

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.  ELECTRONICALLY FILED COST REPORT DATE: 01-28-2013 TIME: 11:57  
 2.  MANUALLY SUBMITTED COST REPORT  
 3.  IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT  
 4.  MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY 5.  COST REPORT STATUS 6. DATE RECEIVED: \_\_\_\_\_ 10. NPR DATE: \_\_\_\_\_  
 1 - AS SUBMITTED 7. CONTRACTOR NO: \_\_\_\_\_ 11. CONTRACTOR'S VENDOR CODE: \_\_\_\_\_  
 2 - SETTLED WITHOUT AUDIT 8.  INITIAL REPORT FOR THIS PROVIDER CCN 12.  IF LINE 5, COLUMN 1 IS 4: ENTER  
 3 - SETTLED WITH AUDIT 9.  FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.  
 4 - REOPENED  
 5 - AMENDED

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 WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY NORTHWESTERN LAKE FOREST HOSPITAL (14-0130) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 09/01/2011 AND ENDING 08/31/2012, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) \_\_\_\_\_  
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)  
 \_\_\_\_\_  
 TITLE  
 \_\_\_\_\_  
 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		122,044	197,609	-51,498		1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF						5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC						10
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		122,044	197,609	-51,498		200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID 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.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 660 WESTMORELAND ROAD  
 2 CITY: LAKE FOREST

STATE: IL

P.O.BOX:  
 ZIP CODE: 60045

COUNTY: LAKE

1  
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)				
						V 6	XVIII 7	XIX 8		
3	HOSPITAL	NORTHWESTERN LAKE FOREST HOSPI	14-0130	29404	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF	NORTHWESTERN LAKE FOREST HOSPI	14-5216	29404		07/01/1970	N	P	N	9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA	NORTHWESTERN LAKE FOREST HOME	14-7045	29404		07/01/1966	N	P	N	12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 09/01/2011				TO: 08/31/2012				20
21	TYPE OF CONTROL									21

INPATIENT PPS INFORMATION

22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND '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.									1	2
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		OUT-OF-STATE		OUT-OF-STATE		OTHER
		MEDICAID PAID DAYS	MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID PAID DAYS	MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO UNPAID DAYS	MEDICAID DAYS	
		1	2	3	4	5	6	
24	IF THIS PROVIDER IS AN IPHS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.					1		26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.					1		27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V	XVIII	XIX
		1	2	3
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
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 RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	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			
1		2	3	4	5
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

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 1	PROGRAM CODE 2	UNWEIGHTED FTEs NONPROVIDER SITE 3	UNWEIGHTED FTEs IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5
<b>INPATIENT PSYCHIATRIC FACILITY PPS</b>				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
<b>INPATIENT REHABILITATION FACILITY PPS</b>				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
<b>LONG TERM CARE HOSPITAL PPS</b>				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
<b>TEFRA PROVIDERS</b>				
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.			N 86
<b>TITLE V AND XIX INPATIENT SERVICES</b>				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			V 1 XIX 2 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/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
<b>RURAL PROVIDERS</b>				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 N 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108
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.		PHY- OCCUP- SICAL ATIONAL N	RESPI- RATORY 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-18 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 897,505 PAID LOSSES: 1,847,885 SELF INSURANCE: 1,446,007			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 IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

ALL PROVIDERS

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.	1 Y	2 HB0640	140
-----	--	--------	-------------	-----

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141	NAME: NORTHWESTERN MEMORIAL HEALTHCA	CONTRACTOR'S NAME: NGS	CONTRACTOR'S NUMBER: 001310	141
142	STREET: 251 E HURON ST	P.O. BOX:		142
143	CITY: CHICAGO	STATE: IL	ZIP CODE: 60611	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)

	TITLE XVIII	TITLE	TITLE	
	PART A	PART B	V	
	1	2	3	
			XIX	
			4	
155	HOSPITAL	N	N	155
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC	N	N	161

PROVIDER CCN: 14-0130 NORTHWESTERN LAKE FOREST HOSPI  
PERIOD FROM 09/01/2011 TO 08/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11  
01/28/2013 11:57

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I (CONT)

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? N 165  
ENTER 'Y' FOR YES OR 'N' FOR NO.

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.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
0	1	2	3	4	5

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167 IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO. Y 167

168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'),  
ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. 168

169 IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH  
(LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR. 1.00 169

HOSPITAL AND 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		
<b>PROVIDER ORGANIZATION AND OPERATION</b>					
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)	1 N	2	1	
		Y/N	DATE	V/I	
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.	1 N	2	3 2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	Y		3	
<b>FINANCIAL DATA AND REPORTS</b>					
		Y/N	TYPE	DATE	
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.	1 Y	2 A	3 4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
<b>APPROVED EDUCATIONAL ACTIVITIES</b>					
		Y/N		Y/N	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1 N	2	6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
				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	
<b>BED COMPLEMENT</b>					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
<b>PS&amp;R REPORT DATA</b>					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
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)	1 N	2	3 N	4 16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	11/15/2012	Y	11/15/2012 17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21

HOSPITAL AND 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 RELIEFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS. 22
- 23 HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS  
MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 23
- 24 WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS  
COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 24
- 25 HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING  
PERIOD? IF YES, SEE INSTRUCTIONS. 25
- 26 WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING  
PERIOD? IF YES, SEE INSTRUCTIONS. 26
- 27 HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD?  
IF YES, SEE INSTRUCTIONS. 27

INTEREST EXPENSE

- 28 WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING  
THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 28
- 29 DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT  
SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE  
INSTRUCTIONS. 29
- 30 HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT?  
IF YES, SEE INSTRUCTIONS. 30
- 31 HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT?  
IF YES, SEE INSTRUCTIONS. 31

PURCHASED SERVICES

- 32 HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED  
THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE  
INSTRUCTIONS. 32
- 33 IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING  
TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS. 33

PROVIDER-BASED PHYSICIANS

- 34 ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH  
PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS. 34
- 35 IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH  
THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE  
INSTRUCTIONS. 35

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

- |   |                                  |                         |    |
|---|----------------------------------|-------------------------|----|
| 41 FIRST NAME: JOHN                         | LAST NAME: VANDER LAAN           | TITLE: MANAGER OF REIMB | 41 |
| 42 EMPLOYER: NORTHWESTERN MEMORIAL HOSPITAL |                                  |                         | 42 |
| 43 PHONE NUMBER: 3129266618                 | E-MAIL ADDRESS: JVANDERL@NMH.ORG |                         | 43 |





HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	94,334,775		94,334,775	2,707,512.00	34.84	1
2							2
3							3
4							4
4.01							4.01
5		3,456,902		3,456,902	20,239.00	170.80	5
6							6
7	21						7
7.01							7.01
8							8
9	44	3,068,431		3,068,431	101,720.00	30.17	9
10		12,261,106	19,211	12,280,317	134,295.00	91.44	10
OTHER WAGES & RELATED COSTS							
11							11
12							12
13							13
14		6,615,899		6,615,899	121,287.00	54.55	14
15							15
16							16
WAGE-RELATED COSTS							
17		17,544,905		17,544,905			17
18							18
19		2,304,039		2,304,039			19
20							20
21							21
22							22
22.01							22.01
23							23
24							24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26		125,282		125,282	4,377.00	28.62	26
27		15,312,236		15,312,236	455,205.00	33.64	27
28							28
29							29
30		1,765,064		1,765,064	72,254.00	24.43	30
31		284,610		284,610	20,068.00	14.18	31
32		1,404,106	-19,211	1,384,895	97,211.00	14.25	32
33							33
34		21,155		21,155	400.00	52.89	34
35							35
36							36
37		502,918		502,918	17,543.00	28.67	37
38		2,503,392		2,503,392	53,902.00	46.44	38
39		723,858		723,858	39,002.00	18.56	39
40		1,551,498		1,551,498	35,080.00	44.23	40
41		1,526,577		1,526,577	49,202.00	31.03	41
42							42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	90,877,873		90,877,873	2,687,273.00	33.82	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	15,329,537	19,211	15,348,748	236,015.00	65.03	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	75,548,336	-19,211	75,529,125	2,451,258.00	30.81	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	6,615,899		6,615,899	121,287.00	54.55	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	17,544,905		17,544,905		23.238	5
6	TOTAL (SUM OF LINES 3 THRU 5)	99,709,140	-19,211	99,689,929	2,572,545.00	38.75	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	25,720,696	-19,211	25,701,485	844,244.00	30.44	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS	1,764,268	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)	1,666,666	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)	4,310,017	8
9 PRESCRIPTION DRUG PLAN	2,172,001	9
10 DENTAL, HEARING AND VISION PLAN	525,115	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	91,234	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	934,537	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	908,261	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	6,825,165	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE	470,399	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	181,281	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	19,848,944	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

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	BENEFIT
0		LABOR	COST
		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

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7045

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY:

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS						1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION						2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: .00	----- NUMBER OF EMPLOYEES ----- (FULL TIME EQUIVALENT)			TOTAL 3	
	STAFF 1	CONTRACT 2			
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)					3
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)					4
5 OTHER ADMINISTRATIVE PERSONNEL		0.54		0.54	5
6 DIRECT NURSING SERVICE		14.10		14.10	6
7 NURSING SUPERVISOR		2.51		2.51	7
8 PHYSICAL THERAPY SERVICE		5.99		5.99	8
9 PHYSICAL THERAPY SUPERVISOR					9
10 OCCUPATIONAL THERAPY SERVICE					10
11 OCCUPATIONAL THERAPY SUPERVISOR					11
12 SPEECH PATHOLOGY SERVICE					12
13 SPEECH PATHOLOGY SUPERVISOR					13
14 MEDICAL SOCIAL SERVICE		0.54		0.54	14
15 MEDICAL SOCIAL SERVICE SUPERVISOR					15
16 HOME HEALTH AIDE		1.62		1.62	16
17 HOME HEALTH AIDE SUPERVISOR					17
18 OTHER (SPECIFY)					18

HOME HEALTH AGENCY CBSA CODES

19 ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.					2	19
20 LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE).					16974	20
20.01					29404	20.01

PPS ACTIVITY

	FULL EPISODES		LUPA EPISODES 3	PEP ONLY EPISODES 4	TOTAL (COLS. 1-4) 5	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2				
21 SKILLED NURSING VISITS	4,817	92	252	115	5,276	21
22 SKILLED NURSING VISIT CHARGES	1,323,886	24,617	72,417	31,481	1,452,401	22
23 PHYSICAL THERAPY VISITS	3,210	45	53	53	3,361	23
24 PHYSICAL THERAPY VISIT CHARGES	903,492	12,651	15,489	14,991	946,623	24
25 OCCUPATIONAL THERAPY VISITS	28				28	25
26 OCCUPATIONAL THERAPY VISIT CHARGES	8,097				8,097	26
27 SPEECH PATHOLOGY VISITS	70			2	72	27
28 SPEECH PATHOLOGY VISIT CHARGES	19,855			616	20,471	28
29 MEDICAL SOCIAL SERVICE VISITS	193	36		4	233	29
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	74,691	13,932		1,548	90,171	30
31 HOME HEALTH AIDE VISITS	635	67		2	704	31
32 HOME HEALTH AIDE VISIT CHARGES	105,410	11,122		332	116,864	32
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	8,953	240	305	176	9,674	33
34 OTHER CHARGES	44,237	514	2,773	319	47,843	34
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	2,479,668	62,836	90,679	49,287	2,682,470	35
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	605		102	16	723	36
37 TOTAL NUMBER OF OUTLIER EPISODES		6		1	7	37
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES						38

PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE				
		1	2				
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1			
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	N		2			
							TOTAL (COLS. 2 + 3)
	GROUP				SNF DAYS	SWING BED SNF DAYS	
	1				2	3	4
3	RUX						3
4	RUL						4
5	RVX						5
6	RVL						6
7	RHX						7
8	RHL						8
9	RMX						9
10	RML						10
11	RLX						11
12	RUC				849		849
13	RUB				1,678		1,678
14	RUA				480		480
15	RVC				1,434		1,434
16	RVB				2,181		2,181
17	RVA				782		782
18	RHC				727		727
19	RHB				514		514
20	RHA				210		210
21	RMC				250		250
22	RMB				275		275
23	RMA				109		109
24	RLB						24
25	RLA						25
26	ES3						26
27	ES2						27
28	ES1				13		13
29	HE2						29
30	HE1				33		33
31	HD2				7		7
32	HD1				4		4
33	HC2						33
34	HC1				9		9
35	HB2						35
36	HB1				20		20
37	LE2						37
38	LE1				76		76
39	LD2						39
40	LD1						40
41	LC2						41
42	LC1						42
43	LB2						43
44	LB1				28		28
45	CE2				7		7
46	CE1				11		11
47	CD2						47
48	CD1						48
49	CC2				2		2
50	CC1				104		104
51	CB2						51
52	CB1				23		23
53	CA2						53
54	CA1				47		47
55	SE3						55
56	SE2						56
57	SE1						57
58	SSC						58
59	SSB						59
60	SSA						60
61	IB2						61
62	IB1						62
63	IA1						63
64	IA2						64
65	BB2						65
66	BB1						66
67	BA2						67
68	BA1						68

PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

		GROUP	SNF	SWING BED	TOTAL
		1	DAYS	SNF DAYS	(COLS.
			2	3	2 + 3)
					4
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1		14		14 72
73	PC2				73
74	PC1		19		19 74
75	PB2				75
76	PB1		13		13 76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL		9,919		9,919 200

CBSA AT CBSA ON/AFTER  
 BEGINNING OCT 1 OF THE  
 OF COST COST REPORTING  
 REPORTING PERIOD (IF  
 PERIOD APPLICABLE)  
 1 2

SNF SERVICES

201 ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY,  
 IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN  
 EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (IF APPLICABLE). 201

A NOTICE PUBLISHED IN THE FEDERAL REGISTER VOLUME 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING  
 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. FOR LINES 202 THROUGH 207:  
 ENTER IN COLUMN 1 THE AMOUNT OF THE EXPENSE FOR EACH CATEGORY. ENTER IN COLUMN 2 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY  
 TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 7, COLUMN 3. IN COLUMN 3, ENTER 'Y' OR 'N' FOR NO IF THE SPENDING REFLECTS  
 INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)

		EXPENSES	PERCENTAGE	ASSOCIATED	
		1	2	WITH	
				DIRECT	
				PATIENT	
				CARE AND	
				RELATED	
				EXPENSES?	
202	STAFFING			Y	202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING			Y	205
206	OTHER (OTHER (STAFF MEETINGS))			Y	206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)	9,438,122			207

