NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 02/26/2018 Time: 20:41 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 CHIEF FINANCIAL 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 10/01/2016 and ending 09/30/2017, 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		1,306,005	-881,873		2,302,828	1
2	SUBPROVIDER - IPF		-47,811			-194,789	2
3	SUBPROVIDER - IRF		131,590				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		1,389,784	-881,873		2,108,039	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.

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 / 2016	To: 09 / 30 / 2017	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.	3,106	2,520	7		3,520	1,299	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.		503					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)(i) or (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)(i) or (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
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	Y			60
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		20.	1	60.01
60.02	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.	1	60.02
		Y/N 1	IME 4	Direct GME 5	
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. Enter in column 4, the 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. Enter in column 4 direct the 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 through 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 is 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 is 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
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers		1	2	
105	Does this hospital qualify as a 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

		1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110

		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-healsh services.			111

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:	4,086,669			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 care related taxes as defined in §1983(w)(3) of the Act? 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 in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date 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 the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

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	01/25/2018	Y	01/25/2018	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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	97,820			31,325	5,263	64,690	1
2	HMO and other (see instructions)						6,315	3,381		2
3	HMO IPF Subprovider						366			3
4	HMO IRF Subprovider						346			4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		268	97,820			31,325	5,263	64,690	7
8	Intensive Care Unit	31	60	21,900			4,013	637	7,988	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	NEONATAL INTENSIVE CARE UNIT	35	12	3,180				60	3,049	12
13	Nursery	43						1,111	5,258	13
14	Total (see instructions)		340	122,900			35,338	7,071	80,985	14
15	CAH Visits									15
16	Subprovider - IPF	40	32	11,680			2,479	2,680	12,867	16
17	Subprovider - IRF	41	20	7,300			3,598	503	5,724	17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					22,539		37,091	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		392							27
28	Observation Bed Days								10,497	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							120	644	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	1,799	18,258	1
2	HMO and other (see instructions)					1,319	860		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	NEONATAL INTENSIVE CARE UNIT								12
13	Nursery								13
14	Total (see instructions)		2,505.53			7,409	1,799	18,258	14
15	CAH Visits								15
16	Subprovider - IPF		57.17			234	432	1,732	16
17	Subprovider - IRF		26.41			257	23	520	17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		57.30						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)		2,646.41						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	187,029,565		187,029,565	5,504,667.00	33.98	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)		14,898,251	270,117	15,168,368	423,713.00	35.80	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		1,626,354		1,626,354	26,600.00	61.14	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		2,832,581		2,832,581	27,105.00	104.50	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)		39,209,653		39,209,653			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		3,206,811		3,206,811			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		2,188,554		2,188,554	46,372.00	47.20	26
27	Administrative & General		32,536,319		32,536,319	840,169.00	38.73	27
28	Administrative & General under contract (see instructions)		572,650		572,650	13,159.00	43.52	28
29	Maintenance & Repairs							29
30	Operation of Plant		2,666,749		2,666,749	78,578.00	33.94	30
31	Laundry & Linen Service							31
32	Housekeeping		3,229,855		3,229,855	225,721.00	14.31	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		2,767,862	-1,429,352	1,338,510	81,935.00	16.34	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			1,429,352	1,429,352	87,495.00	16.34	36
37	Maintenance of Personnel							37
38	Nursing Administration		7,920,571	185,821	8,106,392	193,330.00	41.93	38
39	Central Services and Supply		2,303,380		2,303,380	101,072.00	22.79	39
40	Pharmacy		4,025,855		4,025,855	93,834.00	42.90	40
41	Medical Records & Medical Records Library		2,501,631		2,501,631	87,901.00	28.46	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	187,602,215		187,602,215	5,517,826.00	34.00	1
2	Excluded area salaries (see instructions)	14,898,251	270,117	15,168,368	423,713.00	35.80	2
3	Subtotal salarles (line 1 minus line 2)	172,703,964	-270,117	172,433,847	5,094,113.00	33.85	3
4	Subtotal other wages & related costs (see instructions)	4,458,935		4,458,935	53,705.00	83.03	4
5	Subtotal wage-related costs (see instructions)	39,209,653		39,209,653		22.74%	5
6	Total (sum of lines 3 through 5)	216,372,552	-270,117	216,102,435	5,147,818.00	41.98	6
7	Total overhead cost (see instructions)	60,713,426	185,821	60,899,247	1,849,566.00	32.93	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	4,909,776	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		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)	20,442,694	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	671,695	10
11	Life Insurance (If employee is owner or beneficiary)	68,344	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	465,133	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	1,582,809	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	13,219,289	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	289,271	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	767,454	23
24	Total Wage Related cost (Sum of lines 1-23)	42,416,465	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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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.	4	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
20.03		29404	20.03

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	8,853	971	284	141	10,249	21
22	Skilled Nursing Visit Charges	1,646,658	180,606	52,824	26,226	1,906,314	22
23	Physical Therapy Visits	8,576	452	113	157	9,298	23
24	Physical Therapy Visit Charges	2,287,916	121,136	30,284	42,076	2,481,412	24
25	Occupational Therapy Visits	1,584	184	10	29	1,807	25
26	Occupational Therapy Visit Charges	421,564	49,312	2,680	7,772	481,328	26
27	Speech Pathology Visits	157	34	1	6	198	27
28	Speech Pathology Visit Charges	42,076	9,112	268	1,608	53,064	28
29	Medical Social Service Visits	198	57		2	257	29
30	Medical Social Service Visit Charges	46,656	13,851		486	60,993	30
31	Home Health Aide Visits	552	164	1	13	730	31
32	Home Health Aide Visit Charges	73,035	22,140	135	1,755	97,065	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	19,920	1,862	409	348	22,539	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	4,517,905	396,157	86,191	79,923	5,080,176	35
36	Total Number of Episodes (standard/non-outlier)	1,412		150	28	1,590	36
37	Total Number of Ourlier Episodes		61			61	37
38	Total Non-Routine Medical Supply Charges	202,742	28,176	12,733	1,122	244,773	38

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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)	0.242620	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	18,514,288	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 and/or supplemental payments from Medicaid?		4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	147,334,737	6
7	Medicaid cost (line 1 times line 6)	35,746,354	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.	17,232,066	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

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (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)	17,232,066	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	30,682,429	7,259,599	37,942,028	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	7,444,171	7,259,599	14,703,770	21
22	Payments received from patients for amounts previously written off as charity care	203,076		203,076	22
23	Cost of charity care (line 21 minus line 22)	7,241,095	7,259,599	14,500,694	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, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	17,015,854	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	968,447	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,489,919	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)	15,525,935	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	4,288,374	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	18,789,068	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	36,021,134	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		44,127,079	44,127,079	-20,819,245	23,307,834	5,350,580	28,658,414	1
2	00200	Cap Rel Costs-Mvble Equip				21,313,561	21,313,561	-133,092	21,180,469	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	2,188,554	29,133,230	31,321,784		31,321,784		31,321,784	4
5	00500	Administrative & General	32,536,319	58,814,767	91,351,086	-590,518	90,760,568	-21,412,930	69,347,638	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	2,666,749	16,187,499	18,854,248	78,279	18,932,527	-5,722	18,926,805	7
8	00800	Laundry & Linen Service								8
9	00900	Housekeeping	3,229,855	3,901,556	7,131,411	126,919	7,258,330		7,258,330	9
10	01000	Dietary	2,767,862	2,771,214	5,539,076	-2,860,435	2,678,641		2,678,641	10
11	01100	Cafeteria				2,860,435	2,860,435	-2,137,850	722,585	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	7,920,571	895,388	8,815,959	202,750	9,018,709	-7,850	9,010,859	13
14	01400	Central Services & Supply	2,303,380	1,167,708	3,471,088		3,471,088		3,471,088	14
15	01500	Pharmacy	4,025,855	19,183,339	23,209,194	-18,469,873	4,739,321	-587	4,738,734	15
16	01600	Medical Records & Library	2,501,631	2,676,284	5,177,915	-130	5,177,785	-4,268	5,173,517	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)	738,721	535,558	1,274,279	-617,679	656,600	-342,450	314,150	23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	32,943,922	6,586,838	39,530,760	-7,770,759	31,760,001	-986,609	30,773,392	30
31	03100	Intensive Care Unit	8,439,503	2,984,440	11,423,943	-1,054,695	10,369,248	-1,051,860	9,317,388	31
35	02060	NEONATAL INTENSIVE CARE UNIT	2,101,792	931,831	3,033,623	-1,575,375	1,458,248	-477,576	980,672	35
40	04000	Subprovider - IPF	3,819,475	1,422,598	5,242,073	-24,481	5,217,592	-131,107	5,086,485	40
41	04100	Subprovider - IRF	1,650,677	2,184,324	3,835,001	-83,607	3,751,394		3,751,394	41
43	04300	Nursery				1,441,402	1,441,402		1,441,402	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	12,514,635	26,871,376	39,386,011	-22,446,196	16,939,815	-144,415	16,795,400	50
52	05200	Delivery Room & Labor Room				4,969,304	4,969,304		4,969,304	52
53	05300	Anesthesiology	165,076	767,021	932,097	-568,128	363,969		363,969	53
54	05400	Radiology-Diagnostic	13,005,398	7,626,622	20,632,020	-2,439,790	18,192,230	-37,157	18,155,073	54
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	1,718,651	828,603	2,547,254	-47,584	2,499,670	-50	2,499,620	54.01
56.01	03480	ONCOLOGY	1,302,040	339,924	1,641,964	-86,899	1,555,065	-45,541	1,509,524	56.01
60	06000	Laboratory	6,794,838	9,074,264	15,869,102	-621	15,868,481	-174,333	15,694,148	60
62	06200	Whole Blood & Packed Red Blood Cells	496,990	1,942,289	2,439,279	-227	2,439,052		2,439,052	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	2,313,446	655,530	2,968,976	-120,635	2,848,341		2,848,341	65
66	06600	Physical Therapy	7,282,086	1,931,151	9,213,237	-294,091	8,919,146	-56,476	8,862,670	66
69	06900	Electrocardiology	4,225,730	2,477,959	6,703,689	-297,476	6,406,213	-1,235,792	5,170,421	69
69.01	03630	CARDIAC CATH LAB	1,736,906	7,134,636	8,871,542	-6,838,092	2,033,450		2,033,450	69.01
69.02	03160	CARDIAC REHABILITATION	719,776	251,683	971,459	-6,834	964,625	-281	964,344	69.02
71	07100	Medical Supplies Charged to Patients				19,939,058	19,939,058		19,939,058	71
72	07200	Impl. Dev. Charged to Patients				18,372,924	18,372,924		18,372,924	72
73	07300	Drugs Charged to Patients				18,904,124	18,904,124		18,904,124	73
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS								73.01
74	07400	Renal Dialysis		1,352,257	1,352,257	-9,659	1,342,598		1,342,598	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	1,927,162	2,409,959	4,337,121	-83,478	4,253,643		4,253,643	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	3,460,745	375,744	3,836,489	-11,601	3,824,888		3,824,888	90.02
91	09100	Emergency	10,841,842	4,904,824	15,746,666	-1,987,368	13,759,298		13,759,298	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	4,895,420	864,412	5,759,832		5,759,832		5,759,832	101
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	183,235,607	263,311,907	446,547,514	-896,720	445,650,794	-23,035,366	422,615,428	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	145,932	229,934	375,866		375,866		375,866	190
192	19200	Physicians' Private Offices								192

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	
192.01	19201	DAY SURGERY CENTER								192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	910,230	134,910	1,045,140		1,045,140		1,045,140	192.02
192.03	19203	MOBILE DENTAL CLINIC	223,511	75,301	298,812		298,812		298,812	192.03
192.04	19204	EMS CONTINUING EDUCATION				896,720	896,720		896,720	192.04
194	07950	CORPORATE HEALTH	115,562	42,992	158,554		158,554		158,554	194
194.01	07951	MARKETING/COMMUNICATION	917,766	2,708,410	3,626,176		3,626,176		3,626,176	194.01
194.02	07952	FOUNDATION								194.02
194.03	07953	OTHER NRCC	1,480,957	3,155,848	4,636,805		4,636,805		4,636,805	194.03
200		TOTAL (sum of lines 118-199)	187,029,565	269,659,302	456,688,867		456,688,867	-23,035,366	433,653,501	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	1,429,352	1,431,083	1
500	Total reclassifications				1,429,352	1,431,083	500
	Code Letter - A						
1	FLOAT POOL	B	Nursing Administration	13	185,821	16,929	1
500	Total reclassifications				185,821	16,929	500
	Code Letter - B						
1	TREATMENT CENTER LEASE EXP	C	Cap Rel Costs-Bldg & Fixt	1		93,991	1
500	Total reclassifications					93,991	500
	Code Letter - C						
1	COST OF MEDICAL SUPPLIES SOLD	D	Medical Supplies Charged to P	71		19,939,058	1
2			Impl. Dev. Charged to Patient	72		18,372,924	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
500	Total reclassifications					38,311,982	500
	Code Letter - D						
1	COST OF DRUGS SOLD	E	Drugs Charged to Patients	73		18,904,124	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
500	Total reclassifications					18,904,124	500
	Code Letter - E						
1	PARAMEDICAL EDUCATION	F	EMS CONTINUING EDUCATION	192.04	519,844	376,876	1
500	Total reclassifications				519,844	376,876	500
	Code Letter - F						
1	EQPT	G	Cap Rel Costs-Mvble Equip	2		21,313,561	1
500	Total reclassifications					21,313,561	500
	Code Letter - G						
1	SALT CREEK OCCUPANCY COSTS	H	Cap Rel Costs-Bldg & Fixt	1		90,051	1
2			Operation of Plant	7		78,279	2
3			Housekeeping	9		126,919	3
500	Total reclassifications					295,249	500
	Code Letter - H						

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	30,839	129,448	1
2							2
3							3
4							4
5							5
6							6
500	Total reclassifications				30,839	129,448	500
	Code Letter - I						
1	PROPERTY INSURANCE	J	Cap Rel Costs-Bldg & Fixt	1		310,274	1
2							2
3							3
500	Total reclassifications					310,274	500
	Code Letter - J						
1	LDR COST ALLOCATION	K	Nursery	43	998,650	442,752	1
2			Delivery Room & Labor Room	52	3,525,790	1,455,145	2
500	Total reclassifications				4,524,440	1,897,897	500
	Code Letter - K						
1	EMT CLINICAL EDUCATORS	L	PARAMED ED PRGM-(SPECIFY)	23	279,041		1
2							2
3							3
4							4
5							5
6							6
500	Total reclassifications				279,041		500
	Code Letter - L						
	GRAND TOTAL (Increases)				6,969,337	83,081,414	

