53	Anesthesiology	522		153,515		908,694	522	53
54	Radiology-Diagnostic	34,210	1,236,764	12,926,792		23,719,190	34,210	54
54.01	OFFSITE-DIAGNOSTIC SERVICES		403,247	1,735,802		3,713,526		54.01
56.01	ONCOLOGY	16,964	31,401	1,244,337		2,422,216	16,964	56.01
60	Laboratory	13,490	266,102	6,178,249		14,930,230	13,490	60
62	Whole Blood & Packed Red Blood Cells	930	20,703	502,221		2,400,315	930	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,163	36,618	2,290,608		3,355,261	3,163	65
66	Physical Therapy	9,818	90,420	6,656,836		9,530,941	9,818	66
69	Electrocardiology	5,372	214,417	4,039,210		6,206,601	5,372	69
69.01	CARDIAC CATH LAB	2,387	412,889	1,922,849		3,548,398	2,387	69.01
69.02	CARDIAC REHABILITATION	8,812	21,531	780,222		1,490,865	8,812	69.02
71	Medical Supplies Charged to Patients					28,660,062		71
72	Impl. Dev. Charged to Patients					15,523,040		72
73	Drugs Charged to Patients					16,111,064		73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis		2,048			1,045,640		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	21,601	70,629	1,793,260		4,795,642	21,601	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	4,854	36,009	2,224,913		3,082,810	4,854	90.02
91	Emergency	15,688	151,955	11,708,676		17,417,539	15,688	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	5,176	25,641	5,021,092		7,070,240	5,176	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	674,594	21,239,951	173,691,142	-89,314,748	317,103,838	409,507	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,665	1,097	144,931		648,295	5,665	190
192	Physicians' Private Offices		3,927			1,310,090		192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER		12,447	604,115		833,225		192.02
192.03	MOBILE DENTAL CLINIC		26,874	211,235		366,775		192.03
192.04	EMS CONTINUING EDUCATION			442,466		608,502		192.04
194	CORPORATE HEALTH	2,721	10,379	128,712		310,881	2,721	194
194.01	MARKETING/COMMUNICATION	2,016	581	904,748		3,455,027	2,016	194.01

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
194.02	FOUNDATION	899	47			38,363	899	194.02
194.03	OTHER NRCC	8,160		1,703,233		4,414,459	8,160	194.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	29,580,095	21,554,920	29,958,564		89,314,748	24,055,161	202
203	Unit Cost Multiplier (Wkst. B, Part I)	42.619238	1.012191	0.168467		0.271400	56.076819	203
204	Cost to be allocated (Per Wkst. B, Part II)			458,524		22,313,027	5,492,067	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.002578		0.067802	12.802976	205

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S SERVED	NURSING ADMINIS-TRATION FTE'S NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUISTION	
		9	10	11	13	14	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	428,968						9
10	Dietary	8,327	235,563					10
11	Cafeteria	5,476		4,091,738				11
12	Maintenance of Personnel							12
13	Nursing Administration	6,798		246,918	2,596,589			13
14	Central Services & Supply	12,411		88,673		44,012,183		14
15	Pharmacy	4,949		100,745	4,604		18,178,617	15
16	Medical Records & Library	4,212		81,713				16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	484		53,816	53,816		30	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	91,121	188,154	940,223	940,223	31,604	58,293	30
31	Intensive Care Unit	25,693	12,159	221,317	221,317	3,402	5,485	31
35	NEONATAL INTENSIVE CARE UNIT	1,992		34,625	34,625	61	1,877	35
40	Subprovider - IPF	17,003	28,761	131,252	131,252	1,474	531	40
41	Subprovider - IRF	11,993		50,851			945	41
43	Nursery	4,039		24,407	24,407			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	62,653		367,135	367,135	1,187,658	198,517	50
52	Delivery Room & Labor Room	9,369		105,523	105,523			52
53	Anesthesiology	522		8,615	8,615	282	52,423	53
54	Radiology-Diagnostic	34,210		387,735		2,010,948	15,212	54
54.01	OFFSITE-DIAGNOSTIC SERVICES					117,891	6,814	54.01
56.01	ONCOLOGY	16,964		33,062	33,062	66	485	56.01
60	Laboratory	13,490		195,105		6	450	60
62	Whole Blood & Packed Red Blood Cells	930		17,132		26		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,163		77,135			1,191	65
66	Physical Therapy	9,818		140,869		740	4,227	66
69	Electrocardiology	5,372		111,379	111,379	146,915	192,680	69
69.01	CARDIAC CATH LAB	2,387		48,713	48,713	127,191	631	69.01
69.02	CARDIAC REHABILITATION	8,812		23,662	23,662	1,280	391	69.02
71	Medical Supplies Charged to Patients					24,208,804	784	71
72	Impl. Dev. Charged to Patients					16,083,170		72
73	Drugs Charged to Patients					41,125	17,290,439	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	21,601				6,283	222,641	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	4,854		75,995	75,995		475	90.02
91	Emergency	15,688		412,261	412,261	21,262	29,330	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	5,176				18,368	32,612	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	409,507	229,074	3,978,861	2,596,589	44,008,556	18,116,463	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,665		8,698				190
192	Physicians' Private Offices							192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER		6,489	19,205		1,070	108	192.02
192.03	MOBILE DENTAL CLINIC					620	1,342	192.03
192.04	EMS CONTINUING EDUCATION							192.04
194	CORPORATE HEALTH	2,721		4,472				194
194.01	MARKETING/COMMUNICATION	2,016		26,453				194.01

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S SERVED	NURSING ADMINIS-TRATION FTE'S NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUISTION	
		9	10	11	13	14	15	
194.02	FOUNDATION	899						194.02
194.03	OTHER NRCC	8,160		54,049		1,937	60,704	194.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	9,609,045	5,124,821	2,416,371	16,178,055	5,778,879	9,465,454	202
203	Unit Cost Multiplier (Wkst. B, Part I)	22.400377	21.755628	0.590549	6.230503	0.131302	0.520692	203
204	Cost to be allocated (Per Wkst. B, Part II)	543,873	797,556	420,049	1,320,546	1,392,316	891,207	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.267864	3.385744	0.102658	0.508570	0.031635	0.049025	205

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY GROSS REVENUE	PARAMED EDUCATION EMS ASSIGNED TIME					
		16	23					
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	1,659,944,181						16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)		192					23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	122,583,442	14					30
31	Intensive Care Unit	35,890,925	8					31
35	NEONATAL INTENSIVE CARE UNIT	10,755,074						35
40	Subprovider - IPF	26,690,310	8					40
41	Subprovider - IRF	7,499,550						41
43	Nursery	7,605,035						43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	139,138,927	16					50
52	Delivery Room & Labor Room	7,513,030	10					52
53	Anesthesiology	31,007,985						53
54	Radiology-Diagnostic	340,503,062						54
54.01	OFFSITE-DIAGNOSTIC SERVICES	48,222,845						54.01
56.01	ONCOLOGY	79,803,870						56.01
60	Laboratory	201,273,753						60
62	Whole Blood & Packed Red Blood Cells	8,504,174						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	18,784,140						65
66	Physical Therapy	40,926,027						66
69	Electrocardiology	54,962,910						69
69.01	CARDIAC CATH LAB	45,200,925						69.01
69.02	CARDIAC REHABILITATION	2,074,987						69.02
71	Medical Supplies Charged to Patients	132,839,501						71
72	Impl. Dev. Charged to Patients	64,594,578						72
73	Drugs Charged to Patients	98,292,818						73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis	5,978,474						74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	15,513,191						90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	2,790,368						90.02
91	Emergency	103,420,272	136					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	7,574,008						101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,659,944,181	192					118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER							192.02
192.03	MOBILE DENTAL CLINIC							192.03
192.04	EMS CONTINUING EDUCATION							192.04

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY GROSS REVENUE	PARAMED EDUCATION EMS ASSIGNED TIME					
		16	23					
194	CORPORATE HEALTH							194
194.01	MARKETING/COMMUNICATION							194.01
194.02	FOUNDATION							194.02
194.03	OTHER NRCC							194.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	7,812,041	1,805,212					202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.004706	9,402.145833					203
204	Cost to be allocated (Per Wkst. B, Part II)	699,390	137,888					204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000421	718.166667					205

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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	67,336,086		67,336,086		67,336,086	30
31	Intensive Care Unit	18,436,938		18,436,938	8,144	18,445,082	31
35	NEONATAL INTENSIVE CARE UNIT	3,119,245		3,119,245		3,119,245	35
40	Subprovider - IPF	10,874,007		10,874,007		10,874,007	40
41	Subprovider - IRF	6,080,497		6,080,497		6,080,497	41
43	Nursery	2,512,231		2,512,231		2,512,231	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	33,989,754		33,989,754	59,978	34,049,732	50
52	Delivery Room & Labor Room	9,190,431		9,190,431		9,190,431	52
53	Anesthesiology	1,428,300		1,428,300		1,428,300	53
54	Radiology-Diagnostic	34,944,972		34,944,972	19,056	34,964,028	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	4,967,341		4,967,341		4,967,341	54.01
56.01	ONCOLOGY	5,012,229		5,012,229		5,012,229	56.01
60	Laboratory	21,103,599		21,103,599	64,179	21,167,778	60
62	Whole Blood & Packed Red Blood Cells	3,174,884		3,174,884		3,174,884	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	4,648,672		4,648,672		4,648,672	65
66	Physical Therapy	13,166,213		13,166,213		13,166,213	66
69	Electrocardiology	9,450,647		9,450,647	827,147	10,277,794	69
69.01	CARDIAC CATH LAB	5,260,776		5,260,776		5,260,776	69.01
69.02	CARDIAC REHABILITATION	2,758,564		2,758,564	585	2,759,149	69.02
71	Medical Supplies Charged to Patients	40,242,611		40,242,611		40,242,611	71
72	Impl. Dev. Charged to Patients	22,151,727		22,151,727		22,151,727	72
73	Drugs Charged to Patients	29,954,560		29,954,560		29,954,560	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS						73.01
74	Renal Dialysis	1,357,562		1,357,562		1,357,562	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT CENTERS	7,982,122		7,982,122		7,982,122	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	4,832,157		4,832,157		4,832,157	90.02
91	Emergency	27,971,315		27,971,315		27,971,315	91
92	Observation Beds (Non-Distinct Part)	9,872,848		9,872,848		9,872,848	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	Home Health Agency	9,450,337		9,450,337		9,450,337	101
200	Subtotal (sum of lines 30 thru 199)	411,270,625		411,270,625	979,089	412,249,714	200
201	Less Observation Beds	9,872,848		9,872,848		9,872,848	201
202	Total (line 200 minus line 201)	401,397,777		401,397,777		402,376,866	202