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.300915	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				678,331	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?					4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				48,716,678	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				14,659,579	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.				13,981,248	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				13,981,248	19
		UNINSURED	INSURED		TOTAL	
		PATIENTS	PATIENTS			
		1	2		3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	21,682,087	4,040,085		25,722,172	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	6,524,465	1,215,722		7,740,187	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	46,065	77,349		123,414	22
23	COST OF CHARITY CARE	6,478,400	1,138,373		7,616,773	23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					N 24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)				7,596,043	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				340,926	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				7,255,117	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				2,183,174	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				9,799,947	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				23,781,195	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100		19,343,648	19,343,648	-2,071,472	1
2	00200				7,526,619	2
3	00300					3
4	00400	125,282	16,421,806	16,547,088		4
5	00500	15,312,236	47,840,696	63,152,932	-6,412,449	5
6	00600					6
7	00700	1,765,064	6,017,518	7,782,582	331,570	7
8	00800	284,610	204,639	489,249		8
9	00900	1,404,106	1,154,356	2,558,462	-19,211	9
10	01000	21,155	3,982,235	4,003,390		10
11	01100		790,570	790,570		11
12	01200	502,918	986,713	1,489,631		12
13	01300	2,503,392	583,201	3,086,593	14,637	13
14	01400	723,858	274,579	998,437	-26,065	14
15	01500	1,551,498	7,957,402	9,508,900	-7,254,625	15
16	01600	1,526,577	2,831,739	4,358,316	8,233	16
17	01700					17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	11,145,105	948,522	12,093,627	-1,737,179	30
31	03100	1,748,794	240,909	1,989,703	-114,294	31
43	04300	719,493	72,395	791,888	1,012,137	43
44	04400	3,068,431	276,676	3,345,107	73,742	44
45	04500	1,497,135	889,770	2,386,905	19,211	45
46	04600					46
ANCILLARY SERVICE COST CENTERS						
50	05000	7,630,891	14,513,407	22,144,298	-13,365,105	50
52	05200	2,515,712	507,602	3,023,314	-379,185	52
54	05400	5,696,831	4,880,740	10,577,571	-1,344,221	54
55	05500	784,262	358,065	1,142,327	2,466	55
57	05700	570,216	443,663	1,013,879	-131,447	57
58	05800	2,120,137	920,365	3,040,502	-288,428	58
59	05900	554,018	1,460,412	2,014,430	-1,381,909	59
60	06000	3,405,575	4,672,887	8,078,462	160,924	60
62.30	06250					62.30
65	06500	919,041	147,600	1,066,641	-126,725	65
66	06600	3,865,523	202,242	4,067,765	46,535	66
68	06800	1,142,439	388,252	1,530,691	-254,542	68
69	06900	502,661	75,994	578,655	16,963	69
70	07000	320,496	8,065	328,561		70
71	07100				10,113,744	71
72	07200				7,429,491	72
73	07300				9,429,965	73
76.97	07697	452,624	46,791	499,415		76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	469,046	50,003	519,049	-11,403	90.01
90.02	09002	236,958	616,788	853,746	-165,784	90.02
91	09100	8,243,585	929,989	9,173,574	-640,758	91
92	09200					92
92.01	09201	241,135	7,403	248,538	-47	92.01
OTHER REIMBURSABLE COST CENTERS						
101	10100	2,520,457	1,034,396	3,554,853	27,850	101
SPECIAL PURPOSE COST CENTERS						
118		86,091,261	142,082,038	228,173,299	489,238	118
NONREIMBURSABLE COST CENTERS						
190	19000	378,085	1,002,157	1,380,242		190
192	19200	2,979,059	3,145,359	6,124,418	-424,733	192
194	07950	3,755,889	4,304,387	8,060,276	794	194
194.01	07951	1,130,481	197,714	1,328,195	-65,299	194.01
200		94,334,775	150,731,655	245,066,430		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	17,272,176	-6,111,155	11,161,021	1
2	00200	CAP REL COSTS-MVBLE EQUIP	7,526,619	-2,069,300	5,457,319	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	16,547,088	-12,684	16,534,404	4
5	00500	ADMINISTRATIVE & GENERAL	56,740,483	-2,621,966	54,118,517	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	8,114,152	-48,051	8,066,101	7
8	00800	LAUNDRY & LINEN SERVICE	489,249	-498	488,751	8
9	00900	HOUSEKEEPING	2,539,251	-90	2,539,161	9
10	01000	DIETARY	4,003,390	-701,663	3,301,727	10
11	01100	CAFETERIA	790,570	-373,534	417,036	11
12	01200	MAINTENANCE OF PERSONNEL	1,489,631	-102,191	1,387,440	12
13	01300	NURSING ADMINISTRATION	3,101,230		3,101,230	13
14	01400	CENTRAL SERVICES & SUPPLY	972,372	-58	972,314	14
15	01500	PHARMACY	2,254,275	972	2,255,247	15
16	01600	MEDICAL RECORDS & LIBRARY	4,366,549	-137,484	4,229,065	16
17	01700	SOCIAL SERVICE				17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	10,356,448	-2,587	10,353,861	30
31	03100	INTENSIVE CARE UNIT	1,875,409		1,875,409	31
43	04300	NURSERY	1,804,025		1,804,025	43
44	04400	SKILLED NURSING FACILITY	3,418,849		3,418,849	44
45	04500	NURSING FACILITY	2,406,116	-67,312	2,338,804	45
46	04600	OTHER LONG TERM CARE				46
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	8,779,193		8,779,193	50
52	05200	DELIVERY ROOM & LABOR ROOM	2,644,129	-107,846	2,536,283	52
54	05400	RADIOLOGY-DIAGNOSTIC	9,233,350	-695	9,232,655	54
55	05500	RADIOLOGY-THERAPEUTIC	1,144,793		1,144,793	55
57	05700	COMPUTED TOMOGRAPHY (CT) SCAN	882,432		882,432	57
58	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,752,074		2,752,074	58
59	05900	CARDIAC CATHETERIZATION	632,521		632,521	59
60	06000	LABORATORY	8,239,386	-152,070	8,087,316	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	939,916		939,916	65
66	06600	PHYSICAL THERAPY	4,114,300	-93,951	4,020,349	66
68	06800	SPEECH PATHOLOGY	1,276,149	-1,230	1,274,919	68
69	06900	ELECTROCARDIOLOGY	595,618	-19,000	576,618	69
70	07000	ELECTROENCEPHALOGRAPHY	328,561		328,561	70
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	10,113,744		10,113,744	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	7,429,491		7,429,491	72
73	07300	DRUGS CHARGED TO PATIENTS	9,429,965		9,429,965	73
76.97	07697	CARDIAC REHABILITATION	499,415	-4,140	495,275	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	507,646		507,646	90.01
90.02	09002	WOUND CLINIC	687,962		687,962	90.02
91	09100	EMERGENCY	8,532,816	-3,856,459	4,676,357	91
92	09200	OBSERVATION BEDS				92
92.01	09201	OBSERVATION BEDS-DISTINCT	248,491		248,491	92.01
OTHER REIMBURSABLE COST CENTERS						
101	10100	HOME HEALTH AGENCY	3,582,703	-1,700,144	1,882,559	101
SPECIAL PURPOSE COST CENTERS						
118		SUBTOTALS (SUM OF LINES 1-117)	228,662,537	-18,183,136	210,479,401	118
NONREIMBURSABLE COST CENTERS						
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,380,242	-1,380,242		190
192	19200	PHYSICIANS' PRIVATE OFFICES	5,699,685	-5,699,685		192
194	07950	HEALTH & FITNESS CENTER	8,061,070	-8,061,070		194
194.01	07951	OCCUPATIONAL HEALTH	1,262,896	-6,319	1,256,577	194.01
200		TOTAL (SUM OF LINES 118-199)	245,066,430	-33,330,452	211,735,978	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER 2	INCREASE		OTHER
			LINE #	SALARY	
1			3	4	5
1 IMPLANT RECLASS	A	IMPL. DEV. CHARGED TO PATIENT	72		7,429,491
2 IMPLANT RECLASS	A				2
3 IMPLANT RECLASS	A				3
4 IMPLANT RECLASS	A				4
5 IMPLANT RECLASS	A				5
500 TOTAL RECLASSIFICATIONS					7,429,491
CODE LETTER - A					500
1 MED SUPPLY	B	MEDICAL SUPPLIES CHRGED TO PA	71		10,113,744
2 MED SUPPLY	B				2
3 MED SUPPLY	B				3
4 MED SUPPLY	B				4
5 MED SUPPLY	B				5
6 MED SUPPLY	B				6
7 MED SUPPLY	B				7
8 MED SUPPLY	B				8
9 MED SUPPLY	B				9
10 MED SUPPLY	B				10
11 MED SUPPLY	B				11
12 MED SUPPLY	B				12
13 MED SUPPLY	B				13
14 MED SUPPLY	B				14
15 MED SUPPLY	B				15
16 MED SUPPLY	B				16
17 MED SUPPLY	B				17
18 MED SUPPLY	B				18
500 TOTAL RECLASSIFICATIONS					10,113,744
CODE LETTER - B					500
1 DRUG RECLASS	C	DRUGS CHARGED TO PATIENTS	73		9,429,965
2 DRUG RECLASS	C				2
3 DRUG RECLASS	C				3
4 DRUG RECLASS	C				4
5 DRUG RECLASS	C				5
6 DRUG RECLASS	C				6
7 DRUG RECLASS	C				7
8 DRUG RECLASS	C				8
9 DRUG RECLASS	C				9
10 DRUG RECLASS	C				10
11 DRUG RECLASS	C				11
12 DRUG RECLASS	C				12
13 DRUG RECLASS	C				13
500 TOTAL RECLASSIFICATIONS					9,429,965
CODE LETTER - C					500
1 HOUSEKEEPING	D	NURSING FACILITY	45	19,211	
500 TOTAL RECLASSIFICATIONS				19,211	500
CODE LETTER - D					
1 CAPITAL RELATED RECLASS	E	OPERATION OF PLANT	7		331,570
2		NURSING ADMINISTRATION	13		14,637
3		PHARMACY	15		169,000
4		SKILLED NURSING FACILITY	44		74,497
5		OPERATING ROOM	50		83,695
6		DELIVERY ROOM & LABOR ROOM	52		23,760
7		RADIOLOGY-DIAGNOSTIC	54		148,309
8		RADIOLOGY-THERAPEUTIC	55		2,466
9		CARDIAC CATHETERIZATION	59		37,214
10		LABORATORY	60		103,987
11		PHYSICAL THERAPY	66		8,795
12		EMERGENCY	91		6,295
13		PHYSICIANS' PRIVATE OFFICES	192		131,365
14		HEALTH & FITNESS CENTER	194		794
500 TOTAL RECLASSIFICATIONS					1,136,384
CODE LETTER - E					500
1 RECLASS DEPREC FROM BLDG TO EQUIP	F	CAP REL COSTS-MVBLE EQUIP	2		5,940,479
2 RECLASS HOME OFFICE DEPREC	F	CAP REL COSTS-MVBLE EQUIP	2		1,586,140
3 RECLASS INTEREST	F	CAP REL COSTS-BLDG & FIXT	1		3,869,007
500 TOTAL RECLASSIFICATIONS					11,395,626
CODE LETTER - F					500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----		SALARY	OTHER	
		COST CENTER	LINE #			
	1	2	3	4	5	
1 MOB	G	ADMINISTRATIVE & GENERAL	5		179,082	1
2 MOB	G	MEDICAL RECORDS & LIBRARY	16		8,233	2
3 MOB	G	RADIOLOGY-DIAGNOSTIC	54		55,840	3
4 MOB	G	LABORATORY	60		139,807	4
5 MOB	G	PHYSICAL THERAPY	66		56,634	5
6 MOB	G	SPEECH PATHOLOGY	68		71,689	6
7 MOB	G	ELECTROCARDIOLOGY	69		16,963	7
8 MOB	G	HOME HEALTH AGENCY	101		27,850	8
500 TOTAL RECLASSIFICATIONS					556,098	500
CODE LETTER - G						
1 NURSERY RECLASS	H	NURSERY	43	933,869	124,754	1
500 TOTAL RECLASSIFICATIONS				933,869	124,754	500
CODE LETTER - H						
GRAND TOTAL (INCREASES)				953,080	40,186,062	