(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	1,429,352	1,431,083		1
500	Total reclassifications				1,429,352	1,431,083		500
	Code letter - A							
1	FLOAT POOL	B	Adults & Pediatrics	30	185,821	16,929		1
500	Total reclassifications				185,821	16,929		500
	Code letter - B							
1	TREATMENT CENTER LEASE EXP	C	OUTPATIENT TREATMENT CENTERS	90.01		93,991	10	1
500	Total reclassifications					93,991		500
	Code letter - C							
1	COST OF MEDICAL SUPPLIES SOLD	D						1
2			Pharmacy	15		40,149		2
3			Medical Records & Library	16		130		3
4			Adults & Pediatrics	30		2,495,160		4
5			Intensive Care Unit	31		1,037,981		5
6			NEONATAL INTENSIVE CARE UNIT	35		131,037		6
7			Subprovider - IPF	40		15,070		7
8			Subprovider - IRF	41		81,059		8
9			Operating Room	50		22,199,480		9
10			Anesthesiology	53		510,831		10
11			Radiology-Diagnostic	54		2,427,478		11
12			OFFSITE-DIAGNOSTIC SERVICES	54.01		47,584		12
13			ONCOLOGY	56.01		86,558		13
14			Laboratory	60		123		14
15			Whole Blood & Packed Red Bloo	62		227		15
16			Respiratory Therapy	65		119,554		16
17			Physical Therapy	66		285,662		17
18			Electrocardiology	69		104,069		18
19			CARDIAC CATH LAB	69.01		6,837,864		19
20			CARDIAC REHABILITATION	69.02		6,779		20
21			Renal Dialysis	74		9,659		21
22			OUTPATIENT TREATMENT CENTERS	90.01		135,108		22
23			PARTIAL HOSPITALIZATION PROGR	90.02		10,828		23
24			Emergency	91		1,729,592		24
500	Total reclassifications					38,311,982		500
	Code letter - D							
1	COST OF DRUGS SOLD	E	Pharmacy	15		18,300,276		1
2			Adults & Pediatrics	30		59,000		2
3			Intensive Care Unit	31		6,748		3
4			NEONATAL INTENSIVE CARE UNIT	35		1,623		4
5			Subprovider - IPF	40		487		5
6			Subprovider - IRF	41		2,548		6
7			Operating Room	50		228,633		7
8			Anesthesiology	53		57,297		8
9			Radiology-Diagnostic	54		9,811		9
10			Radiology-Diagnostic	54		2,501		10
11			ONCOLOGY	56.01		341		11
12			Laboratory	60		498		12
13			Respiratory Therapy	65		1,081		13
14			Physical Therapy	66		8,090		14
15			Electrocardiology	69		193,407		15
16			CARDIAC CATH LAB	69.01		228		16
17			CARDIAC REHABILITATION	69.02		55		17
18			PARTIAL HOSPITALIZATION PROGR	90.02		773		18
19			Emergency	91		30,727		19
500	Total reclassifications					18,904,124		500
	Code letter - E							
1	PARAMEDICAL EDUCATION	F	PARAMED ED PRGM-(SPECIFY)	23	519,844	376,876		1
500	Total reclassifications				519,844	376,876		500
	Code letter - F							
1	EQPT	G	Cap Rel Costs-Bldg & Fixt	1		21,313,561	9	1
500	Total reclassifications					21,313,561		500
	Code letter - G							
1	SALT CREEK OCCUPANCY COSTS	H	Administrative & General	5		90,051	10	1
2			Administrative & General	5		78,279		2
3			Administrative & General	5		126,919		3
500	Total reclassifications					295,249		500
	Code letter - H							

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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		129,448		1
2			Adults & Pediatrics	30	15,922			2
3			Intensive Care Unit	31	146			3
4			NEONATAL INTENSIVE CARE UNIT	35	1,313			4
5			Subprovider - IPF	40	36			5
6			Emergency	91	13,422			6
500	Total reclassifications				30,839	129,448		500
	Code letter - I							
1	PROPERTY INSURANCE	J	Administrative & General	5		295,269	12	1
2			Physical Therapy	66		339		2
3			OUTPATIENT TREATMENT CENTERS	90.01		14,666		3
500	Total reclassifications					310,274		500
	Code letter - J							
1	LDR COST ALLOCATION	K	NEONATAL INTENSIVE CARE UNIT	35	998,650	442,752		1
2			Adults & Pediatrics	30	3,525,790	1,455,145		2
500	Total reclassifications				4,524,440	1,897,897		500
	Code letter - K							
1	EMT CLINICAL EDUCATORS	L	Adults & Pediatrics	30	16,992			1
2			Intensive Care Unit	31	9,820			2
3			Subprovider - IPF	40	8,888			3
4			Operating Room	50	18,083			4
5			Delivery Room & Labor Room	52	11,631			5
6			Emergency	91	213,627			6
500	Total reclassifications				279,041			500
	Code letter - L							
	GRAND TOTAL (Decreases)				6,969,337	83,081,414		

(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	230,445		230,445		14,464,755		2
3	Buildings and Fixtures	306,043,520	6,800,470		6,800,470		312,843,990		3
4	Building Improvements	1,317,195	2,135,733		2,135,733		3,452,928		4
5	Fixed Equipment	210,224,132	2,379,183		2,379,183		212,603,315		5
6	Movable Equipment	195,115,716	378,012		378,012		195,493,728		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	727,023,945	11,923,843		11,923,843		738,947,788		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	727,023,945	11,923,843		11,923,843		738,947,788		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	44,127,079						44,127,079	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	44,127,079						44,127,079	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	28,164,098	184,042		310,274			28,658,414	1
2	Cap Rel Costs-Mvble Equip	21,180,469						21,180,469	2
3	Total (sum of lines 1-2)	49,344,567	184,042		310,274			49,838,883	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	-31,843	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	-50,024	Administrative & General	5		7
8	Television and radio service (chapter 21)	A	-5,722	Operation of Plant	7		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-3,949,636				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	-2,137,850	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 and allied health education (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	PHO EXPENSE	A	-339,525	Administrative & General	5		35
36							36
37							37
38	LOBBYING PORTION OF DUES	A	-55,535	Administrative & General	5		38
39	PROVIDER ASSESSMENT REBATE	A	-19,714,595	Administrative & General	5		39
40							40
41							41
41.14	PARAMED EDUCATION TUITION INCOM	B	-342,450	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	232,445	Physical Therapy	66		42
42.01	WELLNESS CENTER RENT TO COST	A	2,073	CARDIAC REHABILITATION	69.02		42.01
43							43
44							44
45							45
45.01	MISC OPERATING INCOME	B	-1,222,672	Administrative & General	5		45.01
45.02	MISC OPERATING INCOME	B	-587	Pharmacy	15		45.02
45.03	MISC OPERATING INCOME	B	-7,850	Nursing Administration	13		45.03
45.04	MISC OPERATING INCOME	B	-4,268	Medical Records & Library	16		45.04
45.05	MISC OPERATING INCOME	B	-58,494	Adults & Pediatrics	30		45.05
45.06	MISC OPERATING INCOME	B	-131,107	Subprovider - IPF	40		45.06
45.07	MISC OPERATING INCOME	B	-37,925	Operating Room	50		45.07
45.08	MISC OPERATING INCOME	B	-19,915	Radiology-Diagnostic	54		45.08
45.09	MISC OPERATING INCOME	B	-1,410	Laboratory	60		45.09
45.10	MISC OPERATING INCOME	B	-2,160	Physical Therapy	66		45.10
45.11	MISC OPERATING INCOME	B	-71,773	Electrocardiology	69		45.11
45.14	MISC OPERATING INCOME	B	-16,140	ONCOLOGY	56.01		45.14
45.16	MISC OPERATING INCOME	B	-394	CARDIAC REHABILITATION	69.02		45.16
45.26	NON ALLOWABLE TRAVEL	A	-30,579	Administrative & General	5		45.26
45.32	CSM AND 901 DEPRECIATION	A	-632,778	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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	5,947,090	Cap Rel Costs-Bldg & Fixt	1	9	45.35
45.36	MED VS BOOK DEPR DIFF	A	-326,721	Cap Rel Costs-Mvble Equip	2	9	45.36
46	MAINFRAME SERVER EDITION-RECORD	A	195,000	Cap Rel Costs-Mvble Equip	2	9	46
47	PT B NON PHY COST	A	-286,761	Physical Therapy	66		47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-23,035,366				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.

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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:

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4	30	Adults & Pediatrics AGGREGATE	928,115	928,115						4
5	31	Intensive Care Unit AGGREGATE	1,084,980	1,033,456	51,524	165,600	416	33,120	1,656	5
6	35	NEONATAL INTENSIVE C AGGREGATE	501,386	477,576	23,810	225,300	416	45,060	2,253	6
7	50	Operating Room AGGREGATE	106,490	106,490		208,000				7
8	54	Radiology-Diagnostic AGGREGATE	42,588		42,588	225,300	234	25,346	1,267	8
9	54.01	OFFSITE-DIAGNOSTIC S AGGREGATE	50	50						9
10	60	Laboratory AGGREGATE	412,889		412,889	215,700	2,314	239,966	11,998	10
11	56.01	ONCOLOGY	65,201		65,201	208,000	358	35,800	1,790	11
12										12
13	69	Electrocardiology AGGREGATE	1,181,853	321,570	781,883	165,600	224	17,834	892	13
14										14
15										15
16	69.02	CARDIAC REHABILITATI AGGREGATE	1,960	1,960		165,600				16
17										17
18										18
19	91	Emergency AGGREGATE	1,454,686		1,454,686	177,200	23,143	1,971,606	98,580	19
20										20
200		TOTAL	5,780,198	2,869,217	2,832,581		27,105	2,368,732	118,436	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										2
3										3
4	30	Adults & Pediatrics AGGREGATE							928,115	4
5	31	Intensive Care Unit AGGREGATE					33,120	18,404	1,051,860	5
6	35	NEONATAL INTENSIVE C AGGREGATE					45,060		477,576	6
7	50	Operating Room AGGREGATE							106,490	7
8	54	Radiology-Diagnostic AGGREGATE					25,346	17,242	17,242	8
9	54.01	OFFSITE-DIAGNOSTIC S AGGREGATE							50	9
10	60	Laboratory AGGREGATE					239,966	172,923	172,923	10
11	56.01	ONCOLOGY					35,800	29,401	29,401	11
12										12
13	69	Electrocardiology AGGREGATE					17,834	764,049	1,164,019	13
14										14
15										15
16	69.02	CARDIAC REHABILITATI AGGREGATE							1,960	16
17										17
18										18
19	91	Emergency AGGREGATE					1,971,606			19
20										20
200		TOTAL					2,368,732	1,002,019	3,949,636	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	28,658,414	28,658,414					1
2	Cap Rel Costs-Mvble Equip	21,180,469		21,180,469				2
4	Employee Benefits Department	31,321,784	422,203	16,961	31,760,948			4
5	Administrative & General	69,347,638	6,632,453	13,887,353	5,590,737	95,458,181	95,458,181	5
6	Maintenance & Repairs							6
7	Operation of Plant	18,926,805	3,891,124	116,567	458,222	23,392,718	6,602,782	7
8	Laundry & Linen Service							8
9	Housekeeping	7,258,330		17,538	554,980	7,830,848	2,210,319	9
10	Dietary	2,678,641	343,832	82,079	229,993	3,334,545	941,202	10
11	Cafeteria	722,585	226,111		245,603	1,194,299	337,100	11
12	Maintenance of Personnel							12
13	Nursing Administration	9,010,859	280,698	119,590	1,392,905	10,804,052	3,049,530	13
14	Central Services & Supply	3,471,088	512,466	306,715	395,785	4,686,054	1,322,676	14
15	Pharmacy	4,738,734	204,351	136,273	691,755	5,771,113	1,628,943	15
16	Medical Records & Library	5,173,517	173,919	46,165	429,850	5,823,451	1,643,716	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)	314,150	19,985		85,556	419,691	118,461	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	30,773,392	3,762,502	422,443	5,017,274	39,975,611	11,283,282	30
31	Intensive Care Unit	9,317,388	1,060,897	181,328	1,448,430	12,008,043	3,389,366	31
35	NEONATAL INTENSIVE CARE UNIT	980,672	82,252	131,850	189,325	1,384,099	390,673	35
40	Subprovider - IPF	5,086,485	702,075	24,859	654,759	6,468,178	1,825,695	40
41	Subprovider - IRF	3,751,394	495,206	26,584	283,633	4,556,817	1,286,198	41
43	Nursery	1,441,402	166,775		171,596	1,779,773	502,355	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	16,795,400	2,587,022	2,325,650	2,147,258	23,855,330	6,733,358	50
52	Delivery Room & Labor Room	4,969,304	386,858		603,831	5,959,993	1,682,256	52
53	Anesthesiology	363,969	21,554		28,365	413,888	116,823	53
54	Radiology-Diagnostic	18,155,073	1,412,574	1,348,128	2,234,692	23,150,467	6,534,405	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	2,499,620		417,292	295,312	3,212,224	906,676	54.01
56.01	ONCOLOGY	1,509,524	700,465	35,484	223,727	2,469,200	696,951	56.01
60	Laboratory	15,694,148	557,019	231,208	1,167,543	17,649,918	4,981,831	60
62	Whole Blood & Packed Red Blood Cells	2,439,052	38,401	20,030	85,397	2,582,880	729,039	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,848,341	130,604	36,774	397,515	3,413,234	963,413	65
66	Physical Therapy	8,862,670	405,398	86,368	1,251,266	10,605,702	2,993,544	66
69	Electrocardiology	5,170,421	221,817	230,950	726,099	6,349,287	1,792,137	69
69.01	CARDIAC CATH LAB	2,033,450	98,562	442,329	298,449	2,872,790	810,868	69.01
69.02	CARDIAC REHABILITATION	964,344	363,859	20,895	123,678	1,472,776	415,703	69.02
71	Medical Supplies Charged to Patients	19,939,058				19,939,058	5,627,959	71
72	Impl. Dev. Charged to Patients	18,372,924				18,372,924	5,185,905	72
73	Drugs Charged to Patients	18,904,124				18,904,124	5,335,840	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis	1,342,598		770		1,343,368	379,176	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	4,253,643	891,933	146,103	336,439	5,628,118	1,588,581	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	3,824,888	200,428	71,458	594,653	4,691,427	1,324,193	90.02
91	Emergency	13,759,298	647,777	140,674	1,823,919	16,371,668	4,621,034	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	5,759,832	213,724	25,248	841,170	6,839,974	1,930,637	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	422,615,428	27,854,844	21,095,666	31,019,716	420,985,823	91,882,627	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	375,866	233,915	1,089	25,075	635,945	179,501	190
192	Physicians' Private Offices			10,990		10,990	3,102	192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER	1,045,140		11,371	156,403	1,212,914	342,355	192.02