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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	113,301,670		113,301,670				30
31	Intensive Care Unit	35,890,925		35,890,925				31
35	NEONATAL INTENSIVE CARE UNIT	10,755,074		10,755,074				35
40	Subprovider - IPF	26,690,310		26,690,310				40
41	Subprovider - IRF	7,499,550		7,499,550				41
43	Nursery	7,605,035		7,605,035				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	56,035,286	83,103,641	139,138,927	0.244286	0.244286	0.244718	50
52	Delivery Room & Labor Room	7,382,001	131,029	7,513,030	1.223266	1.223266	1.223266	52
53	Anesthesiology	10,066,288	20,941,697	31,007,985	0.046062	0.046062	0.046062	53
54	Radiology-Diagnostic	91,360,715	249,142,347	340,503,062	0.102627	0.102627	0.102683	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	279,663	47,943,182	48,222,845	0.103008	0.103008	0.103008	54.01
56.01	ONCOLOGY	10,360,584	69,443,286	79,803,870	0.062807	0.062807	0.062807	56.01
60	Laboratory	87,364,333	113,909,420	201,273,753	0.104850	0.104850	0.105169	60
62	Whole Blood & Packed Red Blood Cells	6,652,661	1,851,513	8,504,174	0.373332	0.373332	0.373332	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	16,203,743	2,580,397	18,784,140	0.247479	0.247479	0.247479	65
66	Physical Therapy	13,706,743	27,219,284	40,926,027	0.321708	0.321708	0.321708	66
69	Electrocardiology	10,964,325	43,998,585	54,962,910	0.171946	0.171946	0.186995	69
69.01	CARDIAC CATH LAB	17,624,531	27,576,394	45,200,925	0.116386	0.116386	0.116386	69.01
69.02	CARDIAC REHABILITATION	1,967	2,073,020	2,074,987	1.329437	1.329437	1.329719	69.02
71	Medical Supplies Charged to Patients	70,329,859	62,509,642	132,839,501	0.302942	0.302942	0.302942	71
72	Impl. Dev. Charged to Patients	35,793,618	28,800,960	64,594,578	0.342935	0.342935	0.342935	72
73	Drugs Charged to Patients	55,375,013	42,917,805	98,292,818	0.304748	0.304748	0.304748	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis	5,266,900	711,574	5,978,474	0.227075	0.227075	0.227075	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	614,588	14,898,603	15,513,191	0.514538	0.514538	0.514538	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	139,224	2,651,144	2,790,368	1.731727	1.731727	1.731727	90.02
91	Emergency	28,128,161	75,292,111	103,420,272	0.270463	0.270463	0.270463	91
92	Observation Beds (Non-Distinct Part)		9,281,772	9,281,772	1.063681	1.063681	1.063681	92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency		7,574,008	7,574,008				101
200	Subtotal (sum of lines 30 thru 199)	725,392,767	934,551,414	1,659,944,181				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	725,392,767	934,551,414	1,659,944,181				202

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	9,641,528		9,641,528	71,593	134.67	29,198	3,932,095	30
31	Intensive Care Unit	2,614,390		2,614,390	7,537	346.87	3,767	1,306,659	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	NEONATAL INTENSIVE CARE UNIT	462,230		462,230	3,282	140.84			35
40	Subprovider - IPF	1,616,739		1,616,739	11,205	144.29	1,547	223,217	40
41	Subprovider - IRF	976,248		976,248	4,325	225.72	2,734	617,118	41
42	Subprovider I								42
43	Nursery	355,750		355,750	5,491	64.79			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	15,666,885		15,666,885	103,433		37,246	6,079,089	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0252** **WORKSHEET D PART II**

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	7,811,766	139,138,927	0.056144	24,912,010	1,398,660	50
52	Delivery Room & Labor Room	1,013,521	7,513,030	0.134902			52
53	Anesthesiology	112,497	31,007,985	0.003628	3,564,034	12,930	53
54	Radiology-Diagnostic	5,769,770	340,503,062	0.016945	48,404,189	820,209	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	1,110,844	48,222,845	0.023036			54.01
56.01	ONCOLOGY	1,214,745	79,803,870	0.015222	4,802,816	73,108	56.01
60	Laboratory	2,223,649	201,273,753	0.011048	40,886,371	451,713	60
62	Whole Blood & Packed Red Blood	243,058	8,504,174	0.028581	3,838,586	109,711	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	466,463	18,784,140	0.024833	9,084,991	225,608	65
66	Physical Therapy	2,146,701	40,926,027	0.052453	4,604,030	241,495	66
69	Electrocardiology	1,166,663	54,962,910	0.021226	5,999,724	127,350	69
69.01	CARDIAC CATH LAB	851,647	45,200,925	0.018841	7,723,111	145,511	69.01
69.02	CARDIAC REHABILITATION	794,237	2,074,987	0.382767	405	155	69.02
71	Medical Supplies Charged to Pat	2,765,008	132,839,501	0.020815	33,325,451	693,669	71
72	Impl. Dev. Charged to Patients	1,588,478	64,594,578	0.024592	18,685,501	459,514	72
73	Drugs Charged to Patients	1,982,710	98,292,818	0.020171	24,548,738	495,173	73
73.01	FLU VACCINE DRUGS CHG TO PATIEN						73.01
74	Renal Dialysis	75,486	5,978,474	0.012626	2,982,341	37,655	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT CENTERS	2,074,988	15,513,191	0.133756	206,751	27,654	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	574,027	2,790,368	0.205717	12,744	2,622	90.02
91	Emergency	2,553,977	103,420,272	0.024695	13,614,255	336,204	91
92	Observation Beds (Non-Distinct	1,413,644	9,281,772	0.152303			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	37,953,879	1,450,627,609		247,196,048	5,658,941	200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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)		131,630			131,630	30
31	Intensive Care Unit		75,217			75,217	31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	NEONATAL INTENSIVE CARE UNIT						35
40	Subprovider - IPF		75,217			75,217	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)		282,064			282,064	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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
		6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	71,593	1.84	29,198	53,724	30
31	Intensive Care Unit	7,537	9.98	3,767	37,595	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	NEONATAL INTENSIVE CARE UNIT	3,282				35
40	Subprovider - IPF	11,205	6.71	1,547	10,380	40
41	Subprovider - IRF	4,325		2,734		41
42	Subprovider I					42
43	Nursery	5,491				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	103,433		37,246	101,699	200

(A) Worksheet A line numbers

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

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [ ] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] 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			150,434		150,434	150,434	50
52	Delivery Room & Labor Room			94,021		94,021	94,021	52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	OFFSITE-DIAGNOSTIC SERVICES							54.01
56.01	ONCOLOGY							56.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
69.01	CARDIAC CATH LAB							69.01
69.02	CARDIAC REHABILITATION							69.02
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN							73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM							90.02
91	Emergency			1,278,693		1,278,693	1,278,693	91
92	Observation Beds (Non-Distinct			19,301		19,301	19,301	92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			1,542,449		1,542,449	1,542,449	200

(A) Worksheet A line numbers

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

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [ ] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/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	139,138,927	0.001081	0.001081	24,912,010	26,930	25,254,399	27,300	50
52	Delivery Room & Labor Room	7,513,030	0.012514	0.012514					52
53	Anesthesiology	31,007,985			3,564,034		6,488,393		53
54	Radiology-Diagnostic	340,503,062			48,404,189		89,826,559		54
54.01	OFFSITE-DIAGNOSTIC SERVICES	48,222,845					16,792,362		54.01
56.01	ONCOLOGY	79,803,870			4,802,816		26,742,690		56.01
60	Laboratory	201,273,753			40,886,371		20,846,908		60
62	Whole Blood & Packed Red Blood	8,504,174			3,838,586		971,564		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	18,784,140			9,084,991		951,462		65
66	Physical Therapy	40,926,027			4,604,030		221,708		66
69	Electrocardiology	54,962,910			5,999,724		14,196,061		69
69.01	CARDIAC CATH LAB	45,200,925			7,723,111		14,286,110		69.01
69.02	CARDIAC REHABILITATION	2,074,987			405		1,058,767		69.02
71	Medical Supplies Charged to Pat	132,839,501			33,325,451		21,733,382		71
72	Impl. Dev. Charged to Patients	64,594,578			18,685,501		16,558,573		72
73	Drugs Charged to Patients	98,292,818			24,548,738		15,121,703		73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	5,978,474			2,982,341		527,405		74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT CENTERS	15,513,191			206,751		2,590,910		90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	2,790,368			12,744		115,227		90.02
91	Emergency	103,420,272	0.012364	0.012364	13,614,255	168,327	17,832,462	220,481	91
92	Observation Beds (Non-Distinct	9,281,772	0.002079	0.002079			3,544,938	7,370	92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,450,627,609			247,196,048	195,257	295,661,583	255,151	200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0252** **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	0.244286	25,254,399			6,169,296			50
52	Delivery Room & Labor Room	1.223266							52
53	Anesthesiology	0.046062	6,488,393			298,868			53
54	Radiology-Diagnostic	0.102627	89,826,559			9,218,630			54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.103008	16,792,362			1,729,748			54.01
56.01	ONCOLOGY	0.062807	26,742,690			1,679,628			56.01
60	Laboratory	0.104850	20,846,908	892		2,185,798	94		60
62	Whole Blood & Packed Red Blood	0.373332	971,564			362,716			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.247479	951,462			235,467			65
66	Physical Therapy	0.321708	221,708			71,325			66
69	Electrocardiology	0.171946	14,196,061			2,440,956			69
69.01	CARDIAC CATH LAB	0.116386	14,286,110			1,662,703			69.01
69.02	CARDIAC REHABILITATION	1.329437	1,058,767			1,407,564			69.02
71	Medical Supplies Charged to Pat	0.302942	21,733,382			6,583,954			71
72	Impl. Dev. Charged to Patients	0.342935	16,558,573			5,678,514			72
73	Drugs Charged to Patients	0.304748	15,121,703	614		4,608,309	187		73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	0.227075	527,405			119,760			74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT CENTERS	0.514538	2,590,910		60,144	1,333,122		30,946	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.731727	115,227			199,542			90.02
91	Emergency	0.270463	17,832,462	52,559		4,823,021	14,215		91
92	Observation Beds (Non-Distinct	1.063681	3,544,938			3,770,683			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		295,661,583	54,065	60,144	54,579,604	14,496	30,946	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		295,661,583	54,065	60,144	54,579,604	14,496	30,946	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S252** **WORKSHEET D PART II**