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 IMPLANT RECLASS	A	ADULTS & PEDIATRICS	30		2,943	1
2 IMPLANT RECLASS	A	OPERATING ROOM	50		6,419,648	2
3 IMPLANT RECLASS	A	DELIVERY ROOM & LABOR ROOM	52		705	3
4 IMPLANT RECLASS	A	RADIOLOGY-DIAGNOSTIC	54		221,614	4
5 IMPLANT RECLASS	A	CARDIAC CATHETERIZATION	59		784,581	5
500 TOTAL RECLASSIFICATIONS					7,429,491	500
CODE LETTER - A						
1 MED SUPPLY	B	CENTRAL SERVICES & SUPPLY	14		26,065	1
2 MED SUPPLY	B	ADULTS & PEDIATRICS	30		346,603	2
3 MED SUPPLY	B	INTENSIVE CARE UNIT	31		114,294	3
4 MED SUPPLY	B	NURSERY	43		46,486	4
5 MED SUPPLY	B					5
6 MED SUPPLY	B	OPERATING ROOM	50		6,804,395	6
7 MED SUPPLY	B	DELIVERY ROOM & LABOR ROOM	52		388,705	7
8 MED SUPPLY	B	RADIOLOGY-DIAGNOSTIC	54		914,626	8
9 MED SUPPLY	B	COMPUTED TOMOGRAPHY (CT) SCAN	57		7,085	9
10 MED SUPPLY	B	MAGNETIC RESONANCE IMAGING (M	58		5,528	10
11 MED SUPPLY	B	CARDIAC CATHETERIZATION	59		600,593	11
12 MED SUPPLY	B	RESPIRATORY THERAPY	65		126,725	12
13 MED SUPPLY	B	PHYSICAL THERAPY	66		18,894	13
14 MED SUPPLY	B	SPEECH PATHOLOGY	68		326,231	14
15 MED SUPPLY	B	OP PEDS ONC CLINIC	90.01		11,403	15
16 MED SUPPLY	B	EMERGENCY	91		353,515	16
17 MED SUPPLY	B	OBSERVATION BEDS-DISTINCT	92.01		47	17
18 MED SUPPLY	B	OCCUPATIONAL HEALTH	194.01		22,549	18
500 TOTAL RECLASSIFICATIONS					10,113,744	500
CODE LETTER - B						
1 DRUG RECLASS	C	PHARMACY	15		7,423,625	1
2 DRUG RECLASS	C	ADULTS & PEDIATRICS	30		329,010	2
3 DRUG RECLASS	C	SKILLED NURSING FACILITY	44		755	3
4 DRUG RECLASS	C	OPERATING ROOM	50		224,757	4
5 DRUG RECLASS	C	DELIVERY ROOM & LABOR ROOM	52		13,535	5
6 DRUG RECLASS	C	RADIOLOGY-DIAGNOSTIC	54		412,130	6
7 DRUG RECLASS	C	COMPUTED TOMOGRAPHY (CT) SCAN	57		124,362	7
8 DRUG RECLASS	C	MAGNETIC RESONANCE IMAGING (M	58		282,900	8
9 DRUG RECLASS	C	CARDIAC CATHETERIZATION	59		33,949	9
10 DRUG RECLASS	C	LABORATORY	60		82,870	10
11 DRUG RECLASS	C	WOUND CLINIC	90.02		165,784	11
12 DRUG RECLASS	C	EMERGENCY	91		293,538	12
13 DRUG RECLASS	C	OCCUPATIONAL HEALTH	194.01		42,750	13
500 TOTAL RECLASSIFICATIONS					9,429,965	500
CODE LETTER - C						
1 HOUSEKEEPING	D	HOUSEKEEPING	9	19,211		1
500 TOTAL RECLASSIFICATIONS				19,211		500
CODE LETTER - D						
1 CAPITAL RELATED RECLASS	E	ADMINISTRATIVE & GENERAL	5		1,136,384	1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
500 TOTAL RECLASSIFICATIONS					1,136,384	500
CODE LETTER - E						
1 RECLASS DEPREC FROM BLDG TO EQUIP	F	CAP REL COSTS-BLDG & FIXT	1		5,940,479	9 1
2 RECLASS HOME OFFICE DEPREC	F	ADMINISTRATIVE & GENERAL	5		1,586,140	9 2
3 RECLASS INTEREST	F	ADMINISTRATIVE & GENERAL	5		3,869,007	9 3
500 TOTAL RECLASSIFICATIONS					11,395,626	500
CODE LETTER - F						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF. 10
			LINE #	SALARY	OTHER	
	1	6	7	8	9	
1 MOB	G	PHYSICIANS' PRIVATE OFFICES	192		179,082	1
2 MOB	G	PHYSICIANS' PRIVATE OFFICES	192		8,233	2
3 MOB	G	PHYSICIANS' PRIVATE OFFICES	192		55,840	3
4 MOB	G	PHYSICIANS' PRIVATE OFFICES	192		139,807	4
5 MOB	G	PHYSICIANS' PRIVATE OFFICES	192		56,634	5
6 MOB	G	PHYSICIANS' PRIVATE OFFICES	192		71,689	6
7 MOB	G	PHYSICIANS' PRIVATE OFFICES	192		16,963	7
8 MOB	G	PHYSICIANS' PRIVATE OFFICES	192		27,850	8
500 TOTAL RECLASSIFICATIONS CODE LETTER - G					556,098	500
1 NURSERY RECLASS	H	ADULTS & PEDIATRICS	30	933,869	124,754	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - H				933,869	124,754	500
GRAND TOTAL (DECREASES)				953,080	40,186,062	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	52,129,000	3,404,262		3,404,262		55,533,262		1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES	156,793,722	2,684,501		2,684,501		159,478,223		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	32,138,682	237,950		237,950	27,847	32,348,785		6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	241,061,404	6,326,713		6,326,713	27,847	247,360,270		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	241,061,404	6,326,713		6,326,713	27,847	247,360,270		10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	19,343,648						19,343,648 1
2 CAP REL COSTS-MVBLE EQUIP							2
3 TOTAL (SUM OF LINES 1-2)	19,343,648						19,343,648 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3		RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL
			(SUM OF COLS. 5-7) 8						
1 CAP REL COSTS-BLDG & FIXT	215,011,505		215,011,505	0.869224					1
2 CAP REL COSTS-MVBLE EQUIP	32,348,765		32,348,765	0.130776					2
3 TOTAL (SUM OF LINES 1-2)	247,360,270		247,360,270	1.000000					3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	11,161,021						11,161,021 1
2 CAP REL COSTS-MVBLE EQUIP	5,457,319						5,457,319 2
3 TOTAL	16,618,340						16,618,340 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-5,691,163			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	824,069			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS					14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES	A	-6,111,155	CAP REL COSTS-BLDG & FIXT	1	9 26
27 DEPRECIATION--MOVABLE EQUIPMENT	A	-2,069,300	CAP REL COSTS-MVBLE EQUIP	2	9 27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33					33
33.03 OTHER FOOD SERVICE	B	-694,822	DIETARY	10	33.03
33.04 OTHER FOOD SERVICE	B	-373,534	CAFETERIA	11	33.04
33.05 OTHER FOOD SERVICE	B	-161,163	HEALTH & FITNESS CENTER	194	33.05
34 HEALTH & FITNESS	B	-8,201,526	HEALTH & FITNESS CENTER	194	34
34.01 RENTAL INCOME	B	-1,001,603	ADMINISTRATIVE & GENERAL	5	34.01
34.02 RENTAL INCOME	B	-91,270	MAINTENANCE OF PERSONNEL	12	34.02
34.03 RENTAL INCOME	B	-46,512	NURSING FACILITY	45	34.03
34.04 RENTAL INCOME	B	-936	RADIOLOGY-DIAGNOSTIC	54	34.04
34.05 RENTAL INCOME	B	-740	LABORATORY	60	34.05
34.06 RENTAL INCOME	B	-832,327	GIFT, FLOWER, COFFEE SHOP & CAN	190	34.06
35 RENTAL INCOME	B	-5,998,365	PHYSICIANS' PRIVATE OFFICES	192	35
35.01 RENTAL INCOME	B	-199,983	HEALTH & FITNESS CENTER	194	35.01
36					36
37 MISC	B	-240,681	ADMINISTRATIVE & GENERAL	5	37
37.01 MISC	B	114	OPERATION OF PLANT	7	37.01
37.02 MISC	B	1,025	PHARMACY	15	37.02
37.03 MISC	B	1,655	RADIOLOGY-DIAGNOSTIC	54	37.03
37.04 MISC	B	3,523	PHYSICIANS' PRIVATE OFFICES	192	37.04
37.05 OTHER OP INCOME	B	-594,103	ADMINISTRATIVE & GENERAL	5	37.05
37.06 OTHER OP INCOME	B	-48,165	OPERATION OF PLANT	7	37.06
37.07 OTHER OP INCOME	B	-498	LAUNDRY & LINEN SERVICE	8	37.07
37.08 OTHER OP INCOME	B	-90	HOUSEKEEPING	9	37.08
37.09 OTHER OP INCOME	B	-6,841	DIETARY	10	37.09
37.10 OTHER OP INCOME	B	-318	MAINTENANCE OF PERSONNEL	12	37.10
37.11 OTHER OP INCOME	B	-58	CENTRAL SERVICES & SUPPLY	14	37.11
37.12 OTHER OP INCOME	B	-53	PHARMACY	15	37.12
37.13 OTHER OP INCOME	B	-3,985	MEDICAL RECORDS & LIBRARY	16	37.13
37.14 OTHER OP INCOME	B	-2,587	ADULTS & PEDIATRICS	30	37.14

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
37.16 OTHER OP INCOME	B	-107,846	DELIVERY ROOM & LABOR ROOM	52	37.16
37.17 OTHER OP INCOME	B	-1,414	RADIOLOGY-DIAGNOSTIC	54	37.17
37.18 OTHER OP INCOME	B	-580	LABORATORY	60	37.18
37.19 OTHER OP INCOME	B	-9,773	PHYSICAL THERAPY	66	37.19
37.20 OTHER OP INCOME	B	-1,230	SPEECH PATHOLOGY	68	37.20
37.21 OTHER OP INCOME	B	-4,140	CARDIAC REHABILITATION	76.97	37.21
37.22 OTHER OP INCOME	B	-1,700,144	HOME HEALTH AGENCY	101	37.22
38 OTHER OP INCOME	B	-600,736	GIFT, FLOWER, COFFEE SHOP & CAN	190	38
39 OTHER OP INCOME	B	-21,589	PHYSICIANS' PRIVATE OFFICES	192	39
40 OTHER OP INCOME	B	-6,319	OCCUPATIONAL HEALTH	194.01	40
41 MISC UNALLOWABLE EXPENSE	A	-162,371	ADMINISTRATIVE & GENERAL	5	41
42 MISC UNALLOWABLE EXPENSE	A	-23,850	HEALTH & FITNESS CENTER	194	42
43 OFFSET LIMITED TO COST	B	52,821	GIFT, FLOWER, COFFEE SHOP & CAN	190	43
44 OFFSET LIMITED TO COST	B	1,784,442	PHYSICIANS' PRIVATE OFFICES	192	44
45 OFFSET LIMITED TO COST	B	816,958	HEALTH & FITNESS CENTER	194	45
46					46
47 REAL ESTATE TAXES	A	-12,684	EMPLOYEE BENEFITS	4	47
48 REAL ESTATE TAXES	A	-10,603	MAINTENANCE OF PERSONNEL	12	48
48.01 REAL ESTATE TAXES	A	-20,800	NURSING FACILITY	45	48.01
49 REAL ESTATE TAXES	A	-1,467,696	PHYSICIANS' PRIVATE OFFICES	192	49
49.01 REAL ESTATE TAXES	A	-291,506	HEALTH & FITNESS CENTER	194	49.01
50 TOTAL (SUM OF LINES 1 THRU 49)		-33,330,452			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

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 THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1	5	ADMINISTRATIVE & GENERAL	22,871,729	22,047,660	824,069	1
2	54	RADIOLOGY-DIAGNOSTIC	42,126	42,126		2
3	60	LABORATORY	54,332	54,332		3
3.01	91	EMERGENCY	16,859	16,859		4.01
3.02	5	ADMINISTRATIVE & GENERAL	2,846,306	2,846,306		4.02
3.03	4	EMPLOYEE BENEFITS	87,347	87,347		4.03
3.04	5	ADMINISTRATIVE & GENERAL	1,769,257	1,769,257		4.04
4						4
5		TOTALS (SUM OF LINES 1-4)	27,687,956	26,863,887	824,069	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.				

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

THE SECRETARY, BY VIRTUE OF 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.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES 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.

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----				
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
6	B	100.00	NM HEALTHCARE		HEALTHCARE	6
7	B		NM HOSPITAL		HEALTHCARE	7
8	B		NM PHYSICIANSGROUP		HEALTHCARE	8
9						9
9.01	B		NHC		HEALTHCARE	10.01
9.05	B		NM INSURANCE CO		HEALTHCARE	10.05
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 PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	4							
	EMPLOYEE BENEFITS							
2	5	1,447,277	1,447,277					
	ADMINISTRATIVE & GENERAL AGGREGATE							
3	13							
	NURSING ADMINISTRATION							
4	16	133,499	133,499					
	MEDICAL RECORDS & LIBRAR AGGREGATE							
5	45							
	NURSING FACILITY							
6	52							
	DELIVERY ROOM & LABOR RO							
7	54							
	RADIOLOGY-DIAGNOSTIC							
8	60	150,750	150,750					
	LABORATORY AGGREGATE							
9	66	84,178	84,178					
	PHYSICAL THERAPY AGGREGATE							
10	69	19,000	19,000					
	ELECTROCARDIOLOGY AGGREGATE							
11	91	3,971,639	3,670,615	301,023	177,200	1,352	115,180	5,759
	EMERGENCY AGGREGATE							
200	TOTAL	5,806,343	5,505,319	301,023		1,352	115,180	5,759

PROVIDER CCN: 14-0130 NORTHWESTERN LAKE FOREST HOSPI  
 PERIOD FROM 09/01/2011 TO 08/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11  
 01/28/2013 11:57