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
192.03	MOBILE DENTAL CLINIC	298,812		51,049	38,405	388,266	109,591	192.03
192.04	EMS CONTINUING EDUCATION	896,720			89,324	986,044	278,319	192.04
194	CORPORATE HEALTH	158,554	112,354	9,705	19,857	300,470	84,810	194
194.01	MARKETING/COMMUNICATION	3,626,176	83,243	575	157,698	3,867,692	1,091,687	194.01
194.02	FOUNDATION		37,121	24		37,145	10,484	194.02
194.03	OTHER NRCC	4,636,805	336,937		254,470	5,228,212	1,475,705	194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	433,653,501	28,658,414	21,180,469	31,760,948	433,653,501	95,458,181	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	29,995,500						7
8	Laundry & Linen Service							8
9	Housekeeping		10,041,167					9
10	Dietary	582,264	194,916	5,052,927				10
11	Cafeteria	382,908	128,181		2,042,488			11
12	Maintenance of Personnel							12
13	Nursing Administration	475,349	159,126		98,251	14,586,308		13
14	Central Services & Supply	867,837	290,513		51,366		7,218,446	14
15	Pharmacy	346,058	115,845		47,687			15
16	Medical Records & Library	294,523	98,593		44,671			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)	33,844	11,329		9,360	113,802		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,371,620	2,132,937	3,612,048	462,399	5,622,294	1,608	30
31	Intensive Care Unit	1,796,578	601,415	294,416	104,602	1,271,850	221	31
35	NEONATAL INTENSIVE CARE UNIT	139,290	46,628		14,154	172,097	12	35
40	Subprovider - IPF	1,188,931	398,002	711,363	60,317	733,389		40
41	Subprovider - IRF	838,608	280,729	316,456	27,916			41
43	Nursery	282,426	94,544		12,827	155,963		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,380,998	1,466,565		176,422	2,145,093	282,041	50
52	Delivery Room & Labor Room	655,125	219,307		37,099	451,081		52
53	Anesthesiology	36,501	12,219		4,276	51,986	30,264	53
54	Radiology-Diagnostic	2,392,127	800,778		182,084		61	54
54.01	OFFSITE-DIAGNOSTIC SERVICES				23,922			54.01
56.01	ONCOLOGY	1,186,204	397,089		15,488	188,317		56.01
60	Laboratory	943,285	315,770		134,764		13	60
62	Whole Blood & Packed Red Blood Cells	65,030	21,769		7,942			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	221,172	74,039		35,737		42,707	65
66	Physical Therapy	686,522	229,817		102,614		26	66
69	Electrocardiology	375,636	125,746		53,279	647,814	7	69
69.01	CARDIAC CATH LAB	166,910	55,874		20,850	253,514		69.01
69.02	CARDIAC REHABILITATION	616,177	206,269		10,769	130,937		69.02
71	Medical Supplies Charged to Patients						3,510,610	71
72	Impl. Dev. Charged to Patients						3,343,486	72
73	Drugs Charged to Patients							73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	1,510,446	505,630		31,793		10	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	339,415	113,621		56,803	690,666		90.02
91	Emergency	1,096,980	367,220		160,994	1,957,505	6,720	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	361,931	121,158					101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	28,634,695	9,585,629	4,934,283	1,988,386	14,586,308	7,217,786	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	396,124	132,605		3,980			190
192	Physicians' Private Offices							192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER			118,644	14,137		195	192.02
192.03	MOBILE DENTAL CLINIC						113	192.03

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		7	9	10	11	13	14	
192.04	EMS CONTINUING EDUCATION							192.04
194	CORPORATE HEALTH	190,265	63,692		1,854			194
194.01	MARKETING/COMMUNICATION	140,968	47,190		12,420			194.01
194.02	FOUNDATION	62,862	21,044					194.02
194.03	OTHER NRCC	570,586	191,007		21,711		352	194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	29,995,500	10,041,167	5,052,927	2,042,488	14,586,308	7,218,446	202

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	PARAMED EDUCATION EMS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	24	25	26	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	7,909,646						15
16	Medical Records & Library		7,904,954					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)			706,487				23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		584,905	42,659	70,089,363		70,089,363	30
31	Intensive Care Unit		185,318	23,949	19,675,758		19,675,758	31
35	NEONATAL INTENSIVE CARE UNIT		45,020		2,191,973		2,191,973	35
40	Subprovider - IPF		93,865	23,949	11,503,689		11,503,689	40
41	Subprovider - IRF		46,202		7,352,926		7,352,926	41
43	Nursery		33,597		2,861,485		2,861,485	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		639,819	47,897	39,727,523		39,727,523	50
52	Delivery Room & Labor Room		32,422	29,187	9,066,470		9,066,470	52
53	Anesthesiology		144,124		810,081		810,081	53
54	Radiology-Diagnostic		1,568,333		34,628,255		34,628,255	54
54.01	OFFSITE-DIAGNOSTIC SERVICES		230,341		4,373,163		4,373,163	54.01
56.01	ONCOLOGY		371,475		5,324,724		5,324,724	56.01
60	Laboratory		990,488		25,016,069		25,016,069	60
62	Whole Blood & Packed Red Blood Cells		44,531		3,451,191		3,451,191	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		88,910		4,839,212		4,839,212	65
66	Physical Therapy		213,848		14,832,073		14,832,073	66
69	Electrocardiology		264,666		9,608,572		9,608,572	69
69.01	CARDIAC CATH LAB		218,200		4,399,006		4,399,006	69.01
69.02	CARDIAC REHABILITATION		9,711		2,862,342		2,862,342	69.02
71	Medical Supplies Charged to Patients		613,656		29,691,283		29,691,283	71
72	Impl. Dev. Charged to Patients		286,291		27,188,606		27,188,606	72
73	Drugs Charged to Patients	7,882,979	499,541		32,622,484		32,622,484	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis		30,694		1,753,238		1,753,238	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		77,386		9,341,964		9,341,964	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM		62,880		7,279,005		7,279,005	90.02
91	Emergency		492,470	538,846	25,613,437		25,613,437	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		36,261		9,289,961		9,289,961	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	7,882,979	7,904,954	706,487	415,393,853		415,393,853	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				1,348,155		1,348,155	190
192	Physicians' Private Offices				14,092		14,092	192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER	46			1,688,291		1,688,291	192.02
192.03	MOBILE DENTAL CLINIC	576			498,546		498,546	192.03

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	PARAMED EDUCATION EMS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	24	25	26	
192.04	EMS CONTINUING EDUCATION				1,264,363		1,264,363	192.04
194	CORPORATE HEALTH				641,091		641,091	194
194.01	MARKETING/COMMUNICATION				5,159,957		5,159,957	194.01
194.02	FOUNDATION				131,535		131,535	194.02
194.03	OTHER NRCC	26,045			7,513,618		7,513,618	194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	7,909,646	7,904,954	706,487	433,653,501		433,653,501	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	66,331	422,203	16,961	505,495	505,495		4
5	Administrative & General	6,882,341	6,632,453	13,887,353	27,402,147	88,942	27,491,089	5
6	Maintenance & Repairs							6
7	Operation of Plant	30,077	3,891,124	116,567	4,037,768	7,294	1,901,547	7
8	Laundry & Linen Service							8
9	Housekeeping	95		17,538	17,633	8,834	636,554	9
10	Dietary	46,036	343,832	82,079	471,947	3,661	271,058	10
11	Cafeteria		226,111		226,111	3,909	97,082	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,944	280,698	119,590	402,232	22,171	878,240	13
14	Central Services & Supply	576,288	512,466	306,715	1,395,469	6,300	380,920	14
15	Pharmacy	1,154	204,351	136,273	341,778	11,011	469,122	15
16	Medical Records & Library	129,883	173,919	46,165	349,967	6,842	473,377	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)		19,985		19,985	1,362	34,116	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	70,885	3,762,502	422,443	4,255,830	79,860	3,249,407	30
31	Intensive Care Unit	5,676	1,060,897	181,328	1,247,901	23,055	976,110	31
35	NEONATAL INTENSIVE CARE UNIT	230	82,252	131,850	214,332	3,014	112,511	35
40	Subprovider - IPF	5,910	702,075	24,859	732,844	10,422	525,785	40
41	Subprovider - IRF	6,419	495,206	26,584	528,209	4,515	370,415	41
43	Nursery		166,775		166,775	2,731	144,674	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	202,855	2,587,022	2,325,650	5,115,527	34,178	1,939,152	50
52	Delivery Room & Labor Room		386,858		386,858	9,611	484,476	52
53	Anesthesiology	15,959	21,554		37,513	451	33,644	53
54	Radiology-Diagnostic	732,826	1,412,574	1,348,128	3,493,528	35,570	1,881,855	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	119,660		417,292	536,952	4,701	261,115	54.01
56.01	ONCOLOGY	1,073	700,465	35,484	737,022	3,561	200,716	56.01
60	Laboratory	106,561	557,019	231,208	894,788	18,584	1,434,727	60
62	Whole Blood & Packed Red Blood Cells	1,924	38,401	20,030	60,355	1,359	209,957	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,696	130,604	36,774	171,074	6,327	277,455	65
66	Physical Therapy	482,092	405,398	86,368	973,858	19,917	862,116	66
69	Electrocardiology	100,138	221,817	230,950	552,905	11,557	516,121	69
69.01	CARDIAC CATH LAB	5,834	98,562	442,329	546,725	4,750	233,523	69.01
69.02	CARDIAC REHABILITATION	3,768	363,859	20,895	388,522	1,969	119,719	69.02
71	Medical Supplies Charged to Patients						1,620,806	71
72	Impl. Dev. Charged to Patients						1,493,498	72
73	Drugs Charged to Patients						1,536,678	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis	818		770	1,588		109,200	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	110,691	891,933	146,103	1,148,727	5,355	457,498	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	6,927	200,428	71,458	278,813	9,465	381,357	90.02
91	Emergency	648,246	647,777	140,674	1,436,697	29,031	1,330,820	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	34,383	213,724	25,248	273,355	13,389	556,008	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,400,720	27,854,844	21,095,666	59,351,230	493,698	26,461,359	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		233,915	1,089	235,004	399	51,695	190
192	Physicians' Private Offices			10,990	10,990		893	192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER	1,548		11,371	12,919	2,489	98,595	192.02
192.03	MOBILE DENTAL CLINIC	12,034		51,049	63,083	611	31,561	192.03

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
192.04	EMS CONTINUING EDUCATION					1,422	80,154	192.04
194	CORPORATE HEALTH	132	112,354	9,705	122,191	316	24,425	194
194.01	MARKETING/COMMUNICATION	5,261	83,243	575	89,079	2,510	314,397	194.01
194.02	FOUNDATION		37,121	24	37,145		3,019	194.02
194.03	OTHER NRCC	456,084	336,937		793,021	4,050	424,991	194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	10,875,779	28,658,414	21,180,469	60,714,662	505,495	27,491,089	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	5,946,609						7
8	Laundry & Linen Service							8
9	Housekeeping		663,021					9
10	Dietary	115,434	12,870	874,970				10
11	Cafeteria	75,912	8,464		411,478			11
12	Maintenance of Personnel							12
13	Nursing Administration	94,238	10,507		19,794	1,427,182		13
14	Central Services & Supply	172,049	19,183		10,348		1,984,269	14
15	Pharmacy	68,606	7,649		9,607			15
16	Medical Records & Library	58,389	6,510		8,999			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)	6,709	748		1,886	11,135		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,263,174	140,837	625,467	93,157	550,106	442	30
31	Intensive Care Unit	356,172	39,712	50,981	21,073	124,443	61	31
35	NEONATAL INTENSIVE CARE UNIT	27,614	3,079		2,851	16,839	3	35
40	Subprovider - IPF	235,706	26,280	123,180	12,151	71,758		40
41	Subprovider - IRF	166,254	18,537	54,798	5,624			41
43	Nursery	55,991	6,243		2,584	15,260		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	868,533	96,838		35,542	209,884	77,530	50
52	Delivery Room & Labor Room	129,879	14,481		7,474	44,136		52
53	Anesthesiology	7,236	807		861	5,086	8,319	53
54	Radiology-Diagnostic	474,239	52,876		36,682		17	54
54.01	OFFSITE-DIAGNOSTIC SERVICES				4,819			54.01
56.01	ONCOLOGY	235,165	26,220		3,120	18,426		56.01
60	Laboratory	187,006	20,850		27,149		3	60
62	Whole Blood & Packed Red Blood Cells	12,892	1,437		1,600			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	43,847	4,889		7,200		11,740	65
66	Physical Therapy	136,103	15,175		20,672		7	66
69	Electrocardiology	74,470	8,303		10,734	63,385	2	69
69.01	CARDIAC CATH LAB	33,090	3,689		4,200	24,805		69.01
69.02	CARDIAC REHABILITATION	122,157	13,620		2,169	12,811		69.02
71	Medical Supplies Charged to Patients						965,026	71
72	Impl. Dev. Charged to Patients						919,087	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	299,446	33,387		6,405		3	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	67,289	7,502		11,444	67,578		90.02
91	Emergency	217,476	24,248		32,434	191,530	1,847	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	71,753	8,000					101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,676,829	632,941	854,426	400,579	1,427,182	1,984,087	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	78,532	8,756		802			190
192	Physicians' Private Offices							192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER			20,544	2,848		54	192.02
192.03	MOBILE DENTAL CLINIC						31	192.03

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		7	9	10	11	13	14	
192.04	EMS CONTINUING EDUCATION							192.04
194	CORPORATE HEALTH	37,720	4,206		373			194
194.01	MARKETING/COMMUNICATION	27,947	3,116		2,502			194.01
194.02	FOUNDATION	12,462	1,390					194.02
194.03	OTHER NRCC	113,119	12,612		4,374		97	194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,946,609	663,021	874,970	411,478	1,427,182	1,984,269	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	907,773						15
16	Medical Records & Library		904,084					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)			75,941				23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		66,890		10,325,170		10,325,170	30
31	Intensive Care Unit		21,193		2,860,701		2,860,701	31
35	NEONATAL INTENSIVE CARE UNIT		5,148		385,391		385,391	35
40	Subprovider - IPF		10,734		1,748,860		1,748,860	40
41	Subprovider - IRF		5,284		1,153,636		1,153,636	41
43	Nursery		3,842		398,100		398,100	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		73,170		8,450,354		8,450,354	50
52	Delivery Room & Labor Room		3,708		1,080,623		1,080,623	52
53	Anesthesiology		16,482		110,399		110,399	53
54	Radiology-Diagnostic		179,426		6,154,193		6,154,193	54
54.01	OFFSITE-DIAGNOSTIC SERVICES		26,342		833,929		833,929	54.01
56.01	ONCOLOGY		42,482		1,266,712		1,266,712	56.01
60	Laboratory		113,272		2,696,379		2,696,379	60
62	Whole Blood & Packed Red Blood Cells		5,093		292,693		292,693	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		10,168		532,700		532,700	65
66	Physical Therapy		24,456		2,052,304		2,052,304	66
69	Electrocardiology		30,267		1,267,744		1,267,744	69
69.01	CARDIAC CATH LAB		24,953		875,735		875,735	69.01
69.02	CARDIAC REHABILITATION		1,111		662,078		662,078	69.02
71	Medical Supplies Charged to Patients		70,178		2,656,010		2,656,010	71
72	Impl. Dev. Charged to Patients		32,740		2,445,325		2,445,325	72
73	Drugs Charged to Patients	904,713	57,128		2,498,519		2,498,519	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis		3,510		114,298		114,298	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		8,850		1,959,671		1,959,671	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM		7,191		830,639		830,639	90.02
91	Emergency		56,319		3,320,402		3,320,402	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		4,147		926,652		926,652	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	904,713	904,084		57,899,217		57,899,217	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				375,188		375,188	190
192	Physicians' Private Offices				11,883		11,883	192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER	5			137,454		137,454	192.02
192.03	MOBILE DENTAL CLINIC	66			95,352		95,352	192.03