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	7,811,766	139,138,927	0.056144			50
52	Delivery Room & Labor Room	1,013,521	7,513,030	0.134902			52
53	Anesthesiology	112,497	31,007,985	0.003628			53
54	Radiology-Diagnostic	5,769,770	340,503,062	0.016945	38,184	647	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	1,110,844	48,222,845	0.023036			54.01
56.01	ONCOLOGY	1,214,745	79,803,870	0.015222	6,456	98	56.01
60	Laboratory	2,223,649	201,273,753	0.011048	272,349	3,009	60
62	Whole Blood & Packed Red Blood	243,058	8,504,174	0.028581			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	466,463	18,784,140	0.024833			65
66	Physical Therapy	2,146,701	40,926,027	0.052453	34,187	1,793	66
69	Electrocardiology	1,166,663	54,962,910	0.021226	39,889	847	69
69.01	CARDIAC CATH LAB	851,647	45,200,925	0.018841			69.01
69.02	CARDIAC REHABILITATION	794,237	2,074,987	0.382767			69.02
71	Medical Supplies Charged to Pat	2,765,008	132,839,501	0.020815	6,566	137	71
72	Impl. Dev. Charged to Patients	1,588,478	64,594,578	0.024592			72
73	Drugs Charged to Patients	1,982,710	98,292,818	0.020171	196,237	3,958	73
73.01	FLU VACCINE DRUGS CHG TO PATIEN						73.01
74	Renal Dialysis	75,486	5,978,474	0.012626			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT CENTERS	2,074,988	15,513,191	0.133756			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	574,027	2,790,368	0.205717	49,470	10,177	90.02
91	Emergency	2,553,977	103,420,272	0.024695	187,952	4,641	91
92	Observation Beds (Non-Distinct		9,281,772				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	36,540,235	1,450,627,609		831,290	25,307	200

(A) Worksheet A line numbers

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

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [ ] Title XIX | [ ] Hospital [XX] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] 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			150,434		150,434	150,434	50
52	Delivery Room & Labor Room			94,021		94,021	94,021	52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	OFFSITE-DIAGNOSTIC SERVICES							54.01
56.01	ONCOLOGY							56.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
69.01	CARDIAC CATH LAB							69.01
69.02	CARDIAC REHABILITATION							69.02
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN							73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM							90.02
91	Emergency			1,278,693		1,278,693	1,278,693	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			1,523,148		1,523,148	1,523,148	200

(A) Worksheet A line numbers

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

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [ ] Title XIX | [ ] Hospital [XX] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/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	139,138,927	0.001081	0.001081					50
52	Delivery Room & Labor Room	7,513,030	0.012514	0.012514					52
53	Anesthesiology	31,007,985							53
54	Radiology-Diagnostic	340,503,062			38,184				54
54.01	OFFSITE-DIAGNOSTIC SERVICES	48,222,845							54.01
56.01	ONCOLOGY	79,803,870			6,456				56.01
60	Laboratory	201,273,753			272,349				60
62	Whole Blood & Packed Red Blood	8,504,174							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	18,784,140							65
66	Physical Therapy	40,926,027			34,187				66
69	Electrocardiology	54,962,910			39,889				69
69.01	CARDIAC CATH LAB	45,200,925							69.01
69.02	CARDIAC REHABILITATION	2,074,987							69.02
71	Medical Supplies Charged to Pat	132,839,501			6,566				71
72	Impl. Dev. Charged to Patients	64,594,578							72
73	Drugs Charged to Patients	98,292,818			196,237				73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	5,978,474							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT CENTERS	15,513,191							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	2,790,368			49,470				90.02
91	Emergency	103,420,272	0.012364	0.012364	187,952	2,324			91
92	Observation Beds (Non-Distinct	9,281,772							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,450,627,609			831,290	2,324			200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S252** **WORKSHEET D PART V**

Check Applicable Boxes: **[ ] Title V - O/P** **[XX] Title XVIII, Part B** **[ ] Title XIX - O/P** **[ ] Hospital** **[XX] 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	0.244286							50
52	Delivery Room & Labor Room	1.223266							52
53	Anesthesiology	0.046062							53
54	Radiology-Diagnostic	0.102627							54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.103008							54.01
56.01	ONCOLOGY	0.062807							56.01
60	Laboratory	0.104850							60
62	Whole Blood & Packed Red Blood	0.373332							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.247479							65
66	Physical Therapy	0.321708							66
69	Electrocardiology	0.171946							69
69.01	CARDIAC CATH LAB	0.116386							69.01
69.02	CARDIAC REHABILITATION	1.329437							69.02
71	Medical Supplies Charged to Pat	0.302942							71
72	Impl. Dev. Charged to Patients	0.342935							72
73	Drugs Charged to Patients	0.304748							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	0.227075							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT CENTERS	0.514538							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.731727							90.02
91	Emergency	0.270463							91
92	Observation Beds (Non-Distinct	1.063681							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-T252** **WORKSHEET D PART II**

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	7,811,766	139,138,927	0.056144	2,588	145	50
52	Delivery Room & Labor Room	1,013,521	7,513,030	0.134902			52
53	Anesthesiology	112,497	31,007,985	0.003628	1,119	4	53
54	Radiology-Diagnostic	5,769,770	340,503,062	0.016945	186,011	3,152	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	1,110,844	48,222,845	0.023036			54.01
56.01	ONCOLOGY	1,214,745	79,803,870	0.015222	29,761	453	56.01
60	Laboratory	2,223,649	201,273,753	0.011048	440,564	4,867	60
62	Whole Blood & Packed Red Blood	243,058	8,504,174	0.028581	6,701	192	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	466,463	18,784,140	0.024833	180,443	4,481	65
66	Physical Therapy	2,146,701	40,926,027	0.052453	3,698,390	193,992	66
69	Electrocardiology	1,166,663	54,962,910	0.021226	10,632	226	69
69.01	CARDIAC CATH LAB	851,647	45,200,925	0.018841			69.01
69.02	CARDIAC REHABILITATION	794,237	2,074,987	0.382767			69.02
71	Medical Supplies Charged to Pat	2,765,008	132,839,501	0.020815	135,052	2,811	71
72	Impl. Dev. Charged to Patients	1,588,478	64,594,578	0.024592	1,796	44	72
73	Drugs Charged to Patients	1,982,710	98,292,818	0.020171	451,964	9,117	73
73.01	FLU VACCINE DRUGS CHG TO PATIEN						73.01
74	Renal Dialysis	75,486	5,978,474	0.012626	111,996	1,414	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT CENTERS	2,074,988	15,513,191	0.133756	10,550	1,411	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	574,027	2,790,368	0.205717			90.02
91	Emergency	2,553,977	103,420,272	0.024695	50,773	1,254	91
92	Observation Beds (Non-Distinct		9,281,772				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	36,540,235	1,450,627,609		5,318,340	223,563	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-T252** | **WORKSHEET D PART IV**

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

(A)	Cost Center Description	Non Physician Anesth-etist Cost (1)	Nursing School (2)	Allied Health (3)	All Other Medical Education Cost (4)	Total Cost (sum of col. 1 through col. 4) (5)	Total Outpatient Cost (sum of col. 2, 3, and 4) (6)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			150,434		150,434	150,434	50
52	Delivery Room & Labor Room			94,021		94,021	94,021	52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	OFFSITE-DIAGNOSTIC SERVICES							54.01
56.01	ONCOLOGY							56.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
69.01	CARDIAC CATH LAB							69.01
69.02	CARDIAC REHABILITATION							69.02
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN							73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM							90.02
91	Emergency			1,278,693		1,278,693	1,278,693	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			1,523,148		1,523,148	1,523,148	200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-T252** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V | [ ] Hospital | [ ] SUB (Other) | [ ] ICF/IID | [XX] PPS
[XX] Title XVIII, Part A | [ ] IPF | [ ] SNF | | [ ] TEFRA
[ ] Title XIX | [XX] IRF | [ ] NF | | [ ] 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	139,138,927	0.001081	0.001081	2,588	3			50
52	Delivery Room & Labor Room	7,513,030	0.012514	0.012514					52
53	Anesthesiology	31,007,985			1,119				53
54	Radiology-Diagnostic	340,503,062			186,011				54
54.01	OFFSITE-DIAGNOSTIC SERVICES	48,222,845							54.01
56.01	ONCOLOGY	79,803,870			29,761				56.01
60	Laboratory	201,273,753			440,564				60
62	Whole Blood & Packed Red Blood	8,504,174			6,701				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	18,784,140			180,443				65
66	Physical Therapy	40,926,027			3,698,390				66
69	Electrocardiology	54,962,910			10,632				69
69.01	CARDIAC CATH LAB	45,200,925							69.01
69.02	CARDIAC REHABILITATION	2,074,987							69.02
71	Medical Supplies Charged to Pat	132,839,501			135,052				71
72	Impl. Dev. Charged to Patients	64,594,578			1,796				72
73	Drugs Charged to Patients	98,292,818			451,964				73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	5,978,474			111,996				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT CENTERS	15,513,191			10,550				90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	2,790,368							90.02
91	Emergency	103,420,272	0.012364	0.012364	50,773	628			91
92	Observation Beds (Non-Distinct	9,281,772							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,450,627,609			5,318,340	631			200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-T252** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[ ] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[XX] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[ ] Title XIX - O/P **[XX] 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	0.244286							50
52	Delivery Room & Labor Room	1.223266							52
53	Anesthesiology	0.046062							53
54	Radiology-Diagnostic	0.102627							54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.103008							54.01
56.01	ONCOLOGY	0.062807							56.01
60	Laboratory	0.104850							60
62	Whole Blood & Packed Red Blood	0.373332							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.247479							65
66	Physical Therapy	0.321708							66
69	Electrocardiology	0.171946							69
69.01	CARDIAC CATH LAB	0.116386							69.01
69.02	CARDIAC REHABILITATION	1.329437							69.02
71	Medical Supplies Charged to Pat	0.302942							71
72	Impl. Dev. Charged to Patients	0.342935							72
73	Drugs Charged to Patients	0.304748							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	0.227075							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT CENTERS	0.514538							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.731727							90.02
91	Emergency	0.270463							91
92	Observation Beds (Non-Distinct	1.063681							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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)	9,641,528		9,641,528	71,593	134.67	2,671	359,704	30
31	Intensive Care Unit	2,614,390		2,614,390	7,537	346.87	460	159,560	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	NEONATAL INTENSIVE CARE UNIT	462,230		462,230	3,282	140.84	354	49,857	35
40	Subprovider - IPF	1,616,739		1,616,739	11,205	144.29	640	92,346	40
41	Subprovider - IRF	976,248		976,248	4,325	225.72			41
42	Subprovider I								42
43	Nursery	355,750		355,750	5,491	64.79	294	19,048	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	15,666,885		15,666,885	103,433		4,419	680,515	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0252** **WORKSHEET D PART II**