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11	12	13	14	15	16	17	18	
1	4	EMPLOYEE BENEFITS							1
2	5	ADMINISTRATIVE & GENERAL	AGGREGATE					1,447,277	2
3	13	NURSING ADMINISTRATION							3
4	16	MEDICAL RECORDS & LIBRAR	AGGREGATE					133,499	4
5	45	NURSING FACILITY							5
6	52	DELIVERY ROOM & LABOR RO							6
7	54	RADIOLOGY-DIAGNOSTIC							7
8	60	LABORATORY	AGGREGATE					150,750	8
9	66	PHYSICAL THERAPY	AGGREGATE					84,178	9
10	69	ELECTROCARDIOLOGY	AGGREGATE					19,000	10
11	91	EMERGENCY	AGGREGATE			115,180	185,843	3,856,459	11
200		TOTAL				115,180	185,843	5,691,163	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	11,161,021	11,161,021				1
2 CAP REL COSTS-MVBLE EQUIP	5,457,319		5,457,319			2
4 EMPLOYEE BENEFITS	16,534,404	75,751		16,610,155		4
5 ADMINISTRATIVE & GENERAL	54,118,517	1,694,701	588,891	2,700,569	59,102,678	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	8,066,101	1,536,066	72,949	311,181	9,986,297	7
8 LAUNDRY & LINEN SERVICE	488,751	149,655	6,951	50,177	695,534	8
9 HOUSEKEEPING	2,539,161	3,216	5,895	247,544	2,795,816	9
10 DIETARY	3,301,727	397,955		3,730	3,703,412	10
11 CAFETERIA	417,036				417,036	11
12 MAINTENANCE OF PERSONNEL	1,387,440	230,533		88,664	1,706,637	12
13 NURSING ADMINISTRATION	3,101,230		58	441,348	3,542,636	13
14 CENTRAL SERVICES & SUPPLY	972,314	358,949		127,616	1,458,879	14
15 PHARMACY	2,255,247	71,293	6,529	273,529	2,606,598	15
16 MEDICAL RECORDS & LIBRARY	4,229,065	80,050	6,812	269,136	4,585,063	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	10,353,861	1,385,392	21,246	1,964,882	13,725,381	30
31 INTENSIVE CARE UNIT	1,875,409	184,713	2,018	308,312	2,370,452	31
43 NURSERY	1,804,025	127,812		126,847	2,058,684	43
44 SKILLED NURSING FACILITY	3,418,849	584,355	1,358	540,964	4,545,526	44
45 NURSING FACILITY	2,338,804	629,220	1,099	263,945	3,233,068	45
46 OTHER LONG TERM CARE						46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	8,779,193	1,075,160	1,307,653	1,345,326	12,507,332	50
52 DELIVERY ROOM & LABOR ROOM	2,536,283	161,850		443,520	3,141,653	52
54 RADIOLOGY-DIAGNOSTIC	9,232,655	635,111	1,720,317	1,004,351	12,592,434	54
55 RADIOLOGY-THERAPEUTIC	1,144,793	203,531	856,023	138,265	2,342,612	55
57 COMPUTED TOMOGRAPHY (CT) SCAN	882,432		17,596	100,529	1,000,557	57
58 MAGNETIC RESONANCE IMAGING (MRI)	2,752,074	57,410	475,651	373,780	3,658,915	58
59 CARDIAC CATHETERIZATION	632,521	18,118	51,881	97,673	800,193	59
60 LABORATORY	8,087,316	275,588	142,041	600,403	9,105,348	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	939,916	10,667	11,285	162,027	1,123,895	65
66 PHYSICAL THERAPY	4,020,349	502,236		681,492	5,204,077	66
68 SPEECH PATHOLOGY	1,274,919		16,222	201,412	1,492,553	68
69 ELECTROCARDIOLOGY	576,618		47,187	88,619	712,424	69
70 ELECTROENCEPHALOGRAPHY	328,561	35,280		56,503	420,344	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	10,113,744				10,113,744	71
72 IMPL. DEV. CHARGED TO PATIENT	7,429,491				7,429,491	72
73 DRUGS CHARGED TO PATIENTS	9,429,965				9,429,965	73
76.97 CARDIAC REHABILITATION	495,275	44,260	30,196	79,798	649,529	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 OP PEDS ONC CLINIC	507,646	54,672		82,693	645,011	90.01
90.02 WOUND CLINIC	687,962		8,558	41,776	738,296	90.02
91 EMERGENCY	4,676,357	415,786	30,841	1,453,344	6,576,328	91
92 OBSERVATION BEDS						92
92.01 OBSERVATION BEDS-DISTINCT	248,491		3,259	42,512	294,262	92.01
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	1,882,559			444,357	2,326,916	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	210,479,401	10,999,330	5,432,516	15,156,824	208,839,576	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		30,345	365	66,656	97,366	190
192 PHYSICIANS' PRIVATE OFFICES				525,208	525,208	192
194 HEALTH & FITNESS CENTER			23,150	662,163	685,313	194
194.01 OCCUPATIONAL HEALTH	1,256,577	131,346	1,288	199,304	1,588,515	194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	211,735,978	11,161,021	5,457,319	16,610,155	211,735,978	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	59,102,678					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	3,866,894	13,853,191				7
8 LAUNDRY & LINEN SERVICE	269,325	263,951	1,228,810			8
9 HOUSEKEEPING	1,082,596	5,672	614,405	4,498,489		9
10 DIETARY	1,434,035	701,884		68,575	5,907,906	10
11 CAFETERIA	161,485			18,287		11
12 MAINTENANCE OF PERSONNEL	660,844	406,596		9,143		12
13 NURSING ADMINISTRATION	1,371,780					13
14 CENTRAL SERVICES & SUPPLY	564,907	633,088		45,716		14
15 PHARMACY	1,009,327	125,742		27,430		15
16 MEDICAL RECORDS & LIBRARY	1,775,428	141,185		100,576		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,314,750	2,443,451	336,037	2,569,258	2,913,833	30
31 INTENSIVE CARE UNIT	917,886	325,782	37,201	205,724	274,865	31
43 NURSERY	797,164	225,425	85,277	64,003		43
44 SKILLED NURSING FACILITY	1,760,119	1,030,643	9,049	146,292	1,408,954	44
45 NURSING FACILITY	1,251,909	1,109,772	54,838		1,310,254	45
46 OTHER LONG TERM CARE						46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,843,089	1,896,288	20,993	475,450		50
52 DELIVERY ROOM & LABOR ROOM	1,216,511	285,460	25,340			52
54 RADIOLOGY-DIAGNOSTIC	4,876,042	1,120,161		109,719		54
55 RADIOLOGY-THERAPEUTIC	907,106	358,973				55
57 COMPUTED TOMOGRAPHY (CT) SCAN	387,436					57
58 MAGNETIC RESONANCE IMAGING (MRI)	1,416,805	101,256				58
59 CARDIAC CATHETERIZATION	309,851	31,955				59
60 LABORATORY	3,525,773	486,062		137,149		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	435,195	18,813		41,145		65
66 PHYSICAL THERAPY	2,015,123	885,807	5,208	50,288		66
68 SPEECH PATHOLOGY	577,946					68
69 ELECTROCARDIOLOGY	275,865					69
70 ELECTROENCEPHALOGRAPHY	162,766	62,225				70
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	3,916,244					71
72 IMPL. DEV. CHARGED TO PATIENT	2,876,848					72
73 DRUGS CHARGED TO PATIENTS	3,651,471					73
76.97 CARDIAC REHABILITATION	251,511	78,062	2,530			76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 OP PEDS ONC CLINIC	249,761	96,426		214,867		90.01
90.02 WOUND CLINIC	285,883					90.02
91 EMERGENCY	2,546,486	733,333	37,932	178,294		91
92 OBSERVATION BEDS						92
92.01 OBSERVATION BEDS-DISTINCT	113,944					92.01
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	901,028					101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	57,981,133	13,568,012	1,228,810	4,461,916	5,907,906	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	37,702	53,520		36,573		190
192 PHYSICIANS' PRIVATE OFFICES	203,371					192
194 HEALTH & FITNESS CENTER	265,367					194
194.01 OCCUPATIONAL HEALTH	615,105	231,659				194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	59,102,678	13,853,191	1,228,810	4,498,489	5,907,906	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	11	12	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						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	596,808					11
12 MAINTENANCE OF PERSONNEL		2,783,220				12
13 NURSING ADMINISTRATION			4,914,416			13
14 CENTRAL SERVICES & SUPPLY				2,702,590		14
15 PHARMACY				21,636	3,790,733	15
16 MEDICAL RECORDS & LIBRARY				72,772		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	294,352	1,012,080	1,927,980	81,049	253,892	30
31 INTENSIVE CARE UNIT	27,766		224,854	13,397	46,339	31
43 NURSERY			111,513	5,856	9,221	43
44 SKILLED NURSING FACILITY	142,330			12,250	5,302	44
45 NURSING FACILITY	132,360			19,245	45,377	45
46 OTHER LONG TERM CARE						46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM			1,093,955	1,437,614	1,959,205	50
52 DELIVERY ROOM & LABOR ROOM			368,703	45,574	151,220	52
54 RADIOLOGY-DIAGNOSTIC			13,383	291,082	220,441	54
55 RADIOLOGY-THERAPEUTIC				4,456		55
57 COMPUTED TOMOGRAPHY (CT) SCAN				13,796	577	57
58 MAGNETIC RESONANCE IMAGING (MRI)			77,323	39,099	7,954	58
59 CARDIAC CATHETERIZATION			56,692	150,577	25,883	59
60 LABORATORY		253,020		292,139	95,667	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY				14,061	6,683	65
66 PHYSICAL THERAPY		253,020	12,902	3,511	208	66
68 SPEECH PATHOLOGY				35,755	889	68
69 ELECTROCARDIOLOGY				2,680	22,617	69
70 ELECTROENCEPHALOGRAPHY				841		70
71 MEDICAL SUPPLIES CHRGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION			50,279	2,227	1,062	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 OP PEDS ONC CLINIC			46,200	3,048	78,875	90.01
90.02 WOUND CLINIC			12,124	18,690	16,928	90.02
91 EMERGENCY		506,040	897,770	64,113	794,983	91
92 OBSERVATION BEDS						92
92.01 OBSERVATION BEDS-DISTINCT				16	13	92.01
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY				5,323	296	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	596,808	2,024,160	4,893,678	2,650,807	3,743,632	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				2,250		190
192 PHYSICIANS' PRIVATE OFFICES			20,738	3,756	5,265	192
194 HEALTH & FITNESS CENTER				38,394		194
194.01 OCCUPATIONAL HEALTH		759,060		7,383	41,836	194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	596,808	2,783,220	4,914,416	2,702,590	3,790,733	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS + LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					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	6,675,024				16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	424,118	31,296,181		31,296,181	30
31 INTENSIVE CARE UNIT	75,258	4,519,524		4,519,524	31
43 NURSERY	48,266	3,405,409		3,405,409	43
44 SKILLED NURSING FACILITY	91,993	9,152,458		9,152,458	44
45 NURSING FACILITY		7,156,823		7,156,823	45
46 OTHER LONG TERM CARE					46
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	675,845	24,909,771		24,909,771	50
52 DELIVERY ROOM & LABOR ROOM	95,670	5,330,131		5,330,131	52
54 RADIOLOGY-DIAGNOSTIC	867,935	20,091,197		20,091,197	54
55 RADIOLOGY-THERAPEUTIC	203,951	3,817,098		3,817,098	55
57 COMPUTED TOMOGRAPHY (CT) SCAN	353,084	1,755,450		1,755,450	57
58 MAGNETIC RESONANCE IMAGING (MRI)	639,965	5,941,317		5,941,317	58
59 CARDIAC CATHETERIZATION	86,443	1,461,594		1,461,594	59
60 LABORATORY	883,161	14,778,319		14,778,319	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	60,063	1,699,855		1,699,855	65
66 PHYSICAL THERAPY	191,440	8,621,584		8,621,584	66
68 SPEECH PATHOLOGY	45,720	2,152,863		2,152,863	68
69 ELECTROCARDIOLOGY	191,440	1,205,026		1,205,026	69
70 ELECTROENCEPHALOGRAPHY	13,010	659,186		659,186	70
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	306,568	14,336,556		14,336,556	71
72 IMPL. DEV. CHARGED TO PATIENT	145,430	10,451,769		10,451,769	72
73 DRUGS CHARGED TO PATIENTS	496,538	13,577,974		13,577,974	73
76.97 CARDIAC REHABILITATION	14,263	1,049,463		1,049,463	76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90.01 OP PEDS ONC CLINIC		1,362,449		1,362,449	90.01
90.02 WOUND CLINIC		1,094,199		1,094,199	90.02
91 EMERGENCY	711,486	13,046,765		13,046,765	91
92 OBSERVATION BEDS					92
92.01 OBSERVATION BEDS-DISTINCT	2,838	411,073		411,073	92.01
OTHER REIMBURSABLE COST CENTERS					
101 HOME HEALTH AGENCY		3,233,563		3,233,563	101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	6,675,024	206,517,597		206,517,597	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		227,411		227,411	190
192 PHYSICIANS' PRIVATE OFFICES		758,338		758,338	192
194 HEALTH & FITNESS CENTER		989,074		989,074	194
194.01 OCCUPATIONAL HEALTH		3,243,558		3,243,558	194.01
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	6,675,024	211,735,978		211,735,978	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	DIR ASSGND	CAP	CAP	SUBTOTAL	EMPLOYEE	
	CAP-REL COSTS 0	BLDGS & FIXTURES 1	MOVABLE EQUIPMENT 2		BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		75,751		75,751	75,751	4
5 ADMINISTRATIVE & GENERAL	1,694,701		588,891	2,283,592	12,636	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,536,066		72,949	1,609,015	1,412	7
8 LAUNDRY & LINEN SERVICE	149,655		6,951	156,606	228	8
9 HOUSEKEEPING	3,216		5,895	9,111	1,123	9
10 DIETARY	397,955			397,955	17	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL	230,533			230,533	402	12
13 NURSING ADMINISTRATION			58	58	2,003	13
14 CENTRAL SERVICES & SUPPLY	358,949			358,949	579	14
15 PHARMACY	71,293		6,529	77,822	1,241	15
16 MEDICAL RECORDS & LIBRARY	80,050		6,812	86,862	1,221	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,385,392		21,246	1,406,638	8,916	30
31 INTENSIVE CARE UNIT	184,713		2,018	186,731	1,399	31
43 NURSERY	127,812			127,812	576	43
44 SKILLED NURSING FACILITY	584,355		1,358	585,713	2,455	44
45 NURSING FACILITY	629,220		1,099	630,319	1,198	45
46 OTHER LONG TERM CARE						46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,075,160		1,307,653	2,382,813	6,105	50
52 DELIVERY ROOM & LABOR ROOM	161,850			161,850	2,013	52
54 RADIOLOGY-DIAGNOSTIC	635,111		1,720,317	2,355,428	4,557	54
55 RADIOLOGY-THERAPEUTIC	203,531		856,023	1,059,554	627	55
57 COMPUTED TOMOGRAPHY (CT) SCAN			17,596	17,596	456	57
58 MAGNETIC RESONANCE IMAGING (MRI)	57,410		475,651	533,061	1,696	58
59 CARDIAC CATHETERIZATION	18,118		51,881	69,999	443	59
60 LABORATORY	275,588		142,041	417,629	2,724	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	10,667		11,285	21,952	735	65
66 PHYSICAL THERAPY	502,236			502,236	3,092	66
68 SPEECH PATHOLOGY			16,222	16,222	914	68
69 ELECTROCARDIOLOGY			47,187	47,187	402	69
70 ELECTROENCEPHALOGRAPHY	35,280			35,280	256	70
71 MEDICAL SUPPLIES CHRGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION	44,260		30,196	74,456	362	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 OP PEDS ONC CLINIC	54,672			54,672	375	90.01
90.02 WOUND CLINIC			8,558	8,558	190	90.02
91 EMERGENCY	415,786		30,841	446,627	6,595	91
92 OBSERVATION BEDS						92
92.01 OBSERVATION BEDS-DISTINCT			3,259	3,259	193	92.01
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY					2,016	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	10,999,330		5,432,516	16,431,846	69,157	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,345		365	30,710	302	190
192 PHYSICIANS' PRIVATE OFFICES					2,383	192
194 HEALTH & FITNESS CENTER			23,150	23,150	3,005	194
194.01 OCCUPATIONAL HEALTH	131,346		1,288	132,634	904	194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	11,161,021		5,457,319	16,618,340	75,751	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	2,296,228					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	150,234	1,760,661				7
8 LAUNDRY & LINEN SERVICE	10,464	33,547	200,845			8
9 HOUSEKEEPING	42,060	721	100,423	153,438		9
10 DIETARY	55,714	89,205		2,339	545,230	10
11 CAFETERIA	6,274			624		11
12 MAINTENANCE OF PERSONNEL	25,675	51,676		312		12
13 NURSING ADMINISTRATION	53,295					13
14 CENTRAL SERVICES & SUPPLY	21,947	80,462		1,559		14
15 PHARMACY	39,214	15,981		936		15
16 MEDICAL RECORDS & LIBRARY	68,978	17,944		3,431		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	206,496	310,551	54,924	87,635	268,912	30
31 INTENSIVE CARE UNIT	35,661	41,405	6,080	7,017	25,367	31
43 NURSERY	30,971	28,650	13,938	2,183		43
44 SKILLED NURSING FACILITY	68,383	130,989	1,479	4,990	130,030	44
45 NURSING FACILITY	48,638	141,046	8,963		120,921	45
46 OTHER LONG TERM CARE						46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	188,160	241,007	3,431	16,217		50
52 DELIVERY ROOM & LABOR ROOM	47,263	36,280	4,142			52
54 RADIOLOGY-DIAGNOSTIC	189,441	142,366		3,742		54
55 RADIOLOGY-THERAPEUTIC	35,242	45,623				55
57 COMPUTED TOMOGRAPHY (CT) SCAN	15,052					57
58 MAGNETIC RESONANCE IMAGING (MRI)	55,045	12,869				58
59 CARDIAC CATHETERIZATION	12,038	4,061				59
60 LABORATORY	136,981	61,776		4,678		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	16,908	2,391		1,403		65
66 PHYSICAL THERAPY	78,290	112,581	851	1,715		66
68 SPEECH PATHOLOGY	22,454					68
69 ELECTROCARDIOLOGY	10,718					69
70 ELECTROENCEPHALOGRAPHY	6,324	7,908				70
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	152,151					71
72 IMPL. DEV. CHARGED TO PATIENT	111,769					72
73 DRUGS CHARGED TO PATIENTS	141,864					73
76.97 CARDIAC REHABILITATION	9,772	9,921	414			76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 OP PEDS ONC CLINIC	9,704	12,255		7,329		90.01
90.02 WOUND CLINIC	11,107					90.02
91 EMERGENCY	98,934	93,202	6,200	6,081		91
92 OBSERVATION BEDS						92
92.01 OBSERVATION BEDS-DISTINCT	4,427					92.01
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	35,006					101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	2,252,654	1,724,417	200,845	152,191	545,230	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,465	6,802		1,247		190
192 PHYSICIANS' PRIVATE OFFICES	7,901					192
194 HEALTH & FITNESS CENTER	10,310					194
194.01 OCCUPATIONAL HEALTH	23,898	29,442				194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,296,228	1,760,661	200,845	153,438	545,230	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	11	12	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						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	6,898					11
12 MAINTENANCE OF PERSONNEL		308,598				12
13 NURSING ADMINISTRATION			55,356			13
14 CENTRAL SERVICES & SUPPLY				463,496		14
15 PHARMACY				3,709	138,903	15
16 MEDICAL RECORDS & LIBRARY				12,475		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,402	112,218	21,716	13,894	9,303	30
31 INTENSIVE CARE UNIT	321		2,533	2,297	1,698	31
43 NURSERY			1,256	1,004	338	43
44 SKILLED NURSING FACILITY	1,645			2,100	194	44
45 NURSING FACILITY	1,530			3,299	1,663	45
46 OTHER LONG TERM CARE						46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM			12,322	246,641	71,791	50
52 DELIVERY ROOM & LABOR ROOM			4,153	7,813	5,541	52
54 RADIOLOGY-DIAGNOSTIC			151	49,900	8,078	54
55 RADIOLOGY-THERAPEUTIC				764		55
57 COMPUTED TOMOGRAPHY (CT) SCAN				2,365	21	57
58 MAGNETIC RESONANCE IMAGING (MRI)			871	6,703	291	58
59 CARDIAC CATHETERIZATION			639	25,813	948	59
60 LABORATORY		28,054		50,081	3,506	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY				2,410	245	65
66 PHYSICAL THERAPY		28,054	145	602	8	66
68 SPEECH PATHOLOGY				6,129	33	68
69 ELECTROCARDIOLOGY				459	829	69
70 ELECTROENCEPHALOGRAPHY				144		70
71 MEDICAL SUPPLIES CHRGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION			566	382	39	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 OP PEDS ONC CLINIC			520	523	2,890	90.01
90.02 WOUND CLINIC			137	3,204	620	90.02
91 EMERGENCY		56,109	10,113	10,991	29,130	91
92 OBSERVATION BEDS						92
92.01 OBSERVATION BEDS-DISTINCT				3		92.01
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY				913	11	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	6,898	224,435	55,122	454,618	137,177	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				386		190
192 PHYSICIANS' PRIVATE OFFICES			234	644	193	192
194 HEALTH & FITNESS CENTER				6,582		194
194.01 OCCUPATIONAL HEALTH		84,163		1,266	1,533	194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	6,898	308,598	55,356	463,496	138,903	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS + LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					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	190,911				16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	12,120	2,516,725		2,516,725	30
31 INTENSIVE CARE UNIT	2,151	312,660		312,660	31
43 NURSERY	1,379	208,107		208,107	43
44 SKILLED NURSING FACILITY	2,629	930,607		930,607	44
45 NURSING FACILITY		957,577		957,577	45
46 OTHER LONG TERM CARE					46
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	19,314	3,187,801		3,187,801	50
52 DELIVERY ROOM & LABOR ROOM	2,734	271,789		271,789	52
54 RADIOLOGY-DIAGNOSTIC	24,803	2,778,466		2,778,466	54
55 RADIOLOGY-THERAPEUTIC	5,828	1,147,638		1,147,638	55
57 COMPUTED TOMOGRAPHY (CT) SCAN	10,090	45,580		45,580	57
58 MAGNETIC RESONANCE IMAGING (MRI)	18,288	628,824		628,824	58
59 CARDIAC CATHETERIZATION	2,470	116,411		116,411	59
60 LABORATORY	25,395	730,824		730,824	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	1,716	47,760		47,760	65
66 PHYSICAL THERAPY	5,471	733,045		733,045	66
68 SPEECH PATHOLOGY	1,307	47,059		47,059	68
69 ELECTROCARDIOLOGY	5,471	65,066		65,066	69
70 ELECTROENCEPHALOGRAPHY	372	50,284		50,284	70
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	8,761	160,912		160,912	71
72 IMPL. DEV. CHARGED TO PATIENT	4,156	115,925		115,925	72
73 DRUGS CHARGED TO PATIENTS	14,190	156,054		156,054	73
76.97 CARDIAC REHABILITATION	408	96,320		96,320	76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90.01 OP PEDS ONC CLINIC	808	89,076		89,076	90.01
90.02 WOUND CLINIC	637	24,453		24,453	90.02
91 EMERGENCY	20,332	784,314		784,314	91
92 OBSERVATION BEDS					92
92.01 OBSERVATION BEDS-DISTINCT	81	7,963		7,963	92.01
OTHER REIMBURSABLE COST CENTERS					
101 HOME HEALTH AGENCY		37,946		37,946	101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	190,911	16,249,186		16,249,186	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		40,912		40,912	190
192 PHYSICIANS' PRIVATE OFFICES		11,355		11,355	192
194 HEALTH & FITNESS CENTER		43,047		43,047	194
194.01 OCCUPATIONAL HEALTH		273,840		273,840	194.01
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	190,911	16,618,340		16,618,340	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	350,518					1
2 CAP REL COSTS-MVBLE EQUIP		540,110,384				2
4 EMPLOYEE BENEFITS	2,379		9,420,949,521			4
5 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	53,223	58,282,971	1,531,223,618	-59,102,678	152,633,300	5
7 OPERATION OF PLANT	48,241	7,219,806	176,506,365		9,986,297	7
8 LAUNDRY & LINEN SERVICE	4,700	687,958	28,461,023		695,534	8
9 HOUSEKEEPING	101	583,463	140,410,579		2,795,816	9
10 DIETARY	12,498		2,115,540		3,703,412	10
11 CAFETERIA					417,036	11
12 MAINTENANCE OF PERSONNEL	7,240		50,291,800		1,706,637	12
13 NURSING ADMINISTRATION		5,779	250,339,248		3,542,636	13
14 CENTRAL SERVICES & SUPPLY	11,273		72,385,824		1,458,879	14
15 PHARMACY	2,239	646,152	155,149,804		2,606,598	15
16 MEDICAL RECORDS & LIBRARY	2,514	674,163	152,657,694		4,585,063	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	43,509	2,102,731	1,114,510,530		13,725,381	30
31 INTENSIVE CARE UNIT	5,801	199,734	174,879,433		2,370,452	31
43 NURSERY	4,014		71,949,342		2,058,684	43
44 SKILLED NURSING FACILITY	18,352	134,400	306,843,082		4,545,526	44
45 NURSING FACILITY	19,761	108,780	149,713,468		3,233,068	45
46 OTHER LONG TERM CARE						46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	33,766	129,419,290	763,089,065		12,507,332	50
52 DELIVERY ROOM & LABOR ROOM	5,083		251,571,245		3,141,653	52
54 RADIOLOGY-DIAGNOSTIC	19,946	170,256,834	569,683,098		12,592,434	54
55 RADIOLOGY-THERAPEUTIC	6,392	84,721,218	78,426,245		2,342,612	55
57 COMPUTED TOMOGRAPHY (CT) SCAN		1,741,500	57,021,589		1,000,557	57
58 MAGNETIC RESONANCE IMAGING (MRI)	1,803	47,075,505	212,013,713		3,658,915	58
59 CARDIAC CATHETERIZATION	569	5,134,687	55,401,840		800,193	59
60 LABORATORY	8,655	14,057,870	340,557,451		9,105,348	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	335	1,116,891	91,904,058		1,123,895	65
66 PHYSICAL THERAPY	15,773		386,552,271		5,204,077	66
68 SPEECH PATHOLOGY		1,605,462	114,243,935		1,492,553	68
69 ELECTROCARDIOLOGY		4,670,136	50,266,107		712,424	69
70 ELECTROENCEPHALOGRAPHY	1,108		32,049,593		420,344	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					10,113,744	71
72 IMPL. DEV. CHARGED TO PATIENT					7,429,491	72
73 DRUGS CHARGED TO PATIENTS					9,429,965	73
76.97 CARDIAC REHABILITATION	1,390	2,988,506	45,262,435		649,529	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 OP PEDS ONC CLINIC	1,717		46,904,632		645,011	90.01
90.02 WOUND CLINIC		846,943	23,695,801		738,296	90.02
91 EMERGENCY	13,058	3,052,369	824,358,451		6,576,328	91
92 OBSERVATION BEDS						92
92.01 OBSERVATION BEDS-DISTINCT		322,545	24,113,479		294,262	92.01
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY			252,045,677		2,326,916	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	345,440	537,655,693	8,596,598,035	-59,102,678	149,736,898	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	953	36,109	37,808,527		97,366	190
192 PHYSICIANS' PRIVATE OFFICES			297,905,932		525,208	192
194 HEALTH & FITNESS CENTER		2,291,155	375,588,920		685,313	194
194.01 OCCUPATIONAL HEALTH	4,125	127,427	113,048,107		1,588,515	194.01