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	PARAMED EDUCATION EMS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	24	25	26	
192.04	EMS CONTINUING EDUCATION				81,576		81,576	192.04
194	CORPORATE HEALTH				189,231		189,231	194
194.01	MARKETING/COMMUNICATION				439,551		439,551	194.01
194.02	FOUNDATION				54,016		54,016	194.02
194.03	OTHER NRCC	2,989			1,355,253		1,355,253	194.03
200	Cross Foot Adjustments			75,941	75,941		75,941	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	907,773	904,084	75,941	60,714,662		60,714,662	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		21,339,274					2
4	Employee Benefits Department	10,225	17,088	184,841,011				4
5	Administrative & General	160,626	13,991,475	32,536,319	-95,458,181	338,195,320		5
6	Maintenance & Repairs							6
7	Operation of Plant	94,236	117,441	2,666,749		23,392,718	428,968	7
8	Laundry & Linen Service							8
9	Housekeeping		17,670	3,229,855		7,830,848		9
10	Dietary	8,327	82,694	1,338,510		3,334,545	8,327	10
11	Cafeteria	5,476		1,429,352		1,194,299	5,476	11
12	Maintenance of Personnel							12
13	Nursing Administration	6,798	120,487	8,106,392		10,804,052	6,798	13
14	Central Services & Supply	12,411	309,015	2,303,380		4,686,054	12,411	14
15	Pharmacy	4,949	137,295	4,025,855		5,771,113	4,949	15
16	Medical Records & Library	4,212	46,511	2,501,631		5,823,451	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		497,918		419,691	484	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	91,121	425,610	29,199,397		39,975,611	91,121	30
31	Intensive Care Unit	25,693	182,688	8,429,537		12,008,043	25,693	31
35	NEONATAL INTENSIVE CARE UNIT	1,992	132,839	1,101,829		1,384,099	1,992	35
40	Subprovider - IPF	17,003	25,045	3,810,551		6,468,178	17,003	40
41	Subprovider - IRF	11,993	26,783	1,650,677		4,556,817	11,993	41
43	Nursery	4,039		998,650		1,779,773	4,039	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	62,653	2,343,087	12,496,552		23,855,330	62,653	50
52	Delivery Room & Labor Room	9,369		3,514,159		5,959,993	9,369	52
53	Anesthesiology	522		165,076		413,888	522	53
54	Radiology-Diagnostic	34,210	1,358,236	13,005,398		23,150,467	34,210	54
54.01	OFFSITE-DIAGNOSTIC SERVICES		420,421	1,718,651		3,212,224		54.01
56.01	ONCOLOGY	16,964	35,750	1,302,040		2,469,200	16,964	56.01
60	Laboratory	13,490	232,942	6,794,838		17,649,918	13,490	60
62	Whole Blood & Packed Red Blood Cells	930	20,180	496,990		2,582,880	930	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,163	37,050	2,313,446		3,413,234	3,163	65
66	Physical Therapy	9,818	87,016	7,282,086		10,605,702	9,818	66
69	Electrocardiology	5,372	232,682	4,225,730		6,349,287	5,372	69
69.01	CARDIAC CATH LAB	2,387	445,645	1,736,906		2,872,790	2,387	69.01
69.02	CARDIAC REHABILITATION	8,812	21,052	719,776		1,472,776	8,812	69.02
71	Medical Supplies Charged to Patients					19,939,058		71
72	Impl. Dev. Charged to Patients					18,372,924		72
73	Drugs Charged to Patients					18,904,124		73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis		776			1,343,368		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	147,198	1,958,001		5,628,118	21,601	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	4,854	71,994	3,460,745		4,691,427	4,854	90.02
91	Emergency	15,688	141,729	10,614,793		16,371,668	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	25,437	4,895,420		6,839,974	5,176	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	674,594	21,253,836	180,527,209	-95,458,181	325,527,642	409,507	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,665	1,097	145,932		635,945	5,665	190
192	Physicians' Private Offices		11,072			10,990		192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER		11,456	910,230		1,212,914		192.02

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
192.03	MOBILE DENTAL CLINIC		51,432	223,511		388,266		192.03
192.04	EMS CONTINUING EDUCATION			519,844		986,044		192.04
194	CORPORATE HEALTH	2,721	9,778	115,562		300,470	2,721	194
194.01	MARKETING/COMMUNICATION	2,016	579	917,766		3,867,692	2,016	194.01
194.02	FOUNDATION	899	24			37,145	899	194.02
194.03	OTHER NRCC	8,160		1,480,957		5,228,212	8,160	194.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	28,658,414	21,180,469	31,760,948		95,458,181	29,995,500	202
203	Unit Cost Multiplier (Wkst. B, Part I)	41.291272	0.992558	0.171828		0.282258	69.924796	203
204	Cost to be allocated (Per Wkst. B, Part II)			505,495		27,491,089	5,946,609	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.002735		0.081288	13.862593	205

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S SERVED	NURSING ADMINIS-TRATION FTE'S NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUISTION	
		9	10	11	13	14	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	428,968						9
10	Dietary	8,327	274,189					10
11	Cafeteria	5,476		4,019,039				11
12	Maintenance of Personnel							12
13	Nursing Administration	6,798		193,330	2,360,554			13
14	Central Services & Supply	12,411		101,073		39,666,264		14
15	Pharmacy	4,949		93,835			18,435,078	15
16	Medical Records & Library	4,212		87,900				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		18,417	18,417			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	91,121	196,002	909,876	909,876	8,837		30
31	Intensive Care Unit	25,693	15,976	205,828	205,828	1,212		31
35	NEONATAL INTENSIVE CARE UNIT	1,992		27,851	27,851	65		35
40	Subprovider - IPF	17,003	38,601	118,687	118,687			40
41	Subprovider - IRF	11,993	17,172	54,930				41
43	Nursery	4,039		25,240	25,240			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	62,653		347,148	347,148	1,549,853		50
52	Delivery Room & Labor Room	9,369		73,000	73,000			52
53	Anesthesiology	522		8,413	8,413	166,303		53
54	Radiology-Diagnostic	34,210		358,289		333		54
54.01	OFFSITE-DIAGNOSTIC SERVICES			47,071				54.01
56.01	ONCOLOGY	16,964		30,476	30,476			56.01
60	Laboratory	13,490		265,177		69		60
62	Whole Blood & Packed Red Blood Cells	930		15,628				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,163		70,321		234,682		65
66	Physical Therapy	9,818		201,915		141		66
69	Electrocardiology	5,372		104,838	104,838	38		69
69.01	CARDIAC CATH LAB	2,387		41,027	41,027			69.01
69.02	CARDIAC REHABILITATION	8,812		21,190	21,190			69.02
71	Medical Supplies Charged to Patients					19,291,200		71
72	Impl. Dev. Charged to Patients					18,372,924		72
73	Drugs Charged to Patients						18,372,924	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		62,559		54		90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	4,854		111,773	111,773			90.02
91	Emergency	15,688		316,790	316,790	36,926		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						101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	409,507	267,751	3,912,582	2,360,554	39,662,637	18,372,924	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,665		7,831				190
192	Physicians' Private Offices							192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER		6,438	27,818		1,070	108	192.02

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

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S SERVED	NURSING ADMINIS-TRATION FTE'S NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUISTION	
		9	10	11	13	14	15	
192.03	MOBILE DENTAL CLINIC					620	1,342	192.03
192.04	EMS CONTINUING EDUCATION							192.04
194	CORPORATE HEALTH	2,721		3,648				194
194.01	MARKETING/COMMUNICATION	2,016		24,439				194.01
194.02	FOUNDATION	899						194.02
194.03	OTHER NRCC	8,160		42,721		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)	10,041,167	5,052,927	2,042,488	14,586,308	7,218,446	7,909,646	202
203	Unit Cost Multiplier (Wkst. B, Part I)	23.407730	18.428628	0.508203	6.179188	0.181979	0.429054	203
204	Cost to be allocated (Per Wkst. B, Part II)	663,021	874,970	411,478	1,427,182	1,984,269	907,773	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.545619	3.191120	0.102382	0.604596	0.050024	0.049242	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	1,712,117,562						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)		6,608					23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	126,685,086	399					30
31	Intensive Care Unit	40,138,127	224					31
35	NEONATAL INTENSIVE CARE UNIT	9,750,869						35
40	Subprovider - IPF	20,330,370	224					40
41	Subprovider - IRF	10,007,028						41
43	Nursery	7,276,790						43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	138,579,029	448					50
52	Delivery Room & Labor Room	7,022,405	273					52
53	Anesthesiology	31,216,037						53
54	Radiology-Diagnostic	339,663,368						54
54.01	OFFSITE-DIAGNOSTIC SERVICES	49,889,746						54.01
56.01	ONCOLOGY	80,458,048						56.01
60	Laboratory	214,530,682						60
62	Whole Blood & Packed Red Blood Cells	9,645,026						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	19,257,122						65
66	Physical Therapy	46,317,559						66
69	Electrocardiology	57,324,144						69
69.01	CARDIAC CATH LAB	47,260,069						69.01
69.02	CARDIAC REHABILITATION	2,103,242						69.02
71	Medical Supplies Charged to Patients	132,912,381						71
72	Impl. Dev. Charged to Patients	62,007,973						72
73	Drugs Charged to Patients	108,196,095						73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis	6,648,022						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	16,761,042						90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	13,619,137						90.02
91	Emergency	106,664,464	5,040					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	7,853,701						101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,712,117,562	6,608					118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.01	DAY SURGERY CENTER							192.01

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY GROSS REVENUE	PARAMED EDUCATION EMS ASSIGNED TIME					
		16	23					
192.02	RESIDENTIAL TREATMENT CENTER							192.02
192.03	MOBILE DENTAL CLINIC							192.03
192.04	EMS CONTINUING EDUCATION							192.04
194	CORPORATE HEALTH							194
194.01	MARKETING/COMMUNICATION							194.01
194.02	FOUNDATION							194.02
194.03	OTHER NRCC							194.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	7,904,954	706,487					202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.004617	106.913892					203
204	Cost to be allocated (Per Wkst. B, Part II)	904,084	75,941					204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000528	11.492282					205

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	70,089,363		70,089,363		70,089,363	30
31	Intensive Care Unit	19,675,758		19,675,758	18,404	19,694,162	31
35	NEONATAL INTENSIVE CARE UNIT	2,191,973		2,191,973		2,191,973	35
40	Subprovider - IPF	11,503,689		11,503,689		11,503,689	40
41	Subprovider - IRF	7,352,926		7,352,926		7,352,926	41
43	Nursery	2,861,485		2,861,485		2,861,485	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	39,727,523		39,727,523		39,727,523	50
52	Delivery Room & Labor Room	9,066,470		9,066,470		9,066,470	52
53	Anesthesiology	810,081		810,081		810,081	53
54	Radiology-Diagnostic	34,628,255		34,628,255	17,242	34,645,497	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	4,373,163		4,373,163		4,373,163	54.01
56.01	ONCOLOGY	5,324,724		5,324,724	29,401	5,354,125	56.01
60	Laboratory	25,016,069		25,016,069	172,923	25,188,992	60
62	Whole Blood & Packed Red Blood Cells	3,451,191		3,451,191		3,451,191	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	4,839,212		4,839,212		4,839,212	65
66	Physical Therapy	14,832,073		14,832,073		14,832,073	66
69	Electrocardiology	9,608,572		9,608,572	764,049	10,372,621	69
69.01	CARDIAC CATH LAB	4,399,006		4,399,006		4,399,006	69.01
69.02	CARDIAC REHABILITATION	2,862,342		2,862,342		2,862,342	69.02
71	Medical Supplies Charged to Patients	29,691,283		29,691,283		29,691,283	71
72	Impl. Dev. Charged to Patients	27,188,606		27,188,606		27,188,606	72
73	Drugs Charged to Patients	32,622,484		32,622,484		32,622,484	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS						73.01
74	Renal Dialysis	1,753,238		1,753,238		1,753,238	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	9,341,964		9,341,964		9,341,964	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	7,279,005		7,279,005		7,279,005	90.02
91	Emergency	25,613,437		25,613,437		25,613,437	91
92	Observation Beds (Non-Distinct Part)	9,785,303		9,785,303		9,785,303	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	9,289,961		9,289,961		9,289,961	101
200	Subtotal (sum of lines 30 thru 199)	425,179,156		425,179,156	1,002,019	426,181,175	200
201	Less Observation Beds	9,785,303		9,785,303		9,785,303	201
202	Total (line 200 minus line 201)	415,393,853		415,393,853		416,395,872	202

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	118,908,964		118,908,964				30
31	Intensive Care Unit	40,138,127		40,138,127				31
35	NEONATAL INTENSIVE CARE UNIT	9,750,869		9,750,869				35
40	Subprovider - IPF	20,330,370		20,330,370				40
41	Subprovider - IRF	10,007,028		10,007,028				41
43	Nursery	7,276,790		7,276,790				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	56,464,536	82,114,493	138,579,029	0.286678	0.286678	0.286678	50
52	Delivery Room & Labor Room	6,888,748	133,657	7,022,405	1.291078	1.291078	1.291078	52
53	Anesthesiology	10,360,729	20,855,308	31,216,037	0.025951	0.025951	0.025951	53
54	Radiology-Diagnostic	94,485,556	245,177,812	339,663,368	0.101949	0.101949	0.102000	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	257,761	49,631,985	49,889,746	0.087657	0.087657	0.087657	54.01
56.01	ONCOLOGY	10,953,979	69,504,069	80,458,048	0.066180	0.066180	0.066546	56.01
60	Laboratory	96,640,645	117,890,037	214,530,682	0.116608	0.116608	0.117414	60
62	Whole Blood & Packed Red Blood Cells	7,509,242	2,135,784	9,645,026	0.357821	0.357821	0.357821	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	16,676,662	2,580,460	19,257,122	0.251295	0.251295	0.251295	65
66	Physical Therapy	15,938,970	30,378,589	46,317,559	0.320226	0.320226	0.320226	66
69	Electrocardiology	12,207,448	45,116,696	57,324,144	0.167618	0.167618	0.180947	69
69.01	CARDIAC CATH LAB	18,800,604	28,459,465	47,260,069	0.093081	0.093081	0.093081	69.01
69.02	CARDIAC REHABILITATION	1,909	2,101,333	2,103,242	1.360919	1.360919	1.360919	69.02
71	Medical Supplies Charged to Patients	71,237,941	61,674,440	132,912,381	0.223390	0.223390	0.223390	71
72	Impl. Dev. Charged to Patients	35,593,657	26,414,316	62,007,973	0.438470	0.438470	0.438470	72
73	Drugs Charged to Patients	58,842,593	49,353,502	108,196,095	0.301513	0.301513	0.301513	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis	6,048,524	599,498	6,648,022	0.263723	0.263723	0.263723	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	793,567	15,967,475	16,761,042	0.557362	0.557362	0.557362	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	10,383,165	3,235,972	13,619,137	0.534469	0.534469	0.534469	90.02
91	Emergency	30,513,404	76,151,060	106,664,464	0.240131	0.240131	0.240131	91
92	Observation Beds (Non-Distinct Part)		7,776,122	7,776,122	1.258378	1.258378	1.258378	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		7,853,701	7,853,701				101
200	Subtotal (sum of lines 30 thru 199)	767,011,788	945,105,774	1,712,117,562				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	767,011,788	945,105,774	1,712,117,562				202