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	7,811,766	139,138,927	0.056144	1,373,333	77,104	50
52	Delivery Room & Labor Room	1,013,521	7,513,030	0.134902	1,674,306	225,867	52
53	Anesthesiology	112,497	31,007,985	0.003628	804,222	2,918	53
54	Radiology-Diagnostic	5,769,770	340,503,062	0.016945	3,563,749	60,388	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	1,110,844	48,222,845	0.023036			54.01
56.01	ONCOLOGY	1,214,745	79,803,870	0.015222	420,924	6,407	56.01
60	Laboratory	2,223,649	201,273,753	0.011048	5,336,971	58,963	60
62	Whole Blood & Packed Red Blood	243,058	8,504,174	0.028581	134,241	3,837	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	466,463	18,784,140	0.024833	1,017,327	25,263	65
66	Physical Therapy	2,146,701	40,926,027	0.052453	143,371	7,520	66
69	Electrocardiology	1,166,663	54,962,910	0.021226	526,638	11,178	69
69.01	CARDIAC CATH LAB	851,647	45,200,925	0.018841	449,399	8,467	69.01
69.02	CARDIAC REHABILITATION	794,237	2,074,987	0.382767			69.02
71	Medical Supplies Charged to Pat	2,765,008	132,839,501	0.020815	3,462,541	72,073	71
72	Impl. Dev. Charged to Patients	1,588,478	64,594,578	0.024592			72
73	Drugs Charged to Patients	1,982,710	98,292,818	0.020171	2,646,130	53,375	73
73.01	FLU VACCINE DRUGS CHG TO PATIEN						73.01
74	Renal Dialysis	75,486	5,978,474	0.012626	165,818	2,094	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT CENTERS	2,074,988	15,513,191	0.133756			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	574,027	2,790,368	0.205717	3,696	760	90.02
91	Emergency	2,553,977	103,420,272	0.024695	130,744	3,229	91
92	Observation Beds (Non-Distinct	1,413,644	9,281,772	0.152303			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	37,953,879	1,450,627,609		21,853,410	619,443	200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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)		131,630			131,630	30
31	Intensive Care Unit		75,217			75,217	31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	NEONATAL INTENSIVE CARE UNIT						35
40	Subprovider - IPF		75,217			75,217	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)		282,064			282,064	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)	71,593	1.84	2,671	4,915	30
31	Intensive Care Unit	7,537	9.98	460	4,591	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	NEONATAL INTENSIVE CARE UNIT	3,282		354		35
40	Subprovider - IPF	11,205	6.71	640	4,294	40
41	Subprovider - IRF	4,325				41
42	Subprovider I					42
43	Nursery	5,491		294		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	103,433		4,419	13,800	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0252** | **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			150,434		150,434	150,434	50
52	Delivery Room & Labor Room			94,021		94,021	94,021	52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	OFFSITE-DIAGNOSTIC SERVICES							54.01
56.01	ONCOLOGY							56.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
69.01	CARDIAC CATH LAB							69.01
69.02	CARDIAC REHABILITATION							69.02
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN							73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM							90.02
91	Emergency			1,278,693		1,278,693	1,278,693	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			1,523,148		1,523,148	1,523,148	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0252** | **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	139,138,927	0.001081	0.001081	1,373,333	1,485			50
52	Delivery Room & Labor Room	7,513,030	0.012514	0.012514	1,674,306	20,952			52
53	Anesthesiology	31,007,985			804,222				53
54	Radiology-Diagnostic	340,503,062			3,563,749				54
54.01	OFFSITE-DIAGNOSTIC SERVICES	48,222,845							54.01
56.01	ONCOLOGY	79,803,870			420,924				56.01
60	Laboratory	201,273,753			5,336,971				60
62	Whole Blood & Packed Red Blood	8,504,174			134,241				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	18,784,140			1,017,327				65
66	Physical Therapy	40,926,027			143,371				66
69	Electrocardiology	54,962,910			526,638				69
69.01	CARDIAC CATH LAB	45,200,925			449,399				69.01
69.02	CARDIAC REHABILITATION	2,074,987							69.02
71	Medical Supplies Charged to Pat	132,839,501			3,462,541				71
72	Impl. Dev. Charged to Patients	64,594,578							72
73	Drugs Charged to Patients	98,292,818			2,646,130				73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	5,978,474			165,818				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT CENTERS	15,513,191							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	2,790,368			3,696				90.02
91	Emergency	103,420,272	0.012364	0.012364	130,744	1,617			91
92	Observation Beds (Non-Distinct	9,281,772							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,450,627,609			21,853,410	24,054			200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0252** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[ ] 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	0.244286							50
52	Delivery Room & Labor Room	1.223266							52
53	Anesthesiology	0.046062							53
54	Radiology-Diagnostic	0.102627							54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.103008							54.01
56.01	ONCOLOGY	0.062807							56.01
60	Laboratory	0.104850							60
62	Whole Blood & Packed Red Blood	0.373332							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.247479							65
66	Physical Therapy	0.321708							66
69	Electrocardiology	0.171946							69
69.01	CARDIAC CATH LAB	0.116386							69.01
69.02	CARDIAC REHABILITATION	1.329437							69.02
71	Medical Supplies Charged to Pat	0.302942							71
72	Impl. Dev. Charged to Patients	0.342935							72
73	Drugs Charged to Patients	0.304748							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	0.227075							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT CENTERS	0.514538							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.731727							90.02
91	Emergency	0.270463							91
92	Observation Beds (Non-Distinct	1.063681							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S252** **WORKSHEET D PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26) 1	Total Charges (from Wkst. C, Part I, (col. 8) 2	Ratio of Cost to Charges (col. 1 ÷ col. 2) 3	Inpatient Program Charges 4	Capital Costs (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	7,811,766	139,138,927	0.056144			50
52	Delivery Room & Labor Room	1,013,521	7,513,030	0.134902			52
53	Anesthesiology	112,497	31,007,985	0.003628			53
54	Radiology-Diagnostic	5,769,770	340,503,062	0.016945	50,286	852	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	1,110,844	48,222,845	0.023036			54.01
56.01	ONCOLOGY	1,214,745	79,803,870	0.015222	12,061	184	56.01
60	Laboratory	2,223,649	201,273,753	0.011048	259,384	2,866	60
62	Whole Blood & Packed Red Blood	243,058	8,504,174	0.028581			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	466,463	18,784,140	0.024833			65
66	Physical Therapy	2,146,701	40,926,027	0.052453	1,062	56	66
69	Electrocardiology	1,166,663	54,962,910	0.021226	53,744	1,141	69
69.01	CARDIAC CATH LAB	851,647	45,200,925	0.018841			69.01
69.02	CARDIAC REHABILITATION	794,237	2,074,987	0.382767			69.02
71	Medical Supplies Charged to Pat	2,765,008	132,839,501	0.020815	14,287	297	71
72	Impl. Dev. Charged to Patients	1,588,478	64,594,578	0.024592			72
73	Drugs Charged to Patients	1,982,710	98,292,818	0.020171	65,521	1,322	73
73.01	FLU VACCINE DRUGS CHG TO PATIEN						73.01
74	Renal Dialysis	75,486	5,978,474	0.012626			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT CENTERS	2,074,988	15,513,191	0.133756			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	574,027	2,790,368	0.205717	66,528	13,686	90.02
91	Emergency	2,553,977	103,420,272	0.024695	1,838	45	91
92	Observation Beds (Non-Distinct		9,281,772				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	36,540,235	1,450,627,609		524,711	20,449	200

(A) Worksheet A line numbers

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

Check Applicable Boxes:
[ ] Title V **[ ] Title XVIII, Part A** **[XX] Title XIX**
[ ] Hospital **[XX] IPF** **[ ] IRF**
[ ] SUB (Other) **[ ] SNF** **[ ] NF**
[ ] ICF/IID
[ ] PPS **[ ] TEFRA** **[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			150,434		150,434	150,434	50
52	Delivery Room & Labor Room			94,021		94,021	94,021	52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	OFFSITE-DIAGNOSTIC SERVICES							54.01
56.01	ONCOLOGY							56.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
69.01	CARDIAC CATH LAB							69.01
69.02	CARDIAC REHABILITATION							69.02
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN							73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM							90.02
91	Emergency			1,278,693		1,278,693	1,278,693	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			1,523,148		1,523,148	1,523,148	200

(A) Worksheet A line numbers

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

Check Applicable Boxes:
[ ] Title V [ ] Title XVIII, Part A [XX] Title XIX
[ ] Hospital [XX] IPF [ ] IRF
[ ] SUB (Other) [ ] SNF [ ] NF
[ ] ICF/IID
[ ] PPS [ ] TEFRA [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	139,138,927	0.001081	0.001081					50
52	Delivery Room & Labor Room	7,513,030	0.012514	0.012514					52
53	Anesthesiology	31,007,985							53
54	Radiology-Diagnostic	340,503,062			50,286				54
54.01	OFFSITE-DIAGNOSTIC SERVICES	48,222,845							54.01
56.01	ONCOLOGY	79,803,870			12,061				56.01
60	Laboratory	201,273,753			259,384				60
62	Whole Blood & Packed Red Blood	8,504,174							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	18,784,140							65
66	Physical Therapy	40,926,027			1,062				66
69	Electrocardiology	54,962,910			53,744				69
69.01	CARDIAC CATH LAB	45,200,925							69.01
69.02	CARDIAC REHABILITATION	2,074,987							69.02
71	Medical Supplies Charged to Pat	132,839,501			14,287				71
72	Impl. Dev. Charged to Patients	64,594,578							72
73	Drugs Charged to Patients	98,292,818			65,521				73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	5,978,474							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT CENTERS	15,513,191							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	2,790,368			66,528				90.02
91	Emergency	103,420,272	0.012364	0.012364	1,838	23			91
92	Observation Beds (Non-Distinct	9,281,772							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,450,627,609			524,711	23			200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S252** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[ ] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[ ] Title XVIII, Part B **[XX] 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	0.244286							50
52	Delivery Room & Labor Room	1.223266							52
53	Anesthesiology	0.046062							53
54	Radiology-Diagnostic	0.102627							54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.103008							54.01
56.01	ONCOLOGY	0.062807							56.01
60	Laboratory	0.104850							60
62	Whole Blood & Packed Red Blood	0.373332							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.247479							65
66	Physical Therapy	0.321708							66
69	Electrocardiology	0.171946							69
69.01	CARDIAC CATH LAB	0.116386							69.01
69.02	CARDIAC REHABILITATION	1.329437							69.02
71	Medical Supplies Charged to Pat	0.302942							71
72	Impl. Dev. Charged to Patients	0.342935							72
73	Drugs Charged to Patients	0.304748							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	0.227075							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT CENTERS	0.514538							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.731727							90.02
91	Emergency	0.270463							91
92	Observation Beds (Non-Distinct	1.063681							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-T252** **WORKSHEET D PART II**