PROVIDER CCN: 14-0130 NORTHWESTERN LAKE FOREST HOSPI  
 PERIOD FROM 09/01/2011 TO 08/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11  
 01/28/2013 11:57

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	11,161,021	5,457,319	16,610,155		59,102,678	202
203	UNIT COST MULT-WS B PT I	31.841506	0.010104	0.001763		0.387220	203
204	COST TO BE ALLOC PER B PT II			75,751		2,296,228	204
205	UNIT COST MULT-WS B PT II			0.000008		0.015044	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	SQUARE	SERVICE	HOURS OF	MEALS	MEALS	
	FEET	POUNDS OF	SERVICE	SERVED	SERVED	
	7	LAUNDRY	9	10	11	
		8				
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	246,675					7
8 LAUNDRY & LINEN SERVICE	4,700	3,144,224				8
9 HOUSEKEEPING	101	1,572,112	984			9
10 DIETARY	12,498		15	146,889		10
11 CAFETERIA			4		146,889	11
12 MAINTENANCE OF PERSONNEL	7,240		2			12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY	11,273		10			14
15 PHARMACY	2,239		6			15
16 MEDICAL RECORDS & LIBRARY	2,514		22			16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	43,509	859,836	562	72,447	72,447	30
31 INTENSIVE CARE UNIT	5,801	95,187	45	6,834	6,834	31
43 NURSERY	4,014	218,202	14			43
44 SKILLED NURSING FACILITY	18,352	23,154	32	35,031	35,031	44
45 NURSING FACILITY	19,761	140,318		32,577	32,577	45
46 OTHER LONG TERM CARE						46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	33,766	53,717	104			50
52 DELIVERY ROOM & LABOR ROOM	5,083	64,840				52
54 RADIOLOGY-DIAGNOSTIC	19,946		24			54
55 RADIOLOGY-THERAPEUTIC	6,392					55
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (MRI)	1,803					58
59 CARDIAC CATHETERIZATION	569					59
60 LABORATORY	8,655		30			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	335		9			65
66 PHYSICAL THERAPY	15,773	13,326	11			66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY	1,108					70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION	1,390	6,474				76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 OP PEDS ONC CLINIC	1,717		47			90.01
90.02 WOUND CLINIC						90.02
91 EMERGENCY	13,058	97,058	39			91
92 OBSERVATION BEDS						92
92.01 OBSERVATION BEDS-DISTINCT						92.01
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY						101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	241,597	3,144,224	976	146,889	146,889	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	953		8			190
192 PHYSICIANS' PRIVATE OFFICES						192
194 HEALTH & FITNESS CENTER						194
194.01 OCCUPATIONAL HEALTH	4,125					194.01

PROVIDER CCN: 14-0130 NORTHWESTERN LAKE FOREST HOSPI  
 PERIOD FROM 09/01/2011 TO 08/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM  
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 01/28/2013 11:57