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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)	10,325,170		10,325,170	75,187	137.33	31,325	4,301,862	30
31	Intensive Care Unit	2,860,701		2,860,701	7,988	358.12	4,013	1,437,136	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	NEONATAL INTENSIVE CARE UNIT	385,391		385,391	3,049	126.40			35
40	Subprovider - IPF	1,748,860		1,748,860	12,867	135.92	2,479	336,946	40
41	Subprovider - IRF	1,153,636		1,153,636	5,724	201.54	3,598	725,141	41
42	Subprovider I								42
43	Nursery	398,100		398,100	5,258	75.71			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	16,871,858		16,871,858	110,073		41,415	6,801,085	200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	8,450,354	138,579,029	0.060979	25,578,337	1,559,741	50
52	Delivery Room & Labor Room	1,080,623	7,022,405	0.153882	1,836	283	52
53	Anesthesiology	110,399	31,216,037	0.003537	4,190,730	14,823	53
54	Radiology-Diagnostic	6,154,193	339,663,368	0.018119	48,629,596	881,120	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	833,929	49,889,746	0.016715			54.01
56.01	ONCOLOGY	1,266,712	80,458,048	0.015744	5,228,394	82,316	56.01
60	Laboratory	2,696,379	214,530,682	0.012569	45,442,735	571,170	60
62	Whole Blood & Packed Red Blood	292,693	9,645,026	0.030347	3,957,876	120,110	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	532,700	19,257,122	0.027662	9,295,449	257,131	65
66	Physical Therapy	2,052,304	46,317,559	0.044309	4,912,683	217,676	66
69	Electrocardiology	1,267,744	57,324,144	0.022115	6,333,725	140,070	69
69.01	CARDIAC CATH LAB	875,735	47,260,069	0.018530	8,356,427	154,845	69.01
69.02	CARDIAC REHABILITATION	662,078	2,103,242	0.314789	1,215	382	69.02
71	Medical Supplies Charged to Pat	2,656,010	132,912,381	0.019983	32,702,760	653,499	71
72	Impl. Dev. Charged to Patients	2,445,325	62,007,973	0.039436	18,083,838	713,154	72
73	Drugs Charged to Patients	2,498,519	108,196,095	0.023093	25,668,023	592,752	73
73.01	FLU VACCINE DRUGS CHG TO PATIEN						73.01
74	Renal Dialysis	114,298	6,648,022	0.017193	3,731,150	64,150	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	1,959,671	16,761,042	0.116918	187,834	21,961	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	830,639	13,619,137	0.060991	9,027	551	90.02
91	Emergency	3,320,402	106,664,464	0.031129	15,038,440	468,132	91
92	Observation Beds (Non-Distinct	1,441,512	7,776,122	0.185377			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	41,542,219	1,497,851,713		257,350,075	6,513,866	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] Title XVIII, Part A** **[ ] Title XIX** **[XX] PPS** **[ ] TEFRA** **[ ] Other**

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)				42,659			42,659	30
31	Intensive Care Unit				23,949			23,949	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				23,949			23,949	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)				90,557			90,557	200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	75,187	0.57	31,325	17,855	30
31	Intensive Care Unit	7,988	3.00	4,013	12,039	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	NEONATAL INTENSIVE CARE UNIT	3,049				35
40	Subprovider - IPF	12,867	1.86	2,479	4,611	40
41	Subprovider - IRF	5,724		3,598		41
42	Subprovider I					42
43	Nursery	5,258				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	110,073		41,415	34,505	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

(A)	Cost Center Description	Non Physician Anesth-etist Cost 1	Nursing School Post-Stepdown Adjustments 2A	Nursing School 2	Allied Health Post-Stepdown Adjustments 3A	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					47,897		47,897	47,897	50
52	Delivery Room & Labor Room					29,187		29,187	29,187	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					538,846		538,846	538,846	91
92	Observation Beds (Non-Distinct					5,959		5,959	5,959	92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)					621,889		621,889	621,889	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	138,579,029	0.000346	0.000346	25,578,337	8,850	25,011,062	8,654	50
52	Delivery Room & Labor Room	7,022,405	0.004156	0.004156	1,836	8			52
53	Anesthesiology	31,216,037			4,190,730		7,112,294		53
54	Radiology-Diagnostic	339,663,368			48,629,596		85,069,307		54
54.01	OFFSITE-DIAGNOSTIC SERVICES	49,889,746					15,048,310		54.01
56.01	ONCOLOGY	80,458,048			5,228,394		29,796,614		56.01
60	Laboratory	214,530,682			45,442,735		20,594,494		60
62	Whole Blood & Packed Red Blood	9,645,026			3,957,876		1,442,431		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	19,257,122			9,295,449		928,177		65
66	Physical Therapy	46,317,559			4,912,683		256,401		66
69	Electrocardiology	57,324,144			6,333,725		15,829,912		69
69.01	CARDIAC CATH LAB	47,260,069			8,356,427		13,355,367		69.01
69.02	CARDIAC REHABILITATION	2,103,242			1,215		1,031,520		69.02
71	Medical Supplies Charged to Pat	132,912,381			32,702,760		20,417,456		71
72	Impl. Dev. Charged to Patients	62,007,973			18,083,838		14,144,441		72
73	Drugs Charged to Patients	108,196,095			25,668,023		18,119,017		73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	6,648,022			3,731,150		439,164		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	16,761,042			187,834		2,696,141		90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	13,619,137			9,027		136,467		90.02
91	Emergency	106,664,464	0.005052	0.005052	15,038,440	75,974	17,815,795	90,005	91
92	Observation Beds (Non-Distinct	7,776,122	0.000766	0.000766			2,872,253	2,200	92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,497,851,713			257,350,075	84,832	292,116,623	100,859	200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	0.286678	25,011,062			7,170,121			50
52	Delivery Room & Labor Room	1.291078							52
53	Anesthesiology	0.025951	7,112,294			184,571			53
54	Radiology-Diagnostic	0.101949	85,069,307	933		8,672,731	95		54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.087657	15,048,310			1,319,090			54.01
56.01	ONCOLOGY	0.066180	29,796,614			1,971,940			56.01
60	Laboratory	0.116608	20,594,494	4,375		2,401,483	510		60
62	Whole Blood & Packed Red Blood	0.357821	1,442,431			516,132			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.251295	928,177			233,246			65
66	Physical Therapy	0.320226	256,401			82,106			66
69	Electrocardiology	0.167618	15,829,912			2,653,378			69
69.01	CARDIAC CATH LAB	0.093081	13,355,367			1,243,131			69.01
69.02	CARDIAC REHABILITATION	1.360919	1,031,520			1,403,815			69.02
71	Medical Supplies Charged to Pat	0.223390	20,417,456			4,561,055			71
72	Impl. Dev. Charged to Patients	0.438470	14,144,441			6,201,913			72
73	Drugs Charged to Patients	0.301513	18,119,017	290		5,463,119	87		73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	0.263723	439,164			115,818			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	0.557362	2,696,141		50,143	1,502,727		27,948	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	0.534469	136,467			72,937			90.02
91	Emergency	0.240131	17,815,795	60,645		4,278,125	14,563		91
92	Observation Beds (Non-Distinct	1.258378	2,872,253			3,614,380			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		292,116,623	66,243	50,143	53,661,818	15,255	27,948	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		292,116,623	66,243	50,143	53,661,818	15,255	27,948	202

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	8,450,354	138,579,029	0.060979			50
52	Delivery Room & Labor Room	1,080,623	7,022,405	0.153882			52
53	Anesthesiology	110,399	31,216,037	0.003537			53
54	Radiology-Diagnostic	6,154,193	339,663,368	0.018119	10,348	187	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	833,929	49,889,746	0.016715			54.01
56.01	ONCOLOGY	1,266,712	80,458,048	0.015744	1,812	29	56.01
60	Laboratory	2,696,379	214,530,682	0.012569	197,685	2,485	60
62	Whole Blood & Packed Red Blood	292,693	9,645,026	0.030347			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	532,700	19,257,122	0.027662			65
66	Physical Therapy	2,052,304	46,317,559	0.044309	53,819	2,385	66
69	Electrocardiology	1,267,744	57,324,144	0.022115	10,943	242	69
69.01	CARDIAC CATH LAB	875,735	47,260,069	0.018530			69.01
69.02	CARDIAC REHABILITATION	662,078	2,103,242	0.314789			69.02
71	Medical Supplies Charged to Pat	2,656,010	132,912,381	0.019983	1,436	29	71
72	Impl. Dev. Charged to Patients	2,445,325	62,007,973	0.039436			72
73	Drugs Charged to Patients	2,498,519	108,196,095	0.023093	240,256	5,548	73
73.01	FLU VACCINE DRUGS CHG TO PATIEN						73.01
74	Renal Dialysis	114,298	6,648,022	0.017193			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	1,959,671	16,761,042	0.116918	1,611	188	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	830,639	13,619,137	0.060991	531	32	90.02
91	Emergency	3,320,402	106,664,464	0.031129	5,883	183	91
92	Observation Beds (Non-Distinct		7,776,122				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	40,100,707	1,497,851,713		524,324	11,308	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 Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room					47,897		47,897	47,897	50
52	Delivery Room & Labor Room					29,187		29,187	29,187	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					538,846		538,846	538,846	91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)					615,930		615,930	615,930	200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	138,579,029	0.000346	0.000346					50
52	Delivery Room & Labor Room	7,022,405	0.004156	0.004156					52
53	Anesthesiology	31,216,037							53
54	Radiology-Diagnostic	339,663,368			10,348				54
54.01	OFFSITE-DIAGNOSTIC SERVICES	49,889,746							54.01
56.01	ONCOLOGY	80,458,048			1,812				56.01
60	Laboratory	214,530,682			197,685				60
62	Whole Blood & Packed Red Blood	9,645,026							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	19,257,122							65
66	Physical Therapy	46,317,559			53,819				66
69	Electrocardiology	57,324,144			10,943				69
69.01	CARDIAC CATH LAB	47,260,069							69.01
69.02	CARDIAC REHABILITATION	2,103,242							69.02
71	Medical Supplies Charged to Pat	132,912,381			1,436				71
72	Impl. Dev. Charged to Patients	62,007,973							72
73	Drugs Charged to Patients	108,196,095			240,256				73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	6,648,022							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	16,761,042			1,611				90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	13,619,137			531				90.02
91	Emergency	106,664,464	0.005052	0.005052	5,883	30			91
92	Observation Beds (Non-Distinct	7,776,122							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,497,851,713			524,324	30			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	0.286678							50
52	Delivery Room & Labor Room	1.291078							52
53	Anesthesiology	0.025951							53
54	Radiology-Diagnostic	0.101949							54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.087657							54.01
56.01	ONCOLOGY	0.066180							56.01
60	Laboratory	0.116608							60
62	Whole Blood & Packed Red Blood	0.357821							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.251295							65
66	Physical Therapy	0.320226							66
69	Electrocardiology	0.167618							69
69.01	CARDIAC CATH LAB	0.093081							69.01
69.02	CARDIAC REHABILITATION	1.360919							69.02
71	Medical Supplies Charged to Pat	0.223390							71
72	Impl. Dev. Charged to Patients	0.438470							72
73	Drugs Charged to Patients	0.301513							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	0.263723							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	0.557362							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	0.534469							90.02
91	Emergency	0.240131							91
92	Observation Beds (Non-Distinct	1.258378							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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	8,450,354	138,579,029	0.060979	14,415	879	50
52	Delivery Room & Labor Room	1,080,623	7,022,405	0.153882			52
53	Anesthesiology	110,399	31,216,037	0.003537	8,412	30	53
54	Radiology-Diagnostic	6,154,193	339,663,368	0.018119	414,983	7,519	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	833,929	49,889,746	0.016715			54.01
56.01	ONCOLOGY	1,266,712	80,458,048	0.015744	13,911	219	56.01
60	Laboratory	2,696,379	214,530,682	0.012569	587,155	7,380	60
62	Whole Blood & Packed Red Blood	292,693	9,645,026	0.030347	19,027	577	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	532,700	19,257,122	0.027662	324,245	8,969	65
66	Physical Therapy	2,052,304	46,317,559	0.044309	4,650,282	206,049	66
69	Electrocardiology	1,267,744	57,324,144	0.022115	24,651	545	69
69.01	CARDIAC CATH LAB	875,735	47,260,069	0.018530			69.01
69.02	CARDIAC REHABILITATION	662,078	2,103,242	0.314789			69.02
71	Medical Supplies Charged to Pat	2,656,010	132,912,381	0.019983	131,031	2,618	71
72	Impl. Dev. Charged to Patients	2,445,325	62,007,973	0.039436	3,569	141	72
73	Drugs Charged to Patients	2,498,519	108,196,095	0.023093	575,253	13,284	73
73.01	FLU VACCINE DRUGS CHG TO PATIEN						73.01
74	Renal Dialysis	114,298	6,648,022	0.017193	169,909	2,921	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	1,959,671	16,761,042	0.116918	8,333	974	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	830,639	13,619,137	0.060991			90.02
91	Emergency	3,320,402	106,664,464	0.031129	4,388	137	91
92	Observation Beds (Non-Distinct		7,776,122				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	40,100,707	1,497,851,713		6,949,564	252,242	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 Post-Stepdown Adjustments 2A	Nursing School 2	Allied Health Post-Stepdown Adjustments 3A	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					47,897		47,897	47,897	50
52	Delivery Room & Labor Room					29,187		29,187	29,187	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					538,846		538,846	538,846	91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)					615,930		615,930	615,930	200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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**

		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	138,579,029	0.000346	0.000346	14,415	5			50
52	Delivery Room & Labor Room	7,022,405	0.004156	0.004156					52
53	Anesthesiology	31,216,037			8,412				53
54	Radiology-Diagnostic	339,663,368			414,983				54
54.01	OFFSITE-DIAGNOSTIC SERVICES	49,889,746							54.01
56.01	ONCOLOGY	80,458,048			13,911				56.01
60	Laboratory	214,530,682			587,155				60
62	Whole Blood & Packed Red Blood	9,645,026			19,027				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	19,257,122			324,245				65
66	Physical Therapy	46,317,559			4,650,282				66
69	Electrocardiology	57,324,144			24,651				69
69.01	CARDIAC CATH LAB	47,260,069							69.01
69.02	CARDIAC REHABILITATION	2,103,242							69.02
71	Medical Supplies Charged to Pat	132,912,381			131,031				71
72	Impl. Dev. Charged to Patients	62,007,973			3,569				72
73	Drugs Charged to Patients	108,196,095			575,253				73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	6,648,022			169,909				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	16,761,042			8,333				90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	13,619,137							90.02
91	Emergency	106,664,464	0.005052	0.005052	4,388	22			91
92	Observation Beds (Non-Distinct	7,776,122							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,497,851,713			6,949,564	27			200