Check Applicable Boxes:
[ ] Title V **[ ] Hospital** **[ ] SUB (Other)**
[ ] Title XVIII, Part A **[ ] IPF**
[XX] Title XIX **[XX] 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	7,811,766	139,138,927	0.056144			50
52	Delivery Room & Labor Room	1,013,521	7,513,030	0.134902			52
53	Anesthesiology	112,497	31,007,985	0.003628			53
54	Radiology-Diagnostic	5,769,770	340,503,062	0.016945			54
54.01	OFFSITE-DIAGNOSTIC SERVICES	1,110,844	48,222,845	0.023036			54.01
56.01	ONCOLOGY	1,214,745	79,803,870	0.015222			56.01
60	Laboratory	2,223,649	201,273,753	0.011048			60
62	Whole Blood & Packed Red Blood	243,058	8,504,174	0.028581			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	466,463	18,784,140	0.024833			65
66	Physical Therapy	2,146,701	40,926,027	0.052453			66
69	Electrocardiology	1,166,663	54,962,910	0.021226			69
69.01	CARDIAC CATH LAB	851,647	45,200,925	0.018841			69.01
69.02	CARDIAC REHABILITATION	794,237	2,074,987	0.382767			69.02
71	Medical Supplies Charged to Pat	2,765,008	132,839,501	0.020815			71
72	Impl. Dev. Charged to Patients	1,588,478	64,594,578	0.024592			72
73	Drugs Charged to Patients	1,982,710	98,292,818	0.020171			73
73.01	FLU VACCINE DRUGS CHG TO PATIEN						73.01
74	Renal Dialysis	75,486	5,978,474	0.012626			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT TREATMENT CENTERS	2,074,988	15,513,191	0.133756			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	574,027	2,790,368	0.205717			90.02
91	Emergency	2,553,977	103,420,272	0.024695			91
92	Observation Beds (Non-Distinct		9,281,772				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	36,540,235	1,450,627,609				200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-T252** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V [ ] Title XVIII, Part A [XX] Title XIX
[ ] Hospital [ ] IPF [XX] IRF
[ ] SUB (Other) [ ] SNF [ ] NF
[ ] ICF/IID
[ ] PPS [ ] TEFRA [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			150,434		150,434	150,434	50
52	Delivery Room & Labor Room			94,021		94,021	94,021	52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	OFFSITE-DIAGNOSTIC SERVICES							54.01
56.01	ONCOLOGY							56.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
69.01	CARDIAC CATH LAB							69.01
69.02	CARDIAC REHABILITATION							69.02
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN							73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM							90.02
91	Emergency			1,278,693		1,278,693	1,278,693	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			1,523,148		1,523,148	1,523,148	200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-T252** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V **[ ] Title XVIII, Part A** **[XX] Title XIX**
[ ] Hospital **[ ] IPF** **[XX] IRF**
[ ] SUB (Other) **[ ] SNF** **[ ] NF**
[ ] ICF/IID
[ ] PPS **[ ] TEFRA** **[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	139,138,927	0.001081	0.001081					50
52	Delivery Room & Labor Room	7,513,030	0.012514	0.012514					52
53	Anesthesiology	31,007,985							53
54	Radiology-Diagnostic	340,503,062							54
54.01	OFFSITE-DIAGNOSTIC SERVICES	48,222,845							54.01
56.01	ONCOLOGY	79,803,870							56.01
60	Laboratory	201,273,753							60
62	Whole Blood & Packed Red Blood	8,504,174							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	18,784,140							65
66	Physical Therapy	40,926,027							66
69	Electrocardiology	54,962,910							69
69.01	CARDIAC CATH LAB	45,200,925							69.01
69.02	CARDIAC REHABILITATION	2,074,987							69.02
71	Medical Supplies Charged to Pat	132,839,501							71
72	Impl. Dev. Charged to Patients	64,594,578							72
73	Drugs Charged to Patients	98,292,818							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	5,978,474							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT CENTERS	15,513,191							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	2,790,368							90.02
91	Emergency	103,420,272	0.012364	0.012364					91
92	Observation Beds (Non-Distinct	9,281,772							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,450,627,609							200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-T252** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[ ] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[ ] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[XX] Title XIX - O/P **[XX] 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	0.244286							50
52	Delivery Room & Labor Room	1.223266							52
53	Anesthesiology	0.046062							53
54	Radiology-Diagnostic	0.102627							54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.103008							54.01
56.01	ONCOLOGY	0.062807							56.01
60	Laboratory	0.104850							60
62	Whole Blood & Packed Red Blood	0.373332							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.247479							65
66	Physical Therapy	0.321708							66
69	Electrocardiology	0.171946							69
69.01	CARDIAC CATH LAB	0.116386							69.01
69.02	CARDIAC REHABILITATION	1.329437							69.02
71	Medical Supplies Charged to Pat	0.302942							71
72	Impl. Dev. Charged to Patients	0.342935							72
73	Drugs Charged to Patients	0.304748							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	0.227075							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT TREATMENT CENTERS	0.514538							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.731727							90.02
91	Emergency	0.270463							91
92	Observation Beds (Non-Distinct	1.063681							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	71,593	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	71,593	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)	61,096	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)	29,198	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)	67,336,086	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)	67,336,086	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)	67,336,086	37

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	940.54	38
39	Program general inpatient routine service cost (line 9 x line 38)	27,461,887	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)	27,461,887	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	18,445,082	7,537	2,447.27	3,767	9,218,866	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	NEONATAL INTENSIVE CARE UNIT	3,119,245	3,282	950.41			47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	51,488,970	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	88,169,723	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	5,330,073	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	5,854,198	51
52	Total Program excludable cost (sum of lines 50 and 51)	11,184,271	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	76,985,452	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)					10,497	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					940.54	88
89	Observation bed cost (line 87 x line 88) (see instructions)					9,872,848	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	9,641,528	67,336,086	0.143185	9,872,848	1,413,644	90
91	Nursing School						91
92	Allied Health	131,630	67,336,086	0.001955	9,872,848	19,301	92
93	Other Medical Education						93

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S252** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,205	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,205	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)	11,205	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)	1,547	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)	10,874,007	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)	10,874,007	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)	10,874,007	37

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S252** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	970.46	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,501,302	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)	1,501,302	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	249,721	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,751,023	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	233,597	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	27,631	51
52	Total Program excludable cost (sum of lines 50 and 51)	261,228	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,489,795	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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T252** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,325	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,325	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)	4,325	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,734	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)	6,080,497	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)	6,080,497	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)	6,080,497	37

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T252** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,405.90	38
39	Program general inpatient routine service cost (line 9 x line 38)	3,843,731	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)	3,843,731	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,530,791	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	5,374,522	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	617,118	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	224,194	51
52	Total Program excludable cost (sum of lines 50 and 51)	841,312	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	4,533,210	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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/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)	71,593	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	71,593	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)	61,096	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,671	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)	5,491	15
16	Nursery days (title V or XIX only)	294	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)	67,336,086	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)	67,336,086	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)	67,336,086	37

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					940.54	38
39	Program general inpatient routine service cost (line 9 x line 38)					2,512,182	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					2,512,182	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)	2,512,231	5,491	457.52	294	134,511	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	18,436,938	7,537	2,446.19	460	1,125,247	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	NEONATAL INTENSIVE CARE UNIT	3,119,245	3,282	950.41	354	336,445	47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,798,037	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					9,906,422	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					597,675	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					643,497	51
52	Total Program excludable cost (sum of lines 50 and 51)					1,241,172	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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					10,497	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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S252** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,205	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,205	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)	11,205	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)	640	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)	10,874,007	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)	10,874,007	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)	10,874,007	37

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S252** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	970.46	38
39	Program general inpatient routine service cost (line 9 x line 38)	621,094	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)	621,094	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	182,698	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	803,792	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	96,640	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	20,472	51
52	Total Program excludable cost (sum of lines 50 and 51)	117,112	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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T252** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,325	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,325	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)	4,325	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)		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)	6,080,497	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)	6,080,497	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)	6,080,497	37

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T252** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,405.90	38
39	Program general inpatient routine service cost (line 9 x line 38)		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)		41
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)		49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		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)		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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0252** **WORKSHEET D-3**

Check Applicable Boxes:

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		55,922,748		30
31	Intensive Care Unit		17,890,338		31
35	NEONATAL INTENSIVE CARE UNIT				35
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.244718	24,912,010	6,096,417	50
52	Delivery Room & Labor Room	1.223266			52
53	Anesthesiology	0.046062	3,564,034	164,167	53
54	Radiology-Diagnostic	0.102683	48,404,189	4,970,287	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.103008			54.01
56.01	ONCOLOGY	0.062807	4,802,816	301,650	56.01
60	Laboratory	0.105169	40,886,371	4,299,979	60
62	Whole Blood & Packed Red Blood Cells	0.373332	3,838,586	1,433,067	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.247479	9,084,991	2,248,344	65
66	Physical Therapy	0.321708	4,604,030	1,481,153	66
69	Electrocardiology	0.186995	5,999,724	1,121,918	69
69.01	CARDIAC CATH LAB	0.116386	7,723,111	898,862	69.01
69.02	CARDIAC REHABILITATION	1.329719	405	539	69.02
71	Medical Supplies Charged to Patients	0.302942	33,325,451	10,095,679	71
72	Impl. Dev. Charged to Patients	0.342935	18,685,501	6,407,912	72
73	Drugs Charged to Patients	0.304748	24,548,738	7,481,179	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS				73.01
74	Renal Dialysis	0.227075	2,982,341	677,215	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT TREATMENT CENTERS	0.514538	206,751	106,381	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.731727	12,744	22,069	90.02
91	Emergency	0.270463	13,614,255	3,682,152	91
92	Observation Beds (Non-Distinct Part)	1.063681			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		247,196,048	51,488,970	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		247,196,048		202