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	SQUARE	SERVICE	HOURS OF	MEALS	MEALS	
	FEET	POUNDS OF	SERVICE	SERVED	SERVED	
	7	LAUNDRY	9	10	11	
		8				
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	13,853,191	1,228,810	4,498,489	5,907,906	596,808	202
203 UNIT COST MULT-WS B PT I	56.159688	0.390815	4,571.635163	40.220207	4.062986	203
204 COST TO BE ALLOC PER B PT II	1,760,661	200,845	153,438	545,230	6,898	204
205 UNIT COST MULT-WS B PT II	7.137574	0.063877	155.932927	3.711850	0.046961	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	
	12	13	14	15	16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						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	1,100					12
13 NURSING ADMINISTRATION		777,049				13
14 CENTRAL SERVICES & SUPPLY			2,574,851,336			14
15 PHARMACY			20,605,836	54,006,185		15
16 MEDICAL RECORDS & LIBRARY			69,306,331		674,062,662	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	400	304,845	77,189,202	3,617,161	42,827,223	30
31 INTENSIVE CARE UNIT		35,553	12,759,309	660,178	7,599,550	31
43 NURSERY		17,632	5,577,087	131,370	4,873,856	43
44 SKILLED NURSING FACILITY			11,666,824	75,536	9,289,450	44
45 NURSING FACILITY			18,329,008	646,479		45
46 OTHER LONG TERM CARE						46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		172,972	1,370,110,122	27,912,727	68,246,522	50
52 DELIVERY ROOM & LABOR ROOM		58,298	43,403,863	2,154,403	9,660,709	52
54 RADIOLOGY-DIAGNOSTIC		2,116	277,221,223	3,140,584	87,643,622	54
55 RADIOLOGY-THERAPEUTIC			4,243,661		20,594,878	55
57 COMPUTED TOMOGRAPHY (CT) SCAN			13,138,885	8,220	35,654,242	57
58 MAGNETIC RESONANCE IMAGING (MRI)		12,226	37,237,054	113,315	64,623,344	58
59 CARDIAC CATHETERIZATION		8,964	143,406,985	368,746	8,728,967	59
60 LABORATORY	100		278,227,721	1,362,948	89,203,048	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			13,391,221	95,211	6,065,178	65
66 PHYSICAL THERAPY	100	2,040	3,343,978	2,966	19,331,486	66
68 SPEECH PATHOLOGY			34,052,745	12,665	4,616,832	68
69 ELECTROCARDIOLOGY			2,552,561	322,219	19,331,486	69
70 ELECTROENCEPHALOGRAPHY			801,400		1,313,735	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					30,957,121	71
72 IMPL. DEV. CHARGED TO PATIENT					14,685,481	72
73 DRUGS CHARGED TO PATIENTS					50,140,181	73
76.97 CARDIAC REHABILITATION		7,950	2,120,554	15,126	1,440,275	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 OP PEDS ONC CLINIC		7,305	2,903,247	1,123,717	2,853,749	90.01
90.02 WOUND CLINIC		1,917	17,800,157	241,171	2,249,571	90.02
91 EMERGENCY	200	141,952	61,060,183	11,325,991	71,845,540	91
92 OBSERVATION BEDS						92
92.01 OBSERVATION BEDS-DISTINCT			15,181	192	286,616	92.01
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY			5,069,960	4,219		101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	800	773,770	2,525,534,298	53,335,144	674,062,662	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			2,142,952			190
192 PHYSICIANS' PRIVATE OFFICES		3,279	3,576,940	75,015		192
194 HEALTH & FITNESS CENTER			36,565,945			194
194.01 OCCUPATIONAL HEALTH	300		7,031,201	596,026		194.01

PROVIDER CCN: 14-0130 NORTHWESTERN LAKE FOREST HOSPI  
 PERIOD FROM 09/01/2011 TO 08/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM  
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VERSION: 2012.11  
 01/28/2013 11:57

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED 12	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY  COSTED REQUIS. 15	MEDICAL RECORDS + LIBRARY GROSS REVENUE 16	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	2,783,220	4,914,416	2,702,590	3,790,733	6,675,024	202
203 UNIT COST MULT-WS B PT I	2,530.200000	6.324461	0.001050	0.070191	0.009903	203
204 COST TO BE ALLOC PER B PT II	308,598	55,356	463,496	138,903	190,911	204
205 UNIT COST MULT-WS B PT II	280.543636	0.071239	0.000180	0.002572	0.000283	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

GENERAL SERVICE COST CENTERS		
1	CAP REL COSTS-BLDG & FIXT	1
2	CAP REL COSTS-MVBLE EQUIP	2
4	EMPLOYEE BENEFITS	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 SRVCES-SALARY & FRINGES APPRVD	21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	22
23	PARAMED ED PRGM-(SPECIFY)	23
INPATIENT ROUTINE SERV COST CENTERS		
30	ADULTS & PEDIATRICS	30
31	INTENSIVE CARE UNIT	31
43	NURSERY	43
44	SKILLED NURSING FACILITY	44
45	NURSING FACILITY	45
46	OTHER LONG TERM CARE	46
ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM	50
52	DELIVERY ROOM & LABOR ROOM	52
54	RADIOLOGY-DIAGNOSTIC	54
55	RADIOLOGY-THERAPEUTIC	55
57	COMPUTED TOMOGRAPHY (CT) SCAN	57
58	MAGNETIC RESONANCE IMAGING (MRI)	58
59	CARDIAC CATHETERIZATION	59
60	LABORATORY	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65	RESPIRATORY THERAPY	65
66	PHYSICAL THERAPY	66
68	SPEECH PATHOLOGY	68
69	ELECTROCARDIOLOGY	69
70	ELECTROENCEPHALOGRAPHY	70
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	71
72	IMPL. DEV. CHARGED TO PATIENT	72
73	DRUGS CHARGED TO PATIENTS	73
76.97	CARDIAC REHABILITATION	76.97
76.98	HYPERBARIC OXYGEN THERAPY	76.98
76.99	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS		
90.01	OP PEDS ONC CLINIC	90.01
90.02	WOUND CLINIC	90.02
91	EMERGENCY	91
92	OBSERVATION BEDS	92
92.01	OBSERVATION BEDS-DISTINCT	92.01
OTHER REIMBURSABLE COST CENTERS		
101	HOME HEALTH AGENCY	101
SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	118
NONREIMBURSABLE COST CENTERS		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190
192	PHYSICIANS' PRIVATE OFFICES	192
194	HEALTH & FITNESS CENTER	194
194.01	OCCUPATIONAL HEALTH	194.01

PROVIDER CCN: 14-0130 NORTHWESTERN LAKE FOREST HOSPI  
PERIOD FROM 09/01/2011 TO 08/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM  
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VERSION: 2012.11  
01/28/2013 11:57

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

200	CROSS FOOT ADJUSTMENTS	200
201	NEGATIVE COST CENTER	201
202	COST TO BE ALLOC PER B PT I	202
203	UNIT COST MULT-WS B PT I	203
204	COST TO BE ALLOC PER B PT II	204
205	UNIT COST MULT-WS B PT II	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	31,296,181		31,296,181		31,296,181	30
31 INTENSIVE CARE UNIT	4,519,524		4,519,524		4,519,524	31
43 NURSERY	3,405,409		3,405,409		3,405,409	43
44 SKILLED NURSING FACILITY	9,152,458		9,152,458		9,152,458	44
45 NURSING FACILITY	7,156,823		7,156,823		7,156,823	45
46 OTHER LONG TERM CARE						46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	24,909,771		24,909,771		24,909,771	50
52 DELIVERY ROOM & LABOR ROOM	5,330,131		5,330,131		5,330,131	52
54 RADIOLOGY-DIAGNOSTIC	20,091,197		20,091,197		20,091,197	54
55 RADIOLOGY-THERAPEUTIC	3,817,098		3,817,098		3,817,098	55
57 COMPUTED TOMOGRAPHY (CT) SC	1,755,450		1,755,450		1,755,450	57
58 MAGNETIC RESONANCE IMAGING	5,941,317		5,941,317		5,941,317	58
59 CARDIAC CATHETERIZATION	1,461,594		1,461,594		1,461,594	59
60 LABORATORY	14,778,319		14,778,319		14,778,319	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	1,699,855		1,699,855		1,699,855	65
66 PHYSICAL THERAPY	8,621,584		8,621,584		8,621,584	66
68 SPEECH PATHOLOGY	2,152,863		2,152,863		2,152,863	68
69 ELECTROCARDIOLOGY	1,205,026		1,205,026		1,205,026	69
70 ELECTROENCEPHALOGRAPHY	659,186		659,186		659,186	70
71 MEDICAL SUPPLIES CHRGED TO	14,336,556		14,336,556		14,336,556	71
72 IMPL. DEV. CHARGED TO PATIE	10,451,769		10,451,769		10,451,769	72
73 DRUGS CHARGED TO PATIENTS	13,577,974		13,577,974		13,577,974	73
76.97 CARDIAC REHABILITATION	1,049,463		1,049,463		1,049,463	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 OP PEDS ONC CLINIC	1,362,449		1,362,449		1,362,449	90.01
90.02 WOUND CLINIC	1,094,199		1,094,199		1,094,199	90.02
91 EMERGENCY	13,046,765		13,046,765	185,843	13,232,608	91
92 OBSERVATION BEDS	2,427,320		2,427,320		2,427,320	92
92.01 OBSERVATION BEDS-DISTINCT	411,073		411,073		411,073	92.01
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	3,233,563		3,233,563		3,233,563	101
200 SUBTOTAL (SEE INSTRUCTIONS)	208,944,917		208,944,917	185,843	209,130,760	200
201 LESS OBSERVATION BEDS	2,427,320		2,427,320		2,427,320	201
202 TOTAL (SEE INSTRUCTIONS)	206,517,597		206,517,597		206,703,440	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I (CONT)

COST CENTER DESCRIPTION	CHARGES			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	37,827,223		37,827,223			30
31 INTENSIVE CARE UNIT	12,599,550		12,599,550			31
43 NURSERY	4,873,856		4,873,856			43
44 SKILLED NURSING FACILITY	9,289,450		9,289,450			44
45 NURSING FACILITY	3,457,616		3,457,616			45
46 OTHER LONG TERM CARE						46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	19,182,209	49,064,313	68,246,522	0.364997	0.364997	0.364997 50
52 DELIVERY ROOM & LABOR ROOM	8,617,198	1,043,511	9,660,709	0.551733	0.551733	0.551733 52
54 RADIOLOGY-DIAGNOSTIC	11,247,418	76,396,204	87,643,622	0.229237	0.229237	0.229237 54
55 RADIOLOGY-THERAPEUTIC	268,044	20,326,834	20,594,878	0.185342	0.185342	0.185342 55
57 COMPUTED TOMOGRAPHY (CT) SC	11,832,943	23,821,299	35,654,242	0.049235	0.049235	0.049235 57
58 MAGNETIC RESONANCE IMAGING	6,858,164	57,765,180	64,623,344	0.091938	0.091938	0.091938 58
59 CARDIAC CATHETERIZATION	5,822,377	2,906,590	8,728,967	0.167442	0.167442	0.167442 59
60 LABORATORY	34,902,931	54,300,116	89,203,047	0.165671	0.165671	0.165671 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	5,279,653	785,525	6,065,178	0.280265	0.280265	0.280265 65
66 PHYSICAL THERAPY	9,254,352	10,077,134	19,331,486	0.445987	0.445987	0.445987 66
68 SPEECH PATHOLOGY	993,901	3,622,931	4,616,832	0.466307	0.466307	0.466307 68
69 ELECTROCARDIOLOGY	6,328,529	12,717,059	19,045,588	0.063271	0.063271	0.063271 69
70 ELECTROENCEPHALOGRAPHY	173,154	1,140,581	1,313,735	0.501765	0.501765	0.501765 70
71 MEDICAL SUPPLIES CHRGD TO	16,506,434	14,450,687	30,957,121	0.463110	0.463110	0.463110 71
72 IMPL. DEV. CHARGED TO PATIE	10,770,334	3,915,137	14,685,471	0.711708	0.711708	0.711708 72
73 DRUGS CHARGED TO PATIENTS	23,243,797	26,896,384	50,140,181	0.270800	0.270800	0.270800 73
76.97 CARDIAC REHABILITATION	2,260	1,438,015	1,440,275	0.728655	0.728655	0.728655 76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 OP PEDS ONC CLINIC	129,471	2,724,278	2,853,749	0.477424	0.477424	0.477424 90.01
90.02 WOUND CLINIC	135,858	2,113,713	2,249,571	0.486403	0.486403	0.486403 90.02
91 EMERGENCY	12,145,265	59,700,275	71,845,540	0.181595	0.181595	0.181595 91
92 OBSERVATION BEDS	50,020	3,855,259	3,905,279	0.621548	0.621548	0.621548 92
92.01 OBSERVATION BEDS-DISTINCT	13,320	273,296	286,616	1.434229	1.434229	1.434229 92.01
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY		5,159,883	5,159,883			101
200 SUBTOTAL (SEE INSTRUCTIONS)	251,805,327	434,494,204	686,299,531			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	251,805,327	434,494,204	686,299,531			202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