(A) Worksheet A line numbers

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	0.286678							50
52	Delivery Room & Labor Room	1.291078							52
53	Anesthesiology	0.025951							53
54	Radiology-Diagnostic	0.101949							54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.087657							54.01
56.01	ONCOLOGY	0.066180							56.01
60	Laboratory	0.116608							60
62	Whole Blood & Packed Red Blood	0.357821							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.251295							65
66	Physical Therapy	0.320226							66
69	Electrocardiology	0.167618							69
69.01	CARDIAC CATH LAB	0.093081							69.01
69.02	CARDIAC REHABILITATION	1.360919							69.02
71	Medical Supplies Charged to Pat	0.223390							71
72	Impl. Dev. Charged to Patients	0.438470							72
73	Drugs Charged to Patients	0.301513							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	0.263723							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	0.557362							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	0.534469							90.02
91	Emergency	0.240131							91
92	Observation Beds (Non-Distinct	1.258378							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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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)	10,325,170		10,325,170	75,187	137.33	5,263	722,768	30
31	Intensive Care Unit	2,860,701		2,860,701	7,988	358.12	637	228,122	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	NEONATAL INTENSIVE CARE UNIT	385,391		385,391	3,049	126.40	60	7,584	35
40	Subprovider - IPF	1,748,860		1,748,860	12,867	135.92	2,680	364,266	40
41	Subprovider - IRF	1,153,636		1,153,636	5,724	201.54	503	101,375	41
42	Subprovider I								42
43	Nursery	398,100		398,100	5,258	75.71	1,111	84,114	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	16,871,858		16,871,858	110,073		10,254	1,508,229	200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	8,450,354	138,579,029	0.060979	1,373,333	83,744	50
52	Delivery Room & Labor Room	1,080,623	7,022,405	0.153882	1,674,306	257,646	52
53	Anesthesiology	110,399	31,216,037	0.003537	804,222	2,845	53
54	Radiology-Diagnostic	6,154,193	339,663,368	0.018119	3,563,749	64,572	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	833,929	49,889,746	0.016715			54.01
56.01	ONCOLOGY	1,266,712	80,458,048	0.015744	420,924	6,627	56.01
60	Laboratory	2,696,379	214,530,682	0.012569	5,336,971	67,080	60
62	Whole Blood & Packed Red Blood	292,693	9,645,026	0.030347	134,241	4,074	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	532,700	19,257,122	0.027662	1,017,327	28,141	65
66	Physical Therapy	2,052,304	46,317,559	0.044309	143,371	6,353	66
69	Electrocardiology	1,267,744	57,324,144	0.022115	526,638	11,647	69
69.01	CARDIAC CATH LAB	875,735	47,260,069	0.018530	449,399	8,327	69.01
69.02	CARDIAC REHABILITATION	662,078	2,103,242	0.314789			69.02
71	Medical Supplies Charged to Pat	2,656,010	132,912,381	0.019983	3,462,541	69,192	71
72	Impl. Dev. Charged to Patients	2,445,325	62,007,973	0.039436			72
73	Drugs Charged to Patients	2,498,519	108,196,095	0.023093	2,646,130	61,107	73
73.01	FLU VACCINE DRUGS CHG TO PATIEN						73.01
74	Renal Dialysis	114,298	6,648,022	0.017193	165,818	2,851	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	1,959,671	16,761,042	0.116918			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	830,639	13,619,137	0.060991	3,696	225	90.02
91	Emergency	3,320,402	106,664,464	0.031129	130,744	4,070	91
92	Observation Beds (Non-Distinct	1,441,512	7,776,122	0.185377			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	41,542,219	1,497,851,713		21,853,410	678,501	200

(A) Worksheet A line numbers

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

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

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)				42,659			42,659	30
31	Intensive Care Unit				23,949			23,949	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				23,949			23,949	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)				90,557			90,557	200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes: **[ ] Title V** **[ ] Title XVIII, Part A** **[XX] Title XIX** **[ ] PPS** **[ ] TEFRA** **[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)	75,187	0.57	5,263	3,000	30
31	Intensive Care Unit	7,988	3.00	637	1,911	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	NEONATAL INTENSIVE CARE UNIT	3,049		60		35
40	Subprovider - IPF	12,867	1.86	2,680	4,985	40
41	Subprovider - IRF	5,724		503		41
42	Subprovider I					42
43	Nursery	5,258		1,111		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	110,073		10,254	9,896	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 Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room					47,897		47,897	47,897	50
52	Delivery Room & Labor Room					29,187		29,187	29,187	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					538,846		538,846	538,846	91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)					615,930		615,930	615,930	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	138,579,029	0.000346	0.000346	1,373,333	475			50
52	Delivery Room & Labor Room	7,022,405	0.004156	0.004156	1,674,306	6,958			52
53	Anesthesiology	31,216,037			804,222				53
54	Radiology-Diagnostic	339,663,368			3,563,749				54
54.01	OFFSITE-DIAGNOSTIC SERVICES	49,889,746							54.01
56.01	ONCOLOGY	80,458,048			420,924				56.01
60	Laboratory	214,530,682			5,336,971				60
62	Whole Blood & Packed Red Blood	9,645,026			134,241				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	19,257,122			1,017,327				65
66	Physical Therapy	46,317,559			143,371				66
69	Electrocardiology	57,324,144			526,638				69
69.01	CARDIAC CATH LAB	47,260,069			449,399				69.01
69.02	CARDIAC REHABILITATION	2,103,242							69.02
71	Medical Supplies Charged to Pat	132,912,381			3,462,541				71
72	Impl. Dev. Charged to Patients	62,007,973							72
73	Drugs Charged to Patients	108,196,095			2,646,130				73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	6,648,022			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	16,761,042							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	13,619,137			3,696				90.02
91	Emergency	106,664,464	0.005052	0.005052	130,744	661			91
92	Observation Beds (Non-Distinct	7,776,122							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,497,851,713			21,853,410	8,094			200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	0.286678							50
52	Delivery Room & Labor Room	1.291078							52
53	Anesthesiology	0.025951							53
54	Radiology-Diagnostic	0.101949							54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.087657							54.01
56.01	ONCOLOGY	0.066180							56.01
60	Laboratory	0.116608							60
62	Whole Blood & Packed Red Blood	0.357821							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.251295							65
66	Physical Therapy	0.320226							66
69	Electrocardiology	0.167618							69
69.01	CARDIAC CATH LAB	0.093081							69.01
69.02	CARDIAC REHABILITATION	1.360919							69.02
71	Medical Supplies Charged to Pat	0.223390							71
72	Impl. Dev. Charged to Patients	0.438470							72
73	Drugs Charged to Patients	0.301513							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	0.263723							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	0.557362							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	0.534469							90.02
91	Emergency	0.240131							91
92	Observation Beds (Non-Distinct	1.258378							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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	8,450,354	138,579,029	0.060979			50
52	Delivery Room & Labor Room	1,080,623	7,022,405	0.153882			52
53	Anesthesiology	110,399	31,216,037	0.003537			53
54	Radiology-Diagnostic	6,154,193	339,663,368	0.018119	50,286	911	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	833,929	49,889,746	0.016715			54.01
56.01	ONCOLOGY	1,266,712	80,458,048	0.015744	12,061	190	56.01
60	Laboratory	2,696,379	214,530,682	0.012569	259,384	3,260	60
62	Whole Blood & Packed Red Blood	292,693	9,645,026	0.030347			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	532,700	19,257,122	0.027662			65
66	Physical Therapy	2,052,304	46,317,559	0.044309	1,062	47	66
69	Electrocardiology	1,267,744	57,324,144	0.022115	53,744	1,189	69
69.01	CARDIAC CATH LAB	875,735	47,260,069	0.018530			69.01
69.02	CARDIAC REHABILITATION	662,078	2,103,242	0.314789			69.02
71	Medical Supplies Charged to Pat	2,656,010	132,912,381	0.019983	14,287	285	71
72	Impl. Dev. Charged to Patients	2,445,325	62,007,973	0.039436			72
73	Drugs Charged to Patients	2,498,519	108,196,095	0.023093	65,521	1,513	73
73.01	FLU VACCINE DRUGS CHG TO PATIEN						73.01
74	Renal Dialysis	114,298	6,648,022	0.017193			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	1,959,671	16,761,042	0.116918			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	830,639	13,619,137	0.060991	66,528	4,058	90.02
91	Emergency	3,320,402	106,664,464	0.031129	1,838	57	91
92	Observation Beds (Non-Distinct		7,776,122				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	40,100,707	1,497,851,713		524,711	11,510	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	[ ] Hospital	[ ] SUB (Other)	[ ] ICF/IID	[ ] PPS
[ ] Title XVIII, Part A	[XX] IPF	[ ] SNF		[ ] TEFRA
[XX] Title XIX	[ ] IRF	[ ] NF		[XX] Other

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room					47,897		47,897	47,897	50
52	Delivery Room & Labor Room					29,187		29,187	29,187	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					538,846		538,846	538,846	91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)					615,930		615,930	615,930	200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	138,579,029	0.000346	0.000346					50
52	Delivery Room & Labor Room	7,022,405	0.004156	0.004156					52
53	Anesthesiology	31,216,037							53
54	Radiology-Diagnostic	339,663,368			50,286				54
54.01	OFFSITE-DIAGNOSTIC SERVICES	49,889,746							54.01
56.01	ONCOLOGY	80,458,048			12,061				56.01
60	Laboratory	214,530,682			259,384				60
62	Whole Blood & Packed Red Blood	9,645,026							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	19,257,122							65
66	Physical Therapy	46,317,559			1,062				66
69	Electrocardiology	57,324,144			53,744				69
69.01	CARDIAC CATH LAB	47,260,069							69.01
69.02	CARDIAC REHABILITATION	2,103,242							69.02
71	Medical Supplies Charged to Pat	132,912,381			14,287				71
72	Impl. Dev. Charged to Patients	62,007,973							72
73	Drugs Charged to Patients	108,196,095			65,521				73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	6,648,022							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	16,761,042							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	13,619,137			66,528				90.02
91	Emergency	106,664,464	0.005052	0.005052	1,838	9			91
92	Observation Beds (Non-Distinct	7,776,122							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,497,851,713			524,711	9			200

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	0.286678							50
52	Delivery Room & Labor Room	1.291078							52
53	Anesthesiology	0.025951							53
54	Radiology-Diagnostic	0.101949							54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.087657							54.01
56.01	ONCOLOGY	0.066180							56.01
60	Laboratory	0.116608							60
62	Whole Blood & Packed Red Blood	0.357821							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.251295							65
66	Physical Therapy	0.320226							66
69	Electrocardiology	0.167618							69
69.01	CARDIAC CATH LAB	0.093081							69.01
69.02	CARDIAC REHABILITATION	1.360919							69.02
71	Medical Supplies Charged to Pat	0.223390							71
72	Impl. Dev. Charged to Patients	0.438470							72
73	Drugs Charged to Patients	0.301513							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	0.263723							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	0.557362							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	0.534469							90.02
91	Emergency	0.240131							91
92	Observation Beds (Non-Distinct	1.258378							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** **[ ] Title XVIII, Part A** **[XX] Title XIX** **[ ] Hospital** **[ ] IPF** **[XX] 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	8,450,354	138,579,029	0.060979			50
52	Delivery Room & Labor Room	1,080,623	7,022,405	0.153882			52
53	Anesthesiology	110,399	31,216,037	0.003537			53
54	Radiology-Diagnostic	6,154,193	339,663,368	0.018119			54
54.01	OFFSITE-DIAGNOSTIC SERVICES	833,929	49,889,746	0.016715			54.01
56.01	ONCOLOGY	1,266,712	80,458,048	0.015744			56.01
60	Laboratory	2,696,379	214,530,682	0.012569			60
62	Whole Blood & Packed Red Blood	292,693	9,645,026	0.030347			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	532,700	19,257,122	0.027662			65
66	Physical Therapy	2,052,304	46,317,559	0.044309			66
69	Electrocardiology	1,267,744	57,324,144	0.022115			69
69.01	CARDIAC CATH LAB	875,735	47,260,069	0.018530			69.01
69.02	CARDIAC REHABILITATION	662,078	2,103,242	0.314789			69.02
71	Medical Supplies Charged to Pat	2,656,010	132,912,381	0.019983			71
72	Impl. Dev. Charged to Patients	2,445,325	62,007,973	0.039436			72
73	Drugs Charged to Patients	2,498,519	108,196,095	0.023093			73
73.01	FLU VACCINE DRUGS CHG TO PATIEN						73.01
74	Renal Dialysis	114,298	6,648,022	0.017193			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	1,959,671	16,761,042	0.116918			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	830,639	13,619,137	0.060991			90.02
91	Emergency	3,320,402	106,664,464	0.031129			91
92	Observation Beds (Non-Distinct		7,776,122				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	40,100,707	1,497,851,713				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 [ ] Title XVIII, Part A [XX] Title XIX
[ ] Hospital [ ] IPF [XX] IRF
[ ] SUB (Other) [ ] SNF [ ] NF
[ ] ICF/IID
[ ] PPS [ ] TEFRA [XX] Other

(A)	Cost Center Description	Non Physician Anesth-etist Cost 1	Nursing School Post-Stepdown Adjustments 2A	Nursing School 2	Allied Health Post-Stepdown Adjustments 3A	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					47,897		47,897	47,897	50
52	Delivery Room & Labor Room					29,187		29,187	29,187	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					538,846		538,846	538,846	91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)					615,930		615,930	615,930	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 [ ] 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	138,579,029	0.000346	0.000346					50
52	Delivery Room & Labor Room	7,022,405	0.004156	0.004156					52
53	Anesthesiology	31,216,037							53
54	Radiology-Diagnostic	339,663,368							54
54.01	OFFSITE-DIAGNOSTIC SERVICES	49,889,746							54.01
56.01	ONCOLOGY	80,458,048							56.01
60	Laboratory	214,530,682							60
62	Whole Blood & Packed Red Blood	9,645,026							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	19,257,122							65
66	Physical Therapy	46,317,559							66
69	Electrocardiology	57,324,144							69
69.01	CARDIAC CATH LAB	47,260,069							69.01
69.02	CARDIAC REHABILITATION	2,103,242							69.02
71	Medical Supplies Charged to Pat	132,912,381							71
72	Impl. Dev. Charged to Patients	62,007,973							72
73	Drugs Charged to Patients	108,196,095							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	6,648,022							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	16,761,042							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	13,619,137							90.02
91	Emergency	106,664,464	0.005052	0.005052					91
92	Observation Beds (Non-Distinct	7,776,122							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,497,851,713							200

(A) Worksheet A line numbers

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	0.286678							50
52	Delivery Room & Labor Room	1.291078							52
53	Anesthesiology	0.025951							53
54	Radiology-Diagnostic	0.101949							54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.087657							54.01
56.01	ONCOLOGY	0.066180							56.01
60	Laboratory	0.116608							60
62	Whole Blood & Packed Red Blood	0.357821							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.251295							65
66	Physical Therapy	0.320226							66
69	Electrocardiology	0.167618							69
69.01	CARDIAC CATH LAB	0.093081							69.01
69.02	CARDIAC REHABILITATION	1.360919							69.02
71	Medical Supplies Charged to Pat	0.223390							71
72	Impl. Dev. Charged to Patients	0.438470							72
73	Drugs Charged to Patients	0.301513							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN								73.01
74	Renal Dialysis	0.263723							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	0.557362							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	0.534469							90.02
91	Emergency	0.240131							91
92	Observation Beds (Non-Distinct	1.258378							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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	75,187	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	75,187	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)	64,690	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)	31,325	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)	70,089,363	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)	70,089,363	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)	70,089,363	37