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
35	NEONATAL INTENSIVE CARE UNIT				35
40	Subprovider - IPF		4,532,946		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.244718			50
52	Delivery Room & Labor Room	1.223266			52
53	Anesthesiology	0.046062			53
54	Radiology-Diagnostic	0.102683	38,184	3,921	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.103008			54.01
56.01	ONCOLOGY	0.062807	6,456	405	56.01
60	Laboratory	0.105169	272,349	28,643	60
62	Whole Blood & Packed Red Blood Cells	0.373332			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.247479			65
66	Physical Therapy	0.321708	34,187	10,998	66
69	Electrocardiology	0.186995	39,889	7,459	69
69.01	CARDIAC CATH LAB	0.116386			69.01
69.02	CARDIAC REHABILITATION	1.329719			69.02
71	Medical Supplies Charged to Patients	0.302942	6,566	1,989	71
72	Impl. Dev. Charged to Patients	0.342935			72
73	Drugs Charged to Patients	0.304748	196,237	59,803	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS				73.01
74	Renal Dialysis	0.227075			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT TREATMENT CENTERS	0.514538			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.731727	49,470	85,669	90.02
91	Emergency	0.270463	187,952	50,834	91
92	Observation Beds (Non-Distinct Part)	1.063681			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		831,290	249,721	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		831,290		202

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-T252** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
35	NEONATAL INTENSIVE CARE UNIT				35
40	Subprovider - IPF				40
41	Subprovider - IRF		4,740,756		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.244718	2,588	633	50
52	Delivery Room & Labor Room	1.223266			52
53	Anesthesiology	0.046062	1,119	52	53
54	Radiology-Diagnostic	0.102683	186,011	19,100	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.103008			54.01
56.01	ONCOLOGY	0.062807	29,761	1,869	56.01
60	Laboratory	0.105169	440,564	46,334	60
62	Whole Blood & Packed Red Blood Cells	0.373332	6,701	2,502	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.247479	180,443	44,656	65
66	Physical Therapy	0.321708	3,698,390	1,189,802	66
69	Electrocardiology	0.186995	10,632	1,988	69
69.01	CARDIAC CATH LAB	0.116386			69.01
69.02	CARDIAC REHABILITATION	1.329719			69.02
71	Medical Supplies Charged to Patients	0.302942	135,052	40,913	71
72	Impl. Dev. Charged to Patients	0.342935	1,796	616	72
73	Drugs Charged to Patients	0.304748	451,964	137,735	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS				73.01
74	Renal Dialysis	0.227075	111,996	25,431	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT TREATMENT CENTERS	0.514538	10,550	5,428	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.731727			90.02
91	Emergency	0.270463	50,773	13,732	91
92	Observation Beds (Non-Distinct Part)	1.063681			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		5,318,340	1,530,791	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,318,340		202

(A) Worksheet A line numbers

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		5,519,401		30
31	Intensive Care Unit		1,858,425		31
35	NEONATAL INTENSIVE CARE UNIT		1,206,349		35
40	Subprovider - IPF				40
41	Subprovider - IRF				41
43	Nursery		2,622,421		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.244286	1,373,333	335,486	50
52	Delivery Room & Labor Room	1.223266	1,674,306	2,048,122	52
53	Anesthesiology	0.046062	804,222	37,044	53
54	Radiology-Diagnostic	0.102627	3,563,749	365,737	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.103008			54.01
56.01	ONCOLOGY	0.062807	420,924	26,437	56.01
60	Laboratory	0.104850	5,336,971	559,581	60
62	Whole Blood & Packed Red Blood Cells	0.373332	134,241	50,116	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.247479	1,017,327	251,767	65
66	Physical Therapy	0.321708	143,371	46,124	66
69	Electrocardiology	0.171946	526,638	90,553	69
69.01	CARDIAC CATH LAB	0.116386	449,399	52,304	69.01
69.02	CARDIAC REHABILITATION	1.329437			69.02
71	Medical Supplies Charged to Patients	0.302942	3,462,541	1,048,949	71
72	Impl. Dev. Charged to Patients	0.342935			72
73	Drugs Charged to Patients	0.304748	2,646,130	806,403	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS				73.01
74	Renal Dialysis	0.227075	165,818	37,653	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT TREATMENT CENTERS	0.514538			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.731727	3,696	6,400	90.02
91	Emergency	0.270463	130,744	35,361	91
92	Observation Beds (Non-Distinct Part)	1.063681			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		21,853,410	5,798,037	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		21,853,410		202

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
35	NEONATAL INTENSIVE CARE UNIT				35
40	Subprovider - IPF		3,203,790		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.244286			50
52	Delivery Room & Labor Room	1.223266			52
53	Anesthesiology	0.046062			53
54	Radiology-Diagnostic	0.102627	50,286	5,161	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.103008			54.01
56.01	ONCOLOGY	0.062807	12,061	758	56.01
60	Laboratory	0.104850	259,384	27,196	60
62	Whole Blood & Packed Red Blood Cells	0.373332			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.247479			65
66	Physical Therapy	0.321708	1,062	342	66
69	Electrocardiology	0.171946	53,744	9,241	69
69.01	CARDIAC CATH LAB	0.116386			69.01
69.02	CARDIAC REHABILITATION	1.329437			69.02
71	Medical Supplies Charged to Patients	0.302942	14,287	4,328	71
72	Impl. Dev. Charged to Patients	0.342935			72
73	Drugs Charged to Patients	0.304748	65,521	19,967	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS				73.01
74	Renal Dialysis	0.227075			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT TREATMENT CENTERS	0.514538			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.731727	66,528	115,208	90.02
91	Emergency	0.270463	1,838	497	91
92	Observation Beds (Non-Distinct Part)	1.063681			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		524,711	182,698	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		524,711		202

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-T252** **WORKSHEET D-3**

Check Applicable Boxes:

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
35	NEONATAL INTENSIVE CARE UNIT				35
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.244286			50
52	Delivery Room & Labor Room	1.223266			52
53	Anesthesiology	0.046062			53
54	Radiology-Diagnostic	0.102627			54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.103008			54.01
56.01	ONCOLOGY	0.062807			56.01
60	Laboratory	0.104850			60
62	Whole Blood & Packed Red Blood Cells	0.373332			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.247479			65
66	Physical Therapy	0.321708			66
69	Electrocardiology	0.171946			69
69.01	CARDIAC CATH LAB	0.116386			69.01
69.02	CARDIAC REHABILITATION	1.329437			69.02
71	Medical Supplies Charged to Patients	0.302942			71
72	Impl. Dev. Charged to Patients	0.342935			72
73	Drugs Charged to Patients	0.304748			73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS				73.01
74	Renal Dialysis	0.227075			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT TREATMENT CENTERS	0.514538			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.731727			90.02
91	Emergency	0.270463			91
92	Observation Beds (Non-Distinct Part)	1.063681			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

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)				1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	67,387,255			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)	1,061,967			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	10,130,331			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	311.32			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				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				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				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)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0250			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1270			31
32	Sum of lines 30 and 31	0.1520			32
33	Allowable disproportionate share percentage (see instructions)	0.0264			33
34	Disproportionate share adjustment (see instructions)	444,756			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)			6,406,145,534	35
35.01	Factor 3 (see instructions)	0.000000000		0.000313365	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			2,007,462	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			2,007,462	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,007,462			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	70,901,440			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)	70,901,440			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	5,852,105			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)				52
53	Nursing and allied health managed care payment	17,629			53
54	Special add-on payments for new technologies	12,867			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).	91,319			57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)	195,257			58
59	Total (sum of amounts on lines 49 through 58)	77,070,617			59
60	Primary payer payments	22,683			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	77,047,934			61
62	Deductibles billed to program beneficiaries	7,003,764			62
63	Coinsurance billed to program beneficiaries	129,605			63
64	Allowable bad debts (see instructions)	1,434,602			64
65	Adjusted reimbursable bad debts (see instructions)	932,491			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,111,871			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	70,847,056			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 (OTHER ADJ-ALLIED HEALTH A&G)				70
70.93	HVBP payment adjustment amount (see instructions)	-311,542			70.93
70.94	HRR adjustment amount (see instructions)	-20,219			70.94
70.99	HAC adjustment amount (see instructions)	764,347			70.99
71	Amount due provider (see instructions)	69,750,948			71
71.01	Sequestration adjustment (see instructions)	1,395,019			71.01
72	Interim payments	65,516,574			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	2,839,355			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	90,973			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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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							1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	67,387,255			67,387,255		67,387,255	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	1,061,967			1,061,967		1,061,967	2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments	10,130,331			10,130,331		10,130,331	4
	Indirect Medical Education Adjustment							
5	Amount from Worksheet E Part A, line 21							5
6	IME payment adjustment							6
6.01	IME payment adjustment for managed care							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)							9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)							9.01
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage	0.0264	0.0264	0.0264	0.0264	0.0264		10
11	Disproportionate share adjustment	444,756			444,756		444,756	11
11.01	Uncompensated care payments	2,007,462			2,007,462		2,007,462	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	70,901,440			70,901,440		70,901,440	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	70,901,440			70,901,440		70,901,440	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	5,852,105			5,852,105		5,852,105	16
17	Special add-on payments for new technologies	12,867			12,867		12,867	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**				76,766,412		76,766,412	19
20	Capital DRG other than outlier	5,405,282			5,405,282		5,405,282	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	277,638			277,638		277,638	21
21.01	Model 4 BPCI Capital DRG outlier payments							21.01
22	Indirect medical education percentage							22
23	Indirect medical education adjustment							23
24	Allowable disproportionate share percentage	0.0313	0.0313		0.0313			24
25	Disproportionate share adjustment	169,185			169,185		169,185	25
26	Total prospective capital payments	5,852,105			5,852,105		5,852,105	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	-311,542			-311,542		-311,542	30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment	-20,219			-20,219		-20,219	31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment				764,347		764,347	32

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0252** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	45,442			1
2	Medical and other services reimbursed under OPPS (see instructions)	54,324,453			2
3	PPS payments	46,895,772			3
4	Outlier payment (see instructions)	19,720			4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.899			5
6	Line 2 times line 5	48,837,683			6
7	Sum of line 3 and line 4 divided by line 6	0.9606			7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	255,151			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	45,442			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	114,209			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)	114,209			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)	114,209			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	68,767			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)	45,442			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)	47,170,643			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	10,512			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	9,327,549			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)	37,878,024			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)	37,878,024			30
31	Primary payer payments	4,692			31
32	Subtotal (line 30 minus line 31)	37,873,332			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)	1,871,760			34
35	Adjusted reimbursable bad debts (see instructions)	1,216,644			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,598,175			36
37	Subtotal (see instructions)	39,089,976			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	39,089,976			40
40.01	Sequestration adjustment (see instructions)	781,800			40.01
41	Interim payments	37,508,559			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	799,617			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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S252** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 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 ()				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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-T252** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over 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 ()				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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0252** **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				64,843,079		36,854,751	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				510,495		457,408	2
3	List separately each retroactive lump sum adjustment		.01	05/02/2016	163,000	05/02/2016	196,400	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		163,000		196,400	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)				65,516,574		37,508,559	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		2,839,355		799,617	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				68,355,929		38,308,176	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.