CHECK [ ] TITLE V  
 APPLICABLE [XX] TITLE XVIII-PT A  
 BOXES [ ] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT (COL.1 MINUS COL.2)	(COL.1 MINUS COL.2)	(COL.3 ÷ COL.4)	PGM DAYS	(COL.5 x COL.6)	
	1	2	3	5	6	7	
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	2,516,725		2,516,725	97.31	9,969	970,083	30
31 INTENSIVE CARE UNIT	312,660		312,660	138.96	1,014	140,905	31
32 CORONARY CARE UNIT							32
33 BURN INTENSIVE CARE UNIT							33
34 SURGICAL INTENSIVE CARE UNIT							34
35 OTHER SPECIAL CARE (SPECIFY)							35
40 SUBPROVIDER - IPF							40
41 SUBPROVIDER - IRF							41
42 SUBPROVIDER I							42
43 NURSERY	208,107		208,107	45.95			43
44 SKILLED NURSING FACILITY	930,607		930,607	79.70	9,919	790,544	44
45 NURSING FACILITY	957,577		957,577				45
200 TOTAL (LINES 30-199)	4,925,676		4,925,676		20,902	1,901,532	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK APPLICABLE BOXES	[ ] TITLE V [XX] TITLE XVIII-PT A [ ] TITLE XIX	[XX] [ ] [ ]	HOSPITAL (14-0130) IPF IRF	[ ] SUB (OTHER)	[XX] [ ]	PPS TEFRA			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5				
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM	3,187,801	68,246,522	0.046710	6,290,231	293,817			50
52	DELIVERY ROOM & LABOR ROOM	271,789	9,660,709	0.028133	107	3			52
54	RADIOLOGY-DIAGNOSTIC	2,778,466	87,643,622	0.031702	5,428,806	172,104			54
55	RADIOLOGY-THERAPEUTIC	1,147,638	20,594,878	0.055724	152,029	8,472			55
57	COMPUTED TOMOGRAPHY (CT) SCAN	45,580	35,654,242	0.001278	5,542,948	7,084			57
58	MAGNETIC RESONANCE IMAGING (M	628,824	64,623,344	0.009731	2,714,044	26,410			58
59	CARDIAC CATHETERIZATION	116,411	8,728,967	0.013336	2,714,441	36,200			59
60	LABORATORY	730,824	89,203,047	0.008193	14,987,798	122,795			60
62.30	BLOOD CLOTTING FOR HEMOPHILIA								62.30
65	RESPIRATORY THERAPY	47,760	6,065,178	0.007874	2,395,242	18,860			65
66	PHYSICAL THERAPY	733,045	19,331,486	0.037920	1,799,023	68,219			66
68	SPEECH PATHOLOGY	47,059	4,616,832	0.010193	247,635	2,524			68
69	ELECTROCARDIOLOGY	65,066	19,045,588	0.003416	3,502,569	11,965			69
70	ELECTROENCEPHALOGRAPHY	50,284	1,313,735	0.038276	87,813	3,361			70
71	MEDICAL SUPPLIES CHRGD TO PA	160,912	30,957,121	0.005198	6,880,772	35,766			71
72	IMPL. DEV. CHARGED TO PATIENT	115,925	14,685,471	0.007894	5,663,676	44,709			72
73	DRUGS CHARGED TO PATIENTS	156,054	50,140,181	0.003112	8,578,214	26,695			73
76.97	CARDIAC REHABILITATION	96,320	1,440,275	0.066876	372	25			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	OP PEDS ONC CLINIC	89,076	2,853,749	0.031214	95,598	2,984			90.01
90.02	WOUND CLINIC	24,453	2,249,571	0.010870	55,809	607			90.02
91	EMERGENCY	784,314	71,845,540	0.010917	5,156,038	56,288			91
92	OBSERVATION BEDS	195,195	3,905,279	0.049982					92
92.01	OBSERVATION BEDS-DISTINCT	7,963	286,616	0.027783	4,854	135			92.01
OTHER REIMBURSABLE COST CENTERS									
200	TOTAL (SUM OF LINES 50-199)	11,480,759	613,091,953		72,298,019	939,023			200

PROVIDER CCN: 14-0130 NORTHWESTERN LAKE FOREST HOSPI  
PERIOD FROM 09/01/2011 TO 08/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11  
01/28/2013 11:57

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

CHECK [ ] TITLE V  
APPLICABLE [XX] TITLE XVIII-PT A  
BOXES [ ] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
30 INPAT ROUTINE SERV COST CTRS					30
31 ADULTS & PEDIATRICS					31
32 INTENSIVE CARE UNIT					32
33 CORONARY CARE UNIT					33
34 BURN INTENSIVE CARE UNIT					34
35 SURGICAL INTENSIVE CARE UNIT					35
40 OTHER SPECIAL CARE (SPECIFY)					40
41 SUBPROVIDER - IPF					41
42 SUBPROVIDER - IRF					42
43 SUBPROVIDER I					43
44 NURSERY					44
45 SKILLED NURSING FACILITY					45
200 NURSING FACILITY					45
TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 14-0130 NORTHWESTERN LAKE FOREST HOSPI  
 PERIOD FROM 09/01/2011 TO 08/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11  
 01/28/2013 11:57

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

CHECK [ ] TITLE V  
 APPLICABLE [XX] TITLE XVIII-PT A  
 BOXES [ ] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	25,864		9,969		30
31 INTENSIVE CARE UNIT	2,250		1,014		31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY	4,529				43
44 SKILLED NURSING FACILITY	11,677		9,919		44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	44,320		20,902		200

PROVIDER CCN: 14-0130 NORTHWESTERN LAKE FOREST HOSPI  
 PERIOD FROM 09/01/2011 TO 08/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11  
 01/28/2013 11:57

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-0130) [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			SCHOOL 2	MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
54 RADIOLOGY-DIAGNOSTIC						54
55 RADIOLOGY-THERAPEUTIC						55
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 OP PEDS ONC CLINIC						90.01
90.02 WOUND CLINIC						90.02
91 EMERGENCY						91
92 OBSERVATION BEDS						92
92.01 OBSERVATION BEDS-DISTINCT						92.01
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK APPLICABLE BOXES	[ ] TITLE V [XX] TITLE XVIII-PT A [ ] TITLE XIX	[XX] HOSPITAL (14-0130) [ ] IPF [ ] IRF	[ ] SUB (OTHER) [ ] SNF [ ] NF	[ ] ICF/MR	[XX] PPS [ ] TEFRA	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS												
50						OPERATING ROOM	68,246,522		6,290,231		9,691,500	50
52						DELIVERY ROOM & LABOR ROOM	9,660,709		107			52
54						RADIOLOGY-DIAGNOSTIC	87,643,622		5,428,806		16,631,415	54
55						RADIOLOGY-THERAPEUTIC	20,594,878		152,029		9,416,029	55
57						COMPUTED TOMOGRAPHY (CT) SCA	35,654,242		5,542,948		6,383,628	57
58						MAGNETIC RESONANCE IMAGING (	64,623,344		2,714,044		12,281,207	58
59						CARDIAC CATHETERIZATION	8,728,967		2,714,441		1,318,905	59
60						LABORATORY	89,203,047		14,987,798		2,785,516	60
62.30						BLOOD CLOTTING FOR HEMOPHILI						62.30
65						RESPIRATORY THERAPY	6,065,178		2,395,242		191,812	65
66						PHYSICAL THERAPY	19,331,486		1,799,023		90,823	66
68						SPEECH PATHOLOGY	4,616,832		247,635		423,568	68
69						ELECTROCARDIOLOGY	19,045,588		3,502,569		3,202,148	69
70						ELECTROENCEPHALOGRAPHY	1,313,735		87,813		239,515	70
71						MEDICAL SUPPLIES CHRGED TO P	30,957,121		6,880,772		3,436,395	71
72						IMPL. DEV. CHARGED TO PATIEN	14,685,471		5,663,676		1,211,624	72
73						DRUGS CHARGED TO PATIENTS	50,140,181		8,578,214		8,343,575	73
76.97						CARDIAC REHABILITATION	1,440,275		372		916,599	76.97
76.98						HYPERBARIC OXYGEN THERAPY						76.98
76.99						LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS												
90.01						OP PEDS ONC CLINIC	2,853,749		95,598		1,337,428	90.01
90.02						WOUND CLINIC	2,249,571		55,809		987,713	90.02
91						EMERGENCY	71,845,540		5,156,038		6,083,180	91
92						OBSERVATION BEDS	3,905,279					92
92.01						OBSERVATION BEDS-DISTINCT	286,616		4,854		16,046	92.01
OTHER REIMBURSABLE COST CENTERS												
200						TOTAL (SUM OF LINES 50-199)	613,091,953		72,298,019		84,988,626	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-0130) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT SUBJECT TO	COST SERVICES	COST SVCES NOT SUBJECT TO	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.364997	9,691,500			3,537,368		50
52 DELIVERY ROOM & LABOR ROOM	0.551733						52
54 RADIOLOGY-DIAGNOSTIC	0.229237	16,631,415			3,812,536		54
55 RADIOLOGY-THERAPEUTIC	0.185342	9,416,029			1,745,186		55
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.049235	6,383,628			314,298		57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.091938	12,281,207			1,129,110		58
59 CARDIAC CATHETERIZATION	0.167442	1,318,905			220,840		59
60 LABORATORY	0.165671	2,785,516			461,479		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.280265	191,812			53,758		65
66 PHYSICAL THERAPY	0.445987	90,823			40,506		66
68 SPEECH PATHOLOGY	0.466307	423,568		855	197,513	399	68
69 ELECTROCARDIOLOGY	0.063271	3,202,148			202,603		69
70 ELECTROENCEPHALOGRAPHY	0.501765	239,515			120,180		70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.463110	3,436,395			1,591,429		71
72 IMPL. DEV. CHARGED TO PATIENT	0.711708	1,211,624			862,322		72
73 DRUGS CHARGED TO PATIENTS	0.270800	8,343,575		7,935	2,259,440	2,149	73
76.97 CARDIAC REHABILITATION	0.728655	916,599			667,884		76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90.01 OP PEDS ONC CLINIC	0.477424	1,337,428			638,520		90.01
90.02 WOUND CLINIC	0.486403	987,713			480,427		90.02
91 EMERGENCY	0.181595	6,083,180		15,741	1,104,675	2,858	91
92 OBSERVATION BEDS	0.621548						92
92.01 OBSERVATION BEDS-DISTINCT	1.434229	16,046			23,014		92.01
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)		84,988,626		24,531	19,463,088	5,406	200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		84,988,626		24,531	19,463,088	5,406	202

PROVIDER CCN: 14-0130 NORTHWESTERN LAKE FOREST HOSPI  
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 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11  
 01/28/2013 11:57

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [XX] SNF (14-5216) [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			SCHOOL 2	MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
54 RADIOLOGY-DIAGNOSTIC						54
55 RADIOLOGY-THERAPEUTIC						55
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 OP PEDS ONC CLINIC						90.01
90.02 WOUND CLINIC						90.02
91 EMERGENCY						91
92 OBSERVATION BEDS						92
92.01 OBSERVATION BEDS-DISTINCT						92.01
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200



APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [ ] HOSPITAL [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [XX] SNF (14-5216) [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT SUBJECT TO	COST SERVICES	COST SVCES NOT SUBJECT TO	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.364997						50
52 DELIVERY ROOM & LABOR ROOM	0.551733						52
54 RADIOLOGY-DIAGNOSTIC	0.229237						54
55 RADIOLOGY-THERAPEUTIC	0.185342						55
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.049235						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.091938						58
59 CARDIAC CATHETERIZATION	0.167442						59
60 LABORATORY	0.165671						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.280265						65
66 PHYSICAL THERAPY	0.445987						66
68 SPEECH PATHOLOGY	0.466307						68
69 ELECTROCARDIOLOGY	0.063271						69
70 ELECTROENCEPHALOGRAPHY	0.501765						70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.463110						71
72 IMPL. DEV. CHARGED TO PATIENT	0.711708						72
73 DRUGS CHARGED TO PATIENTS	0.270800						73
76.97 CARDIAC REHABILITATION	0.728655						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90.01 OP PEDS ONC CLINIC	0.477424						90.01
90.02 WOUND CLINIC	0.486403						90.02
91 EMERGENCY	0.181595						91
92 OBSERVATION BEDS	0.621548						92
92.01 OBSERVATION BEDS-DISTINCT	1.434229						92.01
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

CHECK [ ] TITLE V  
 APPLICABLE [ ] TITLE XVIII-PT A  
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT (COL.1 MINUS COL.2)	(COL.1 MINUS COL.2)	(COL.3 ÷ COL.4)	PGM DAYS	(COL.5 x COL.6)	
	1	2	4	5	6	7	
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	2,516,725		25,864	97.31	1,246	121,248	30
31 INTENSIVE CARE UNIT	312,660		2,250	138.96	97	13,479	31
32 CORONARY CARE UNIT							32
33 BURN INTENSIVE CARE UNIT							33
34 SURGICAL INTENSIVE CARE UNIT							34
35 OTHER SPECIAL CARE (SPECIFY)							35
40 SUBPROVIDER - IPF							40
41 SUBPROVIDER - IRF							41
42 SUBPROVIDER I							42
43 NURSERY	208,107		4,529	45.95	198	9,098	43
44 SKILLED NURSING FACILITY	930,607		11,677	79.70			44
45 NURSING FACILITY	957,577						45
200 TOTAL (LINES 30-199)	4,925,676		44,320		1,541	143,825	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK APPLICABLE BOXES	[ ] TITLE V [ ] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (14-0130) [ ] IPF [ ] IRF	[ ] SUB (OTHER)	[ ] PPS [ ] TEFRA [XX] OTHER	
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	3,187,801	68,246,522	0.046710	50
52	DELIVERY ROOM & LABOR ROOM	271,789	9,660,709	0.028133	52
54	RADIOLOGY-DIAGNOSTIC	2,778,466	87,643,622	0.031702	54
55	RADIOLOGY-THERAPEUTIC	1,147,638	20,594,878	0.055724	55
57	COMPUTED TOMOGRAPHY (CT) SCAN	45,580	35,654,242	0.001278	57
58	MAGNETIC RESONANCE IMAGING (M	628,824	64,623,344	0.009731	58
59	CARDIAC CATHETERIZATION	116,411	8,728,967	0.013336	59
60	LABORATORY	730,824	89,203,047	0.008193	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA				62.30
65	RESPIRATORY THERAPY	47,760	6,065,178	0.007874	65
66	PHYSICAL THERAPY	733,045	19,331,486	0.037920	66
68	SPEECH PATHOLOGY	47,059	4,616,832	0.010193	68
69	ELECTROCARDIOLOGY	65,066	19,045,588	0.003416	69
70	ELECTROENCEPHALOGRAPHY	50,284	1,313,735	0.038276	70
71	MEDICAL SUPPLIES CHRGD TO PA	160,912	30,957,121	0.005198	71
72	IMPL. DEV. CHARGED TO PATIENT	115,925	14,685,471	0.007894	72
73	DRUGS CHARGED TO PATIENTS	156,054	50,140,181	0.003112	73
76.97	CARDIAC REHABILITATION	96,320	1,440,275	0.066876	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	OP PEDS ONC CLINIC	89,076	2,853,749	0.031214	90.01
90.02	WOUND CLINIC	24,453	2,249,571	0.010870	90.02
91	EMERGENCY	784,314	71,845,540	0.010917	91
92	OBSERVATION BEDS	195,195	3,905,279	0.049982	92
92.01	OBSERVATION BEDS-DISTINCT	7,963	286,616	0.027783	92.01
OTHER REIMBURSABLE COST CENTERS					
200	TOTAL (SUM OF LINES 50-199)	11,480,759	613,091,953		200

PROVIDER CCN: 14-0130 NORTHWESTERN LAKE FOREST HOSPI  
PERIOD FROM 09/01/2011 TO 08/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM  
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

CHECK [ ] TITLE V  
APPLICABLE [ ] TITLE XVIII-PT A  
BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
30 INPAT ROUTINE SERV COST CTRS					30
31 ADULTS & PEDIATRICS					31
32 INTENSIVE CARE UNIT					32
33 CORONARY CARE UNIT					33
34 BURN INTENSIVE CARE UNIT					34
35 SURGICAL INTENSIVE CARE UNIT					35
40 OTHER SPECIAL CARE (SPECIFY)					40
41 SUBPROVIDER - IPF					41
42 SUBPROVIDER - IRF					42
43 SUBPROVIDER I					43
44 NURSERY					44
45 SKILLED NURSING FACILITY					45
200 NURSING FACILITY					45
TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 14-0130 NORTHWESTERN LAKE FOREST HOSPI  
 PERIOD FROM 09/01/2011 TO 08/31/2012