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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)					932.20	38
39	Program general inpatient routine service cost (line 9 x line 38)					29,201,165	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					29,201,165	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	19,694,162	7,988	2,465.47	4,013	9,893,931	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	NEONATAL INTENSIVE CARE UNIT	2,191,973	3,049	718.92			47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					53,017,095	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					92,112,191	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					5,768,892	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					6,598,698	51
52	Total Program excludable cost (sum of lines 50 and 51)					12,367,590	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					79,744,601	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] Title XVIII, Part A [ ] Title XIX - I/P | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] 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)					932.20	88
89	Observation bed cost (line 87 x line 88) (see instructions)					9,785,303	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	10,325,170	70,089,363	0.147314	9,785,303	1,441,512	90
91	Nursing School						91
92	Allied Health	42,659	70,089,363	0.000609	9,785,303	5,959	92
93	Other Medical Education						93

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,867	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,867	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)	12,867	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)	2,479	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)	11,503,689	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)	11,503,689	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)	11,503,689	37

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	894.05	38
39	Program general inpatient routine service cost (line 9 x line 38)	2,216,350	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)	2,216,350	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	118,957	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,335,307	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	341,557	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	11,338	51
52	Total Program excludable cost (sum of lines 50 and 51)	352,895	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,982,412	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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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)	5,724	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,724	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)	5,724	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,598	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	7,352,926	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,352,926	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,352,926	37

Check Applicable Boxes: [ ] Title V - I/P [XX] Title XVIII, Part A [ ] Title XIX - I/P | [ ] Hospital [ ] IPF [XX] IRF | [ ] SUB (Other) | [XX] PPS [ ] TEFRA [ ] 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)	1,284.58	38
39	Program general inpatient routine service cost (line 9 x line 38)	4,621,919	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	4,621,919	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,953,224	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	6,575,143	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	725,141	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	252,269	51
52	Total Program excludable cost (sum of lines 50 and 51)	977,410	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	5,597,733	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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	75,187	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	75,187	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)	64,690	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)	5,263	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)	5,258	15
16	Nursery days (title V or XIX only)	1,111	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)	70,089,363	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)	70,089,363	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)	70,089,363	37

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					932.20	38
39	Program general inpatient routine service cost (line 9 x line 38)					4,906,169	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					4,906,169	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)	2,861,485	5,258	544.22	1,111	604,628	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	19,675,758	7,988	2,463.16	637	1,569,033	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	NEONATAL INTENSIVE CARE UNIT	2,191,973	3,049	718.92	60	43,135	47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,717,886	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					12,840,851	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,047,499	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					686,595	51
52	Total Program excludable cost (sum of lines 50 and 51)					1,734,094	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

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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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)	12,867	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,867	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)	12,867	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)	2,680	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)	11,503,689	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)	11,503,689	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)	11,503,689	37

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

Check Applicable Boxes: [ ] Title V - I/P [XX] Title XVIII, Part A [XX] Title XIX - I/P | [ ] Hospital [XX] IPF [ ] IRF | [ ] SUB (Other) | [ ] PPS [ ] TEFRA [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)	894.05	38
39	Program general inpatient routine service cost (line 9 x line 38)	2,396,054	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)	2,396,054	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	104,464	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,500,518	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	369,251	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	11,519	51
52	Total Program excludable cost (sum of lines 50 and 51)	380,770	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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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)	5,724	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,724	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)	5,724	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)	503	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	7,352,926	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,352,926	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,352,926	37

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,284.58	38
39	Program general inpatient routine service cost (line 9 x line 38)	646,144	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)	646,144	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)	646,144	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	101,375	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)	101,375	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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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		57,838,701		30
31	Intensive Care Unit		18,975,196		31
35	NEONATAL INTENSIVE CARE UNIT				35
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.286678	25,578,337	7,332,746	50
52	Delivery Room & Labor Room	1.291078	1,836	2,370	52
53	Anesthesiology	0.025951	4,190,730	108,754	53
54	Radiology-Diagnostic	0.102000	48,629,596	4,960,219	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.087657			54.01
56.01	ONCOLOGY	0.066546	5,228,394	347,929	56.01
60	Laboratory	0.117414	45,442,735	5,335,613	60
62	Whole Blood & Packed Red Blood Cells	0.357821	3,957,876	1,416,211	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.251295	9,295,449	2,335,900	65
66	Physical Therapy	0.320226	4,912,683	1,573,169	66
69	Electrocardiology	0.180947	6,333,725	1,146,069	69
69.01	CARDIAC CATH LAB	0.093081	8,356,427	777,825	69.01
69.02	CARDIAC REHABILITATION	1.360919	1,215	1,654	69.02
71	Medical Supplies Charged to Patients	0.223390	32,702,760	7,305,470	71
72	Impl. Dev. Charged to Patients	0.438470	18,083,838	7,929,220	72
73	Drugs Charged to Patients	0.301513	25,668,023	7,739,243	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS				73.01
74	Renal Dialysis	0.263723	3,731,150	983,990	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	0.557362	187,834	104,692	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	0.534469	9,027	4,825	90.02
91	Emergency	0.240131	15,038,440	3,611,196	91
92	Observation Beds (Non-Distinct Part)	1.258378			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		257,350,075	53,017,095	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		257,350,075		202

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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		5,900,214		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.286678			50
52	Delivery Room & Labor Room	1.291078			52
53	Anesthesiology	0.025951			53
54	Radiology-Diagnostic	0.102000	10,348	1,055	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.087657			54.01
56.01	ONCOLOGY	0.066546	1,812	121	56.01
60	Laboratory	0.117414	197,685	23,211	60
62	Whole Blood & Packed Red Blood Cells	0.357821			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.251295			65
66	Physical Therapy	0.320226	53,819	17,234	66
69	Electrocardiology	0.180947	10,943	1,980	69
69.01	CARDIAC CATH LAB	0.093081			69.01
69.02	CARDIAC REHABILITATION	1.360919			69.02
71	Medical Supplies Charged to Patients	0.223390	1,436	321	71
72	Impl. Dev. Charged to Patients	0.438470			72
73	Drugs Charged to Patients	0.301513	240,256	72,440	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS				73.01
74	Renal Dialysis	0.263723			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	0.557362	1,611	898	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	0.534469	531	284	90.02
91	Emergency	0.240131	5,883	1,413	91
92	Observation Beds (Non-Distinct Part)	1.258378			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		524,324	118,957	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		524,324		202

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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		6,238,932		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.286678	14,415	4,132	50
52	Delivery Room & Labor Room	1.291078			52
53	Anesthesiology	0.025951	8,412	218	53
54	Radiology-Diagnostic	0.102000	414,983	42,328	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.087657			54.01
56.01	ONCOLOGY	0.066546	13,911	926	56.01
60	Laboratory	0.117414	587,155	68,940	60
62	Whole Blood & Packed Red Blood Cells	0.357821	19,027	6,808	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.251295	324,245	81,481	65
66	Physical Therapy	0.320226	4,650,282	1,489,141	66
69	Electrocardiology	0.180947	24,651	4,461	69
69.01	CARDIAC CATH LAB	0.093081			69.01
69.02	CARDIAC REHABILITATION	1.360919			69.02
71	Medical Supplies Charged to Patients	0.223390	131,031	29,271	71
72	Impl. Dev. Charged to Patients	0.438470	3,569	1,565	72
73	Drugs Charged to Patients	0.301513	575,253	173,446	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS				73.01
74	Renal Dialysis	0.263723	169,909	44,809	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	0.557362	8,333	4,644	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	0.534469			90.02
91	Emergency	0.240131	4,388	1,054	91
92	Observation Beds (Non-Distinct Part)	1.258378			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		6,949,564	1,953,224	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		6,949,564		202

(A) Worksheet A line numbers

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

Check Applicable Boxes:

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

(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	0.286678	1,373,333	393,704	50
52	Delivery Room & Labor Room	1.291078	1,674,306	2,161,660	52
53	Anesthesiology	0.025951	804,222	20,870	53
54	Radiology-Diagnostic	0.101949	3,563,749	363,321	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.087657			54.01
56.01	ONCOLOGY	0.066180	420,924	27,857	56.01
60	Laboratory	0.116608	5,336,971	622,334	60
62	Whole Blood & Packed Red Blood Cells	0.357821	134,241	48,034	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.251295	1,017,327	255,649	65
66	Physical Therapy	0.320226	143,371	45,911	66
69	Electrocardiology	0.167618	526,638	88,274	69
69.01	CARDIAC CATH LAB	0.093081	449,399	41,831	69.01
69.02	CARDIAC REHABILITATION	1.360919			69.02
71	Medical Supplies Charged to Patients	0.223390	3,462,541	773,497	71
72	Impl. Dev. Charged to Patients	0.438470			72
73	Drugs Charged to Patients	0.301513	2,646,130	797,843	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS				73.01
74	Renal Dialysis	0.263723	165,818	43,730	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	0.557362			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	0.534469	3,696	1,975	90.02
91	Emergency	0.240131	130,744	31,396	91
92	Observation Beds (Non-Distinct Part)	1.258378			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		21,853,410	5,717,886	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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
35	NEONATAL INTENSIVE CARE UNIT				35
40	Subprovider - IPF		3,203,790		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.286678			50
52	Delivery Room & Labor Room	1.291078			52
53	Anesthesiology	0.025951			53
54	Radiology-Diagnostic	0.101949	50,286	5,127	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.087657			54.01
56.01	ONCOLOGY	0.066180	12,061	798	56.01
60	Laboratory	0.116608	259,384	30,246	60
62	Whole Blood & Packed Red Blood Cells	0.357821			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.251295			65
66	Physical Therapy	0.320226	1,062	340	66
69	Electrocardiology	0.167618	53,744	9,008	69
69.01	CARDIAC CATH LAB	0.093081			69.01
69.02	CARDIAC REHABILITATION	1.360919			69.02
71	Medical Supplies Charged to Patients	0.223390	14,287	3,192	71
72	Impl. Dev. Charged to Patients	0.438470			72
73	Drugs Charged to Patients	0.301513	65,521	19,755	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS				73.01
74	Renal Dialysis	0.263723			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	0.557362			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	0.534469	66,528	35,557	90.02
91	Emergency	0.240131	1,838	441	91
92	Observation Beds (Non-Distinct Part)	1.258378			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		524,711	104,464	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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
35	NEONATAL INTENSIVE CARE UNIT				35
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.286678			50
52	Delivery Room & Labor Room	1.291078			52
53	Anesthesiology	0.025951			53
54	Radiology-Diagnostic	0.101949			54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.087657			54.01
56.01	ONCOLOGY	0.066180			56.01
60	Laboratory	0.116608			60
62	Whole Blood & Packed Red Blood Cells	0.357821			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.251295			65
66	Physical Therapy	0.320226			66
69	Electrocardiology	0.167618			69
69.01	CARDIAC CATH LAB	0.093081			69.01
69.02	CARDIAC REHABILITATION	1.360919			69.02
71	Medical Supplies Charged to Patients	0.223390			71
72	Impl. Dev. Charged to Patients	0.438470			72
73	Drugs Charged to Patients	0.301513			73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS				73.01
74	Renal Dialysis	0.263723			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	0.557362			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	0.534469			90.02
91	Emergency	0.240131			91
92	Observation Beds (Non-Distinct Part)	1.258378			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

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)	72,786,947			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)	895,266			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	12,459,090			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	307.95			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)	0.0235			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1280			31
32	Sum of lines 30 and 31	0.1515			32
33	Allowable disproportionate share percentage (see instructions)	0.0260			33
34	Disproportionate share adjustment (see instructions)	473,115			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)			5,977,483,147	35
35.01	Factor 3 (see instructions)	0.000000000		0.000274298	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			1,639,612	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			1,639,612	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,639,612			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

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46
47	Subtotal (see instructions)	75,794,940			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)	75,794,940			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	6,306,570			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	127,537			53
54	Special add-on payments for new technologies	13,536			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).	29,894			57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)	84,832			58
59	Total (sum of amounts on lines 49 through 58)	82,357,309			59
60	Primary payer payments	16,600			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	82,340,709			61
62	Deductibles billed to program beneficiaries	7,474,124			62
63	Coinsurance billed to program beneficiaries	123,620			63
64	Allowable bad debts (see instructions)	658,497			64
65	Adjusted reimbursable bad debts (see instructions)	428,023			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	416,519			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	75,170,988			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)	-598,847			70.93
70.94	HRR adjustment amount (see instructions)	-14,561			70.94
70.99	HAC adjustment amount (see instructions)	815,016			70.99
71	Amount due provider (see instructions)	73,742,564			71
71.01	Sequestration adjustment (see instructions)	1,474,851			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	70,961,708			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	1,306,005			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	414,883			75
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96
	HSP Bonus Payment Amount	**Prior to 10/1**	**On or After 10/1**		
100	HSP bonus amount (see instructions)				100
	HVBP Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
	HRR Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

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

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to 10/1		On or after 10/1		Total (cols. 2 and 3)	
		(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments							1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1							1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	72,786,947			72,786,947		72,786,947	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	895,266			895,266		895,266	2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments	12,459,090			12,459,090		12,459,090	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	0.0260	0.0260	0.0260	0.0260	0.0260		10
11	Disproportionate share adjustment	473,115			473,115		473,115	11
11.01	Uncompensated care payments	1,639,612			1,639,612		1,639,612	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	75,794,940			75,794,940		75,794,940	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	75,794,940			75,794,940		75,794,940	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	6,306,570			6,306,570		6,306,570	16
17	Special add-on payments for new technologies	13,536			13,536		13,536	17
17.01	DO NOT USE THIS LINE							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**				82,115,046		82,115,046	19
20	Capital DRG other than outlier	5,891,305			5,891,305		5,891,305	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	231,456			231,456		231,456	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	0.0312	0.0312		0.0312			24
25	Disproportionate share adjustment	183,809			183,809		183,809	25
26	Total prospective capital payments	6,306,570			6,306,570		6,306,570	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	-598,847			-598,847		-598,847	30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment	-14,561			-14,561		-14,561	31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment				815,016		815,016	32

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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)	43,203			1
2	Medical and other services reimbursed under OPPS (see instructions)	53,560,959			2
3	OPPS payments	47,294,733			3
4	Outlier payment (see instructions)	52,595			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)	0.899			5
6	Line 2 times line 5	48,151,302			6
7	Sum of lines 3, 4, and 4.01, divided by line 6	0.9833			7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	100,859			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	43,203			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	116,386			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)	116,386			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)	116,386			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	73,183			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) (see instructions)	43,203			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, 4.01, 8 and 9)	47,448,187			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	12,316			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	9,048,472			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)	38,430,602			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)	38,430,602			30
31	Primary payer payments	5,609			31
32	Subtotal (line 30 minus line 31)	38,424,993			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)	720,865			34
35	Adjusted reimbursable bad debts (see instructions)	468,562			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	527,534			36
37	Subtotal (see instructions)	38,893,555			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)	38,893,555			40
40.01	Sequestration adjustment (see instructions)	777,871			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	38,997,557			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-881,873			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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, 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) (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, 4.01, 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
40.02	Demonstration payment adjustment amount after sequestration				40.02
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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, 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) (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, 4.01, 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
40.02	Demonstration payment adjustment amount after sequestration				40.02
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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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				69,746,515		37,551,006	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				936,693		1,039,451	2
3	List separately each retroactive lump sum adjustment		.01	04/12/2017	278,500	04/12/2017	407,100	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		278,500		407,100	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)				70,961,708		38,997,557	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		1,306,005			6.01
	based on the cost report (1)		.02				-881,873	6.02
7	Total Medicare program liability (see instructions)				72,267,713		38,115,684	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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				2,027,754			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				59,884			2
3	List separately each retroactive lump sum adjustment		.01	04/12/2017	62,900			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		62,900			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				2,150,538			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02		-47,811			6.02
7	Total Medicare program liability (see instructions)				2,102,727			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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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				5,112,896			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)				5,112,896			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		131,590			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				5,244,486			7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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