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				1,472,623			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)				1,472,623			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		122,498			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				1,595,121			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.

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-T252** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[ ] Hospital [ ] SUB (Other) [ ] IPF [ ] SNF [XX] 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				3,749,653			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)				3,749,653			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		619			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				3,750,272			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.

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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)	17,557	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	32,965	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	4,988	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	71,915	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	1,659,944,181	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	37,449,609	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)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S252** **WORKSHEET E-3 PART II**

Check Applicable Box: **[ ] Hospital** **[XX] Subprovider IPF**

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	1,714,421	1
2	Net IPF PPS Outlier payment	1,267	2
3	Net IPF PPS ECT payment		3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)		4
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	New teaching program adjustment (see instructions)		5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)		6
7	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)		7
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)		8
9	Average daily census (see instructions)	30.614754	9
10	Teaching adjustment factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}		10
11	Teaching adjustment (line 1 multiplied by line 10)		11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,715,688	12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	1,715,688	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	1,715,688	18
19	Deductibles	153,944	19
20	Subtotal (line 18 minus line 19)	1,561,744	20
21	Coinsurance	59,052	21
22	Subtotal (line 20 minus line 21)	1,502,692	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	172,736	23
24	Adjusted reimbursable bad debts (see instructions)	112,278	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	120,163	25
26	Subtotal (sum of lines 22 and 24)	1,614,970	26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (for freestanding IPF only)		27
28	Other pass through costs (see instructions)	12,704	28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions)		30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	1,627,674	31
31.01	Sequestration adjustment (see instructions)	32,553	31.01
32	Interim payments	1,472,623	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	122,498	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part II, line 2 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the time value of money (see instructions)		52
53	Time value of money (see instructions)		53

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-T252** **WORKSHEET E-3 PART III**

Check Applicable Box: **[ ] Hospital** **[XX] Subprovider IRF**

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	3,763,666		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)			2
3	Inpatient Rehabilitation LIP payments (see instructions)			3
4	Outlier payments	90,735		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	11.816940		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	3,854,401		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	3,854,401		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	3,854,401		19
20	Deductibles	17,976		20
21	Subtotal (line 19 minus line 20)	3,836,425		21
22	Coinsurance	10,248		22
23	Subtotal (line 21 minus line 22)	3,826,177		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)			24
25	Adjusted reimbursable bad debts (see instructions)			25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)			26
27	Subtotal (sum of lines 23 and 25)	3,826,177		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)	631		29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	3,826,808		32
32.01	Sequestration adjustment (see instructions)	76,536		32.01
33	Interim payments	3,749,653		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	619		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions)			50
51	Outlier reconciliation adjustment amount (see instructions)			51
52	The rate used to calculate the Time Value of Money (see instructions)			52
53	Time Value of Money (see instructions)			53

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0252** **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	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	9,906,422		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	9,906,422		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	9,906,422		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	11,206,595		8
9	Ancillary service charges	21,853,410		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)	33,060,005		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)	33,060,005		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	23,153,583		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			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)	9,906,422		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)	9,906,422		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	9,906,422		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)	9,906,422		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	9,906,422		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)	9,906,422		40
41	Interim payments	10,538,023		41
42	Balance due provider/program (line 40 minus line 41)	-631,601		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S252** **WORKSHEET E-3 PART VII**

Check Applicable Boxes:	**[ ] Title V**	**[ ] Hospital**	**[ ] NF**	**[ ] PPS**
	[XX] Title XIX	**[XX] Subprovider IPF**	**[ ] 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	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	803,792		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	803,792		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	803,792		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	3,203,790		8
9	Ancillary service charges	524,711		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)	3,728,501		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)	3,728,501		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,924,709		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			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)	803,792		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)	803,792		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	803,792		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)	803,792		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	803,792		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)	803,792		40
41	Interim payments	2,695,307		41
42	Balance due provider/program (line 40 minus line 41)	-1,891,515		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-T252** **WORKSHEET E-3 PART VII**

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			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)			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)			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

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	9,195,402				1
2	Temporary investments	52,382,284				2
3	Notes receivable					3
4	Accounts receivable	28,559,050				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	7,284,052				7
8	Prepaid expenses	2,759,741				8
9	Other current assets	12,696,321				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	112,876,850				11
	FIXED ASSETS					
12	Land	89,072				12
13	Land improvements	14,413,382				13
14	Accumulated depreciation	-11,081,096				14
15	Buildings	313,202,923				15
16	Accumulated depreciation	-133,400,749				16
17	Leasehold improvements	3,382,022				17
18	Accumulated depreciation	-1,248,966				18
19	Fixed equipment	210,224,131				19
20	Accumulated depreciation	-113,925,475				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	195,115,736				23
24	Accumulated depreciation	-79,593,675				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)	397,177,305				30
	OTHER ASSETS					
31	Investments	42,935,463				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	29,056,160				34
35	Total other assets (sum of lines 31-34)	71,991,623				35
36	Total assets (sum of lines 11, 30 and 35)	582,045,778				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	16,898,171				37
38	Salaries, wages and fees payable	26,379,149				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	7,010,000				40
41	Deferred income	409,090				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	50,696,410				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	262,936,620				47
48	Unsecured loans					48
49	Other long term liabilities	65,323,757				49
50	Total long term liabilities (sum of lines 46 thru 49)	328,260,377				50
51	Total liabilities (sum of lines 45 and 50)	378,956,787				51
	CAPITAL ACCOUNTS					
52	General fund balance	203,088,991				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	203,088,991				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	582,045,778				60

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		187,337,269			1
2	Net income (loss) (from Worksheet G-3, line 29)		15,751,722			2
3	Total (sum of line 1 and line 2)		203,088,991			3
4	Additions (credit adjustments) (specify)					4
5	RESTRICTED NET ASSETS TRANSFER					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		203,088,991			11
12	Deductions (debit adjustments) (specify)					12
13	RESTRICTED NET ASSETS TRANSFER					13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		203,088,991			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	RESTRICTED NET ASSETS TRANSFER					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	RESTRICTED NET ASSETS TRANSFER					13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

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	120,906,705		120,906,705	1
2	Subprovider IPF	26,690,310		26,690,310	2
3	Subprovider IRF	7,499,550		7,499,550	3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	155,096,565		155,096,565	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	35,890,925		35,890,925	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	NEONATAL INTENSIVE CARE UNIT	10,755,074		10,755,074	15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	46,645,999		46,645,999	16
17	Total inpatient routine care services (sum of lines 10 and 16)	201,742,564		201,742,564	17
18	Ancillary services	523,872,428	919,777,863	1,443,650,291	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		7,574,008	7,574,008	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	OTHER PATIENT REVENUES	709,468	878,751	1,588,219	27
			817,358	817,358	
		3,605,952	7,536,817	11,142,769	
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	729,930,412	936,584,797	1,666,515,209	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		437,964,308	29
30	MISC WORKSHEET A-8 ADJUSTMENT			30
31				31
32				32
33				33
34				34
35	OTHER			35
36	Total additions (sum of lines 30-35)			36
37	PROVISION FOR BA DEBT - MISC RECEIP			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		437,964,308	43

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	1,666,515,209	1
2	Less contractual allowances and discounts on patients' accounts	1,219,808,430	2
3	Net patient revenues (line 1 minus line 2)	446,706,779	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	437,964,308	4
5	Net income from service to patients (line 3 minus line 4)	8,742,471	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	1,114,923	6
7	Income from investments	538,116	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	140,573	11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	2,072,330	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	1,890,829	22
23	Governmental appropriations		23
24	Other (CAPITATION)	430,225	24
24.01	Other (OTHER REVENUE - ACCT 533990)	3,415,683	24.01
24.02	Other (MGT SERVICES)	754,695	24.02
24.03	Other (NON OPERATING)	-4,532,546	24.03
24.04	Other (MEANINGFUL USE)	706,286	24.04
24.05	Other (RESEARCH)	145,500	24.05
24.06	Other (LOSS ON SALE OF INVESTMENT)	332,637	24.06
25	Total other income (sum of lines 6-24)	7,009,251	25
26	Total (line 5 plus line 25)	15,751,722	26
29	Net income (or loss) for the period (line 26 minus line 28)	15,751,722	29

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7094** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR-TATION (see ins-tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST 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	1,697,907	126,801		84,297	128,334	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,661,652	124,093	49,998			6
7	Physical Therapy	1,281,297	95,688	39,528			7
8	Occupational Therapy	208,762	15,590	5,950			8
9	Speech Pathology	24,054	1,796	621			9
10	Medical Social Services	95,887	7,161	965			10
11	Home Health Aide	50,965	3,806	3,476			11
12	Supplies (see instructions)				268,604		12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	5,020,524	374,935	100,538	352,901	128,334	24

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7094** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST 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	2,037,339	569	2,037,908		2,037,908	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,835,743		1,835,743		1,835,743	6
7	Physical Therapy	1,416,513		1,416,513		1,416,513	7
8	Occupational Therapy	230,302		230,302		230,302	8
9	Speech Pathology	26,471		26,471		26,471	9
10	Medical Social Services	104,013		104,013		104,013	10
11	Home Health Aide	58,247		58,247		58,247	11
12	Supplies (see instructions)	268,604		268,604		268,604	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	5,977,232	569	5,977,801		5,977,801	24

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7094** **WORKSHEET H-1 PART I**

			CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST 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	2,037,908				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	1,835,743				6
7	Physical Therapy	1,416,513				7
8	Occupational Therapy	230,302				8
9	Speech Pathology	26,471				9
10	Medical Social Services	104,013				10
11	Home Health Aide	58,247				11
12	Supplies (see instructions)	268,604				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)	5,977,801				24

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7094** **WORKSHEET H-1 PART I**

		TRANSPORT-ATION	SUBTOTAL (cols. 0-4)	ADMINI-STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST 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		2,037,908	2,037,908		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		1,835,743	979,918	2,815,661	6
7	Physical Therapy		1,416,513	726,507	2,143,020	7
8	Occupational Therapy		230,302	95,485	325,787	8
9	Speech Pathology		26,471	13,388	39,859	9
10	Medical Social Services		104,013	71,635	175,648	10
11	Home Health Aide		58,247	31,050	89,297	11
12	Supplies (see instructions)		268,604	41,114	309,718	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			78,811	78,811	23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		5,977,801		5,977,801	24

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

COST ALLOCATION - HHA STATISTICAL BASIS **HHA CCN: 14-7094** **WORKSHEET H-1 PART II**

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORT-ATION (Mileage)	RECONCIL-IATION	ADMINI-STRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
	GENERAL SERVICE COST 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					-2,037,908	18,369,497	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care					6,997,162	8,832,905	6
7	Physical Therapy					5,132,137	6,548,650	7
8	Occupational Therapy					630,388	860,690	8
9	Speech Pathology					94,207	120,678	9
10	Medical Social Services					541,695	645,708	10
11	Home Health Aide					221,630	279,877	11
12	Supplies (see instructions)					101,991	370,595	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					710,394	710,394	23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					12,391,696	18,369,497	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						2,037,908	25
26	Unit Cost Multiplier						0.110940	26

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	Administrative and General		220,597	25,954	286,136	532,687	144,571	1
2	Skilled Nursing Care	2,815,661			279,934	3,095,595	840,146	2
3	Physical Therapy	2,143,020			215,856	2,358,876	640,199	3
4	Occupational Therapy	325,787			35,170	360,957	97,964	4
5	Speech Pathology	39,859			4,052	43,911	11,917	5
6	Medical Social Services	175,648			16,154	191,802	52,055	6
7	Home Health Aide	89,297			8,586	97,883	26,565	7
8	Supplies	309,718				309,718	84,057	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	78,811				78,811	21,389	19
20	Totals (sum of lines 1-19)(2)	5,977,801	220,597	25,954	845,888	7,070,240	1,918,863	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.

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

	HHA COST CENTER (omit cents)	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	Administrative and General		290,254		115,944			1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)		290,254		115,944			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.

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

	HHA COST CENTER (omit cents)	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	Administrative and General					35,643		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			2,412				8
9	Drugs				16,981			9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)			2,412	16,981	35,643		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.

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

	HHA COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION EMS	SUBTOTAL (sum of col.4A-23)	
		19	20	21	22	23	24	
1	Administrative and General						1,119,099	1
2	Skilled Nursing Care						3,935,741	2
3	Physical Therapy						2,999,075	3
4	Occupational Therapy						458,921	4
5	Speech Pathology						55,828	5
6	Medical Social Services						243,857	6
7	Home Health Aide						124,448	7
8	Supplies						396,187	8
9	Drugs						16,981	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						100,200	19
20	Totals (sum of lines 1-19)(2)						9,450,337	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.

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

	HHA COST CENTER (omit cents)	I&R COST & POST STEP-DOWN ADJS	SUBTOTAL (cols 23 +/- 24)	ALLOCATED HHA A&G (see PtII)	TOTAL HHA COSTS			
		25	26	27	28			
1	Administrative and General		1,119,099					1
2	Skilled Nursing Care		3,935,741	528,670	4,464,411			2
3	Physical Therapy		2,999,075	402,854	3,401,929			3
4	Occupational Therapy		458,921	61,645	520,566			4
5	Speech Pathology		55,828	7,499	63,327			5
6	Medical Social Services		243,857	32,756	276,613			6
7	Home Health Aide		124,448	16,717	141,165			7
8	Supplies		396,187	53,218	449,405			8
9	Drugs		16,981	2,281	19,262			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		100,200	13,459	113,659			19
20	Totals (sum of lines 1-19)(2)		9,450,337	1,119,099	9,450,337			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.			0.134326				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.

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	
		1	2	4	4A	5	6	
1	Administrative and General	5,176	25,641	1,698,475		532,687		1
2	Skilled Nursing Care			1,661,652		3,095,595		2
3	Physical Therapy			1,281,297		2,358,876		3
4	Occupational Therapy			208,762		360,957		4
5	Speech Pathology			24,054		43,911		5
6	Medical Social Services			95,887		191,802		6
7	Home Health Aide			50,965		97,883		7
8	Supplies					309,718		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					78,811		19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	5,176	25,641	5,021,092		7,070,240		20
21	Total cost to be allocated	220,597	25,954	845,888		1,918,863		21
22	Unit Cost Multiplier	42.619204		0.168467		0.271400		22
22	Unit Cost Multiplier		1.012207					22

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

	HHA COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S SERVED	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	
		7	8	9	10	11	12	
1	Administrative and General	5,176		5,176				1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	5,176		5,176				20
21	Total cost to be allocated	290,254		115,944				21
22	Unit Cost Multiplier	56.076893		22.400309				22
22	Unit Cost Multiplier							22

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

	HHA COST CENTER	NURSING ADMINIS-TRATION FTE'S NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUISTION	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	Administrative and General				7,574,008			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		18,368					8
9	Drugs			32,612				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)		18,368	32,612	7,574,008			20
21	Total cost to be allocated		2,412	16,981	35,643			21
22	Unit Cost Multiplier			0.520698				22
22	Unit Cost Multiplier		0.131315		0.004706			22

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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

	HHA COST CENTER	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION EMS ASSIGNED TIME			
		20	21	22	23			
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)							20
21	Total cost to be allocated							21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier							22

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7094** **WORKSHEET H-3 PARTS I & II**

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation

	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	Skilled Nursing Care	2	4,464,411		4,464,411	19,015	234.78	1
2	Physical Therapy	3	3,401,929		3,401,929	15,033	226.30	2
3	Occupational Therapy	4	520,566		520,566	2,263	230.03	3
4	Speech Pathology	5	63,327		63,327	236	268.33	4
5	Medical Social Services	6	276,613		276,613	367	753.71	5
6	Home Health Aide	7	141,165		141,165	1,322	106.78	6
7	Total (sum of lines 1-6)		8,868,011		8,868,011	38,236		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	11340				8
8.01	Skilled Nursing Care	16974		11,605		8.01
8.02	Skilled Nursing Care	20994		42		8.02
9	Physical Therapy	11340				9
9.01	Physical Therapy	16974		8,903		9.01
9.02	Physical Therapy	20994		5		9.02
10	Occupational Therapy	11340				10
10.01	Occupational Therapy	16974		1,521		10.01
10.02	Occupational Therapy	20994		1		10.02
11	Speech Pathology	11340				11
11.01	Speech Pathology	16974		132		11.01
11.02	Speech Pathology	20994				11.02
12	Medical Social Services	11340				12
12.01	Medical Social Services	16974		256		12.01
12.02	Medical Social Services	20994		1		12.02
13	Home Health Aide	11340				13
13.01	Home Health Aide	16974		972		13.01
13.02	Home Health Aide	20994				13.02
14	Total (sum of lines 8-13)			23,438		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	449,405	78,566	527,971	259,344	2.035794	15
16	Cost of Drugs	9	19,262		19,262			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	0.321708			col. 2, line 2	1
2	Occupational Therapy	67				col. 2, line 3	2
3	Speech Pathology	68				col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.302942	259,344	78,566	col. 2, line 15	4
5	Drugs Charged to Patients	73	0.304748			col. 2, line 16	5
5.01	FLU VACCINE DRUGS CHG TO PATIEN	73.01				col. 2, line 16	5.01

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7094** **WORKSHEET H-3 PARTS I & II**

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services				
			Part B			Part B			
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		11,647			2,734,483		2,734,483	1
2	Physical Therapy		8,908			2,015,880		2,015,880	2
3	Occupational Therapy		1,522			350,106		350,106	3
4	Speech Pathology		132			35,420		35,420	4
5	Medical Social Services		257			193,703		193,703	5
6	Home Health Aide		972			103,790		103,790	6
7	Total (sum of lines 1-6)		23,438			5,433,382		5,433,382	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		176,699					16

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

CALCULATION OF HHA REIMBURSEMRNT SETTLEMENT **HHA CCN: 14-7094** **WORKSHEET H-4**
PARTS I & II

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

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

			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Description	1	2	3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges		176,699		2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)		4,756,805		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)		176,699		6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)		176,699		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		4,595,255	11
12	Total PPS Reimbursement - Full Episodes with Outliers		40,674	12
13	Total PPS Reimbursement - LUPA Episodes		78,914	13
14	Total PPS Reimbursement - PEP Episodes		37,735	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		4,226	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)		4,756,804	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		4,756,804	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		4,756,804	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)		4,756,804	29
30	Other adjustments (see instructions) (specify)		-35	30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		4,756,769	31
31.01	Sequestration adjustment (see instructions)		95,135	31.01
32	Interim payments (see instructions)		4,661,634	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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **HHA CCN: 14-7094** **WORKSHEET H-5**

				Part A		Part B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider						4,661,634	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)						4,661,634	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)						4,661,634	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.

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0252** **WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	5,405,282	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	277,638	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)	198.25	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0250	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.1270	8
9	Sum of lines 7 and 8	0.1520	9
10	Allowable disproportionate share percentage (see instructions)	0.0313	10
11	Disproportionate share adjustment (see instructions)	169,185	11
12	Total prospective capital payments (see instructions)	5,852,105	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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
35	NEONATAL INTENSIVE CARE UNIT							35
40	Subprovider - IPF							40
41	Subprovider - IRF							41
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	OFFSITE-DIAGNOSTIC SERVICES							54.01
56.01	ONCOLOGY							56.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
69.01	CARDIAC CATH LAB							69.01
69.02	CARDIAC REHABILITATION							69.02
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM							90.02
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER							192.02
192.03	MOBILE DENTAL CLINIC							192.03
192.04	EMS CONTINUING EDUCATION							192.04
194	CORPORATE HEALTH							194
194.01	MARKETING/COMMUNICATION							194.01
194.02	FOUNDATION							194.02

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/27/2017 Run Time: 18:14 Version: 2017.01 (02/22/2017)

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		
194.03	OTHER NRCC							194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202