CALCULATION OF REIMBURSEMENT SETTLEMENT **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)	2,273,660	1
2	Net IPF PPS Outlier payment	4,497	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)	35.252055	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)	2,278,157	12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	2,278,157	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	2,278,157	18
19	Deductibles	189,644	19
20	Subtotal (line 18 minus line 19)	2,088,513	20
21	Coinsurance	19,376	21
22	Subtotal (line 20 minus line 21)	2,069,137	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	110,557	23
24	Adjusted reimbursable bad debts (see instructions)	71,862	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	86,428	25
26	Subtotal (sum of lines 22 and 24)	2,140,999	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)	4,641	28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions)		30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	2,145,640	31
31.01	Sequestration adjustment (see instructions)	42,913	31.01
31.02	Demonstration payment adjustment amount after sequestration		31.02
32	Interim payments	2,150,538	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	-47,811	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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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)	4,953,804		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)			2
3	Inpatient Rehabilitation LIP payments (see instructions)	134,248		3
4	Outlier payments	314,047		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)	15.682192		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	5,402,099		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)	5,402,099		17
18	Primary payer payments	13,573		18
19	Subtotal (line 17 less line 18)	5,388,526		19
20	Deductibles	18,284		20
21	Subtotal (line 19 minus line 20)	5,370,242		21
22	Coinsurance	18,753		22
23	Subtotal (line 21 minus line 22)	5,351,489		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)	5,351,489		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)	27		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)	5,351,516		32
32.01	Sequestration adjustment (see instructions)	107,030		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	5,112,896		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34)	131,590		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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0252** **WORKSHEET E-3 PART VII**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XIX** **[XX] Hospital** **[ ] SUB (Other)** **[ ] 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	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	12,840,851		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	12,840,851		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	12,840,851		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)	20,219,154		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)	12,840,851		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)	12,840,851		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)	12,840,851		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)	12,840,851		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	12,840,851		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)	12,840,851		40
41	Interim payments	10,538,023		41
42	Balance due provider/program (line 40 minus line 41)	2,302,828		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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

Check Applicable Boxes: **[ ] Title V** **[XX] Title XIX** **[ ] Hospital** **[XX] Subprovider IPF** **[ ] 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	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	2,500,518		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	2,500,518		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	2,500,518		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)	1,227,983		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)	2,500,518		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)	2,500,518		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)	2,500,518		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)	2,500,518		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	2,500,518		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)	2,500,518		40
41	Interim payments	2,695,307		41
42	Balance due provider/program (line 40 minus line 41)	-194,789		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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	646,144		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	646,144		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	646,144		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)	646,144		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)	646,144		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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	19,039,838				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	63,419,350				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory					7
8	Prepaid expenses	12,250,097				8
9	Other current assets	9,817,495				9
10	Due from other funds	58,526,918				10
11	Total current assets (sum of lines 1-10)	163,053,698				11
	FIXED ASSETS					
12	Land	89,072				12
13	Land improvements	14,474,755				13
14	Accumulated depreciation					14
15	Buildings	307,551,751				15
16	Accumulated depreciation	-300,000,000				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	216,056,242				19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	195,493,728				23
24	Accumulated depreciation	-60,871,419				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable	5,292,239				29
30	Total fixed assets (sum of lines 12-29)	378,086,368				30
	OTHER ASSETS					
31	Investments	12,643,063				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	14,262,957				34
35	Total other assets (sum of lines 31-34)	26,906,020				35
36	Total assets (sum of lines 11, 30 and 35)	568,046,086				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	19,418,279				37
38	Salaries, wages and fees payable	32,051,741				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	7,315,000				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	1,184,016				43
44	Other current liabilities	51,231,663				44
45	Total current liabilities (sum of lines 37 thru 44)	111,200,699				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	252,175,837				47
48	Unsecured loans					48
49	Other long term liabilities	17,776,822				49
50	Total long term liabilities (sum of lines 46 thru 49)	269,952,659				50
51	Total liabilities (sum of lines 45 and 50)	381,153,358				51
	CAPITAL ACCOUNTS					
52	General fund balance	186,892,728				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)	186,892,728				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	568,046,086				60

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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		194,690,121			1
2	Net income (loss) (from Worksheet G-3, line 29)		-7,797,393			2
3	Total (sum of line 1 and line 2)		186,892,728			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)		186,892,728			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)		186,892,728			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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	126,185,454		126,185,454	1
2	Subprovider IPF	20,330,370		20,330,370	2
3	Subprovider IRF	10,007,028		10,007,028	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)	156,522,852		156,522,852	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	40,138,127		40,138,127	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	NEONATAL INTENSIVE CARE UNIT	9,750,869		9,750,869	15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	49,888,996		49,888,996	16
17	Total inpatient routine care services (sum of lines 10 and 16)	206,411,848		206,411,848	17
18	Ancillary services	560,599,722	937,252,073	1,497,851,795	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		7,853,701	7,853,701	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	OTHER PATIENT REVENUES	2,303,492	350,581	2,654,073	27
		3,639,666	9,822,821	13,462,487	
			876,246	876,246	
		583,693	341,437	925,130	
			8,190	8,190	
			281,634	281,634	
			156,342	156,342	
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	773,538,421	956,943,025	1,730,481,446	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		456,688,867	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)		456,688,867	43

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	1,730,481,446	1
2	Less contractual allowances and discounts on patients' accounts	1,288,599,223	2
3	Net patient revenues (line 1 minus line 2)	441,882,223	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	456,688,867	4
5	Net income from service to patients (line 3 minus line 4)	-14,806,644	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)	-7,797,393	26
29	Net income (or loss) for the period (line 26 minus line 28)	-7,797,393	29

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	1,369,955	99,816			201,566	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,693,629	123,399	53,338			6
7	Physical Therapy	1,407,047	102,519	42,168			7
8	Occupational Therapy	230,013	16,759	6,348			8
9	Speech Pathology	24,289	1,770	662			9
10	Medical Social Services	83,424	6,078	1,029			10
11	Home Health Aide	87,063	6,344	3,708			11
12	Supplies (see instructions)					198,908	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)	4,895,420	356,685	107,253		400,474	24

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	1,671,337		1,671,337		1,671,337	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,870,366		1,870,366		1,870,366	6
7	Physical Therapy	1,551,734		1,551,734		1,551,734	7
8	Occupational Therapy	253,120		253,120		253,120	8
9	Speech Pathology	26,721		26,721		26,721	9
10	Medical Social Services	90,531		90,531		90,531	10
11	Home Health Aide	97,115		97,115		97,115	11
12	Supplies (see instructions)	198,908		198,908		198,908	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)	5,759,832		5,759,832		5,759,832	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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	1,671,337				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	1,870,366				6
7	Physical Therapy	1,551,734				7
8	Occupational Therapy	253,120				8
9	Speech Pathology	26,721				9
10	Medical Social Services	90,531				10
11	Home Health Aide	97,115				11
12	Supplies (see instructions)	198,908				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)	5,759,832				24

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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		1,671,337	1,671,337		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		1,870,366	800,335	2,670,701	6
7	Physical Therapy		1,551,734	603,246	2,154,980	7
8	Occupational Therapy		253,120	79,740	332,860	8
9	Speech Pathology		26,721	10,914	37,635	9
10	Medical Social Services		90,531	57,061	147,592	10
11	Home Health Aide		97,115	28,768	125,883	11
12	Supplies (see instructions)		198,908	27,157	226,065	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			64,116	64,116	23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		5,759,832		5,759,832	24

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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					-1,671,337	18,518,099	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care					6,997,162	8,867,528	6
7	Physical Therapy					5,132,137	6,683,871	7
8	Occupational Therapy					630,388	883,508	8
9	Speech Pathology					94,207	120,928	9
10	Medical Social Services					541,695	632,226	10
11	Home Health Aide					221,630	318,745	11
12	Supplies (see instructions)					101,991	300,899	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)					12,758,267	18,518,099	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						1,671,337	25
26	Unit Cost Multiplier						0.090254	26

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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		213,724	25,248	235,397	474,369	133,894	1
2	Skilled Nursing Care	2,670,701			291,011	2,961,712	835,967	2
3	Physical Therapy	2,154,980			241,770	2,396,750	676,502	3
4	Occupational Therapy	332,860			39,523	372,383	105,108	4
5	Speech Pathology	37,635			4,174	41,809	11,801	5
6	Medical Social Services	147,592			14,335	161,927	45,705	6
7	Home Health Aide	125,883			14,960	140,843	39,754	7
8	Supplies	226,065				226,065	63,809	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	64,116				64,116	18,097	19
20	Totals (sum of lines 1-19)(2)	5,759,832	213,724	25,248	841,170	6,839,974	1,930,637	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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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		361,931		121,158			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)		361,931		121,158			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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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					36,261		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)					36,261		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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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						1,127,613	1
2	Skilled Nursing Care						3,797,679	2
3	Physical Therapy						3,073,252	3
4	Occupational Therapy						477,491	4
5	Speech Pathology						53,610	5
6	Medical Social Services						207,632	6
7	Home Health Aide						180,597	7
8	Supplies						289,874	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						82,213	19
20	Totals (sum of lines 1-19)(2)						9,289,961	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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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		1,127,613					1
2	Skilled Nursing Care		3,797,679	524,642	4,322,321			2
3	Physical Therapy		3,073,252	424,564	3,497,816			3
4	Occupational Therapy		477,491	65,964	543,455			4
5	Speech Pathology		53,610	7,406	61,016			5
6	Medical Social Services		207,632	28,684	236,316			6
7	Home Health Aide		180,597	24,949	205,546			7
8	Supplies		289,874	40,046	329,920			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		82,213	11,358	93,571			19
20	Totals (sum of lines 1-19)(2)		9,289,961	1,127,613	9,289,961			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.			0.138148				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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	25,437	1,369,955		474,369		1
2	Skilled Nursing Care			1,693,629		2,961,712		2
3	Physical Therapy			1,407,047		2,396,750		3
4	Occupational Therapy			230,013		372,383		4
5	Speech Pathology			24,289		41,809		5
6	Medical Social Services			83,424		161,927		6
7	Home Health Aide			87,063		140,843		7
8	Supplies					226,065		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					64,116		19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	5,176	25,437	4,895,420		6,839,974		20
21	Total cost to be allocated	213,724	25,248	841,170		1,930,637		21
22	Unit Cost Multiplier	41.291345		0.171828		0.282258		22
22	Unit Cost Multiplier		0.992570					22

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	361,931		121,158				21
22	Unit Cost Multiplier	69.924845		23.407651				22
22	Unit Cost Multiplier							22

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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				7,853,701			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)				7,853,701			20
21	Total cost to be allocated				36,261			21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier				0.004617			22

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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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	4,322,321		4,322,321	17,151	252.02	1
2	Physical Therapy	3	3,497,816		3,497,816	15,339	228.03	2
3	Occupational Therapy	4	543,455		543,455	2,634	206.32	3
4	Speech Pathology	5	61,016		61,016	323	188.90	4
5	Medical Social Services	6	236,316		236,316	322	733.90	5
6	Home Health Aide	7	205,546		205,546	1,322	155.48	6
7	Total (sum of lines 1-6)		8,866,470		8,866,470	37,091		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		10,170		8.01
8.02	Skilled Nursing Care	20994		7		8.02
8.03	Skilled Nursing Care	29404		72		8.03
9	Physical Therapy	11340				9
9.01	Physical Therapy	16974		9,179		9.01
9.02	Physical Therapy	20994		6		9.02
9.03	Physical Therapy	29404		113		9.03
10	Occupational Therapy	11340				10
10.01	Occupational Therapy	16974		1,759		10.01
10.02	Occupational Therapy	20994				10.02
10.03	Occupational Therapy	29404		48		10.03
11	Speech Pathology	11340				11
11.01	Speech Pathology	16974		189		11.01
11.02	Speech Pathology	20994				11.02
11.03	Speech Pathology	29404		9		11.03
12	Medical Social Services	11340				12
12.01	Medical Social Services	16974		257		12.01
12.02	Medical Social Services	20994				12.02
12.03	Medical Social Services	29404				12.03
13	Home Health Aide	11340				13
13.01	Home Health Aide	16974		727		13.01
13.02	Home Health Aide	20994				13.02
13.03	Home Health Aide	29404		3		13.03
14	Total (sum of lines 8-13)			22,539		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	329,920	57,935	387,855	259,344	1.495523	15
16	Cost of Drugs	9						16

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

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	66	0.320226			col. 2, line 2	1

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

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	0.223390	259,344	57,935	col. 2, line 15	4
5	Drugs Charged to Patients	73	0.301513			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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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		10,249			2,582,953		2,582,953	1
2	Physical Therapy		9,298			2,120,223		2,120,223	2
3	Occupational Therapy		1,807			372,820		372,820	3
4	Speech Pathology		198			37,402		37,402	4
5	Medical Social Services		257			188,612		188,612	5
6	Home Health Aide		730			113,500		113,500	6
7	Total (sum of lines 1-6)		22,539			5,415,510		5,415,510	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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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		4,544,765	11
12	Total PPS Reimbursement - Full Episodes with Outliers		259,427	12
13	Total PPS Reimbursement - LUPA Episodes		72,987	13
14	Total PPS Reimbursement - PEP Episodes		44,186	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers			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)		4,921,365	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		4,921,365	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		4,921,365	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)		4,921,365	29
30	Other adjustments (see instructions) (specify)		-2,647	30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		4,918,718	31
31.01	Sequestration adjustment (see instructions)		98,373	31.01
31.02	Demonstration payment adjustment amount after sequestration			31.02
32	Interim payments (see instructions)		4,820,345	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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						4,820,345	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)						4,820,345	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)						4,820,345	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: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	5,891,305	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	231,456	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)	209.24	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)	0.0235	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.1280	8
9	Sum of lines 7 and 8	0.1515	9
10	Allowable disproportionate share percentage (see instructions)	0.0312	10
11	Disproportionate share adjustment (see instructions)	183,809	11
12	Total prospective capital payments (see instructions)	6,306,570	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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/26/2018 Run Time: 20:41 Version: 2018.01 (02/22/2018)

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

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
192.04	EMS CONTINUING EDUCATION							192.04
194	CORPORATE HEALTH							194
194.01	MARKETING/COMMUNICATION							194.01
194.02	FOUNDATION							194.02
194.03	OTHER NRCC							194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202