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

CHECK [ ] TITLE V  
 APPLICABLE [ ] TITLE XVIII-PT A  
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	25,864		1,246		30
31 INTENSIVE CARE UNIT	2,250		97		31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY	4,529		198		43
44 SKILLED NURSING FACILITY	11,677				44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	44,320		1,541		200

PROVIDER CCN: 14-0130 NORTHWESTERN LAKE FOREST HOSPI  
 PERIOD FROM 09/01/2011 TO 08/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11  
 01/28/2013 11:57

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-0130) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [ ] NF [XX] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			SCHOOL 2	MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
54 RADIOLOGY-DIAGNOSTIC						54
55 RADIOLOGY-THERAPEUTIC						55
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90.01 OP PEDS ONC CLINIC						90.01
90.02 WOUND CLINIC						90.02
91 EMERGENCY						91
92 OBSERVATION BEDS						92
92.01 OBSERVATION BEDS-DISTINCT						92.01
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ] TITLE V	[XX] HOSPITAL (14-0130)	[ ] SUB (OTHER)	[ ] ICF/MR	[ ] PPS		
APPLICABLE	[ ] TITLE XVIII-PT A	[ ] IPF	[ ] SNF		[ ] TEFRA		
BOXES	[XX] TITLE XIX	[ ] IRF	[ ] NF		[XX] OTHER		
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	68,246,522					50
52	DELIVERY ROOM & LABOR ROOM	9,660,709					52
54	RADIOLOGY-DIAGNOSTIC	87,643,622					54
55	RADIOLOGY-THERAPEUTIC	20,594,878					55
57	COMPUTED TOMOGRAPHY (CT) SCA	35,654,242					57
58	MAGNETIC RESONANCE IMAGING (	64,623,344					58
59	CARDIAC CATHETERIZATION	8,728,967					59
60	LABORATORY	89,203,047					60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	6,065,178					65
66	PHYSICAL THERAPY	19,331,486					66
68	SPEECH PATHOLOGY	4,616,832					68
69	ELECTROCARDIOLOGY	19,045,588					69
70	ELECTROENCEPHALOGRAPHY	1,313,735					70
71	MEDICAL SUPPLIES CHRGED TO P	30,957,121					71
72	IMPL. DEV. CHARGED TO PATIEN	14,685,471					72
73	DRUGS CHARGED TO PATIENTS	50,140,181					73
76.97	CARDIAC REHABILITATION	1,440,275					76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC	2,853,749					90.01
90.02	WOUND CLINIC	2,249,571					90.02
91	EMERGENCY	71,845,540					91
92	OBSERVATION BEDS	3,905,279					92
92.01	OBSERVATION BEDS-DISTINCT	286,616					92.01
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	613,091,953					200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-0130) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [ ] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [XX] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	----- PROGRAM CHARGES -----				----- PROGRAM COSTS -----		
	COST TO		COST REIMB.	COST REIMB.	COST	COST	
	CHARGE RATIO	PPS	SERVICES	SVCES NOT	SERVICES	SVCES NOT	
	FROM WKST C,	REIMBURSED	SUBJECT TO	SUBJECT TO	PPS	SUBJECT TO	SUBJECT TO
	PT I, COL. 9	SERVICES	DED & COINS	DED & COINS	SERVICES	DED & COINS	DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.364997						50
52 DELIVERY ROOM & LABOR ROOM	0.551733						52
54 RADIOLOGY-DIAGNOSTIC	0.229237						54
55 RADIOLOGY-THERAPEUTIC	0.185342						55
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.049235						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.091938						58
59 CARDIAC CATHETERIZATION	0.167442						59
60 LABORATORY	0.165671						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.280265						65
66 PHYSICAL THERAPY	0.445987						66
68 SPEECH PATHOLOGY	0.466307						68
69 ELECTROCARDIOLOGY	0.063271						69
70 ELECTROENCEPHALOGRAPHY	0.501765						70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.463110						71
72 IMPL. DEV. CHARGED TO PATIENT	0.711708						72
73 DRUGS CHARGED TO PATIENTS	0.270800						73
76.97 CARDIAC REHABILITATION	0.728655						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90.01 OP PEDS ONC CLINIC	0.477424						90.01
90.02 WOUND CLINIC	0.486403						90.02
91 EMERGENCY	0.181595						91
92 OBSERVATION BEDS	0.621548						92
92.01 OBSERVATION BEDS-DISTINCT	1.434229						92.01
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-0130) [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX-INPT [ ] IRF [ ] NF [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	25,864	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	25,864	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	23,858	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	9,969	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	31,296,181	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	31,296,181	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	31,296,181	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-0130) [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [ ] TITLE XIX-INPT [ ] IRF [ ] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,210.03 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 12,062,789 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) 12,062,789 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT	4,519,524	2,250	2,008.68	1,014	2,036,802	43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					19,453,490	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					33,553,081	49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 1,110,988 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 939,023 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 2,050,011 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 31,503,070 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 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 (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61  
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62  
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST  
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 64  
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65  
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66  
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67  
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68  
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 2,006 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 1,210.03 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 2,427,320 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	2,516,725	31,296,181	0.080416	2,427,320	195,195	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [ ] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [XX] SNF (14-5216) [ ] TEFRA  
 BOXES [ ] TITLE XIX-INPT [ ] IRF [ ] NF [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	11,677	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	11,677	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	11,677	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 (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	9,919	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	9,152,458	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	9,152,458	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	9,152,458	37

PROVIDER CCN: 14-0130 NORTHWESTERN LAKE FOREST HOSPI  
PERIOD FROM 09/01/2011 TO 08/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11  
01/28/2013 11:57

WORKSHEET D-1  
PARTS III & IV

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [ ] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [XX] SNF (14-5216) [ ] TEFRA  
BOXES [ ] TITLE XIX-INPT [ ] IRF [ ] NF [ ] OTHER

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

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COSTS (LINE 37)	9,152,458	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	783.80	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	7,774,512	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (LINE 14 x LINE 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (LINE 72 + LINE 73)	7,774,512	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (FROM WKST B, PART II, COL. 26, LINE 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (LINE 75 ÷ LINE 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (LINE 9 x LINE 76)		77
78	INPATIENT ROUTINE SERVICE COST (LINE 74 MINUS LINE 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (FROM PROVIDER RECORDS)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (LINE 78 MINUS LINE 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (LINE 9 x LINE 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (SEE INSTRUCTIONS)	7,774,512	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)		84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	7,774,512	86

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-0130) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX-INPT [ ] IRF [ ] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	25,864	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	25,864	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	23,858	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,246	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	4,529	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	198	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)	31,296,181	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	31,296,181	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	31,296,181	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-0130) [ ] SUB (OTHER) [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [XX] TITLE XIX-INPT [ ] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,210.03 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,507,697 39  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 1,507,697 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)	3,405,409	4,529	751.91	198	148,878 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	4,519,524	2,250	2,008.68	97	194,842 43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					1,851,417 49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 143,825 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 143,825 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 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 (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61  
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62  
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST  
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 64  
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65  
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66  
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67  
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68  
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 2,006 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

	ROUTINE COST (FROM LINE 27)	COL. 1 ÷ COL. 2	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)
	1	2	3	4
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST				
90 CAPITAL-RELATED COST				90
91 NURSING SCHOOL COST				91
92 ALLIED HEALTH COST				92
93 ALL OTHER MEDICAL EDUCATION				93

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [XX] HOSPITAL (14-0130) [ ] SUB (OTHER) [ ] S/B SNF [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [ ] OTHER

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		13,802,910		30
31 INTENSIVE CARE UNIT		8,730,541		31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.364997	6,290,231	2,295,915	50
52 DELIVERY ROOM & LABOR ROOM	0.551733	107	59	52
54 RADIOLOGY-DIAGNOSTIC	0.229237	5,428,806	1,244,483	54
55 RADIOLOGY-THERAPEUTIC	0.185342	152,029	28,177	55
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.049235	5,542,948	272,907	57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.091938	2,714,044	249,524	58
59 CARDIAC CATHETERIZATION	0.167442	2,714,441	454,511	59
60 LABORATORY	0.165671	14,987,798	2,483,043	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.280265	2,395,242	671,302	65
66 PHYSICAL THERAPY	0.445987	1,799,023	802,341	66
68 SPEECH PATHOLOGY	0.466307	247,635	115,474	68
69 ELECTROCARDIOLOGY	0.063271	3,502,569	221,611	69
70 ELECTROENCEPHALOGRAPHY	0.501765	87,813	44,061	70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.463110	6,880,772	3,186,554	71
72 IMPL. DEV. CHARGED TO PATIENT	0.711708	5,663,676	4,030,884	72
73 DRUGS CHARGED TO PATIENTS	0.270800	8,578,214	2,322,980	73
76.97 CARDIAC REHABILITATION	0.728655	372	271	76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90.01 OP PEDS ONC CLINIC	0.477424	95,598	45,641	90.01
90.02 WOUND CLINIC	0.486403	55,809	27,146	90.02
91 EMERGENCY	0.184181	5,156,038	949,644	91
92 OBSERVATION BEDS	0.621548			92
92.01 OBSERVATION BEDS-DISTINCT	1.434229	4,854	6,962	92.01
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		72,298,019	19,453,490	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		72,298,019		202

PROVIDER CCN: 14-0130 NORTHWESTERN LAKE FOREST HOSPI  
 PERIOD FROM 09/01/2011 TO 08/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11  
 01/28/2013 11:57

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [ ] S/B SNF [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [XX] SNF (14-5216) [ ] S/B NF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [ ] OTHER

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
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.364997			50
52 DELIVERY ROOM & LABOR ROOM	0.551733			52
54 RADIOLOGY-DIAGNOSTIC	0.229237			54
55 RADIOLOGY-THERAPEUTIC	0.185342			55
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.049235			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.091938			58
59 CARDIAC CATHETERIZATION	0.167442			59
60 LABORATORY	0.165671			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.280265			65
66 PHYSICAL THERAPY	0.445987			66
68 SPEECH PATHOLOGY	0.466307			68
69 ELECTROCARDIOLOGY	0.063271			69
70 ELECTROENCEPHALOGRAPHY	0.501765			70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.463110			71
72 IMPL. DEV. CHARGED TO PATIENT	0.711708			72
73 DRUGS CHARGED TO PATIENTS	0.270800			73
76.97 CARDIAC REHABILITATION	0.728655			76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90.01 OP PEDS ONC CLINIC	0.477424			90.01
90.02 WOUND CLINIC	0.486403			90.02
91 EMERGENCY	0.181595			91
92 OBSERVATION BEDS	0.621548			92
92.01 OBSERVATION BEDS-DISTINCT	1.434229			92.01
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

PROVIDER CCN: 14-0130 NORTHWESTERN LAKE FOREST HOSPI  
 PERIOD FROM 09/01/2011 TO 08/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11  
 01/28/2013 11:57

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [XX] HOSPITAL (14-0130) [ ] SUB (OTHER) [ ] S/B SNF [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] OTHER

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
43 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.364997			50
52 DELIVERY ROOM & LABOR ROOM	0.551733			52
54 RADIOLOGY-DIAGNOSTIC	0.229237			54
55 RADIOLOGY-THERAPEUTIC	0.185342			55
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.049235			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.091938			58
59 CARDIAC CATHETERIZATION	0.167442			59
60 LABORATORY	0.165671			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.280265			65
66 PHYSICAL THERAPY	0.445987			66
68 SPEECH PATHOLOGY	0.466307			68
69 ELECTROCARDIOLOGY	0.063271			69
70 ELECTROENCEPHALOGRAPHY	0.501765			70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.463110			71
72 IMPL. DEV. CHARGED TO PATIENT	0.711708			72
73 DRUGS CHARGED TO PATIENTS	0.270800			73
76.97 CARDIAC REHABILITATION	0.728655			76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90.01 OP PEDS ONC CLINIC	0.477424			90.01
90.02 WOUND CLINIC	0.486403			90.02
91 EMERGENCY	0.181595			91
92 OBSERVATION BEDS	0.621548			92
92.01 OBSERVATION BEDS-DISTINCT	1.434229			92.01
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART A

CHECK [XX] HOSPITAL (14-0130)  
 APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	19,682,494	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	471,379	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	111.52	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) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)		30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)		31
32	SUM OF LINES 30 AND 31		32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)		34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
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 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	20,153,873	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	20,153,873	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	1,627,866	50

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A

CHECK [XX] HOSPITAL (14-0130)  
APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	21,781,739	59
60	PRIMARY PAYER PAYMENTS		60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	21,781,739	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	2,467,132	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	71,988	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	208,576	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	146,003	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	147,809	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	19,388,622	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	19,388,622	71
72	INTERIM PAYMENTS	19,266,578	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	122,044	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96





ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK  HOSPITAL (14-0130)  SUB (OTHER)  
 APPLICABLE  IPF  SNF  
 BOX:  IRF  SWING BED SNF

INPATIENT  
 PART A

PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER					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.		19,266,578		11,402,145	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 .03 .04 .05 .06 .07 .08 .09 .50 .51 .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		19,266,578		11,402,145	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 .03 .04 .05 .06 .07 .08 .09 .50 .51 .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	.01 .02	122,044		197,609	6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		19,388,622		11,599,754	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

PROVIDER CCN: 14-0130 NORTHWESTERN LAKE FOREST HOSPI  
PERIOD FROM 09/01/2011 TO 08/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11  
01/28/2013 11:57

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK [XX] HOSPITAL (14-0130) [ ] CAH  
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	8,655	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	10,983	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	205	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	26,108	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	686,299,531	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	25,722,172	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	1,558,815	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)	1,610,313	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	-51,498	32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
PART VI

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

PROSPECTIVE PAYMENT AMOUNT	
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT 1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS 2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS 3
4	SUBTOTAL (SUM OF LINES 1-3) 4
COMPUTATION OF NET COST OF COVERED SERVICES	
5	MEDICAL AND OTHER SERVICES 5
6	DEDUCTIBLES 6
7	COINSURANCE 7
8	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS) 8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS) 9
10	ALLOWABLE REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) 10
11	UTILIZATION REVIEW 11
12	SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS) 12
13	INPATIENT PRIMARY PAYER PAYMENTS 13
14	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS) 14
15	SUBTOTAL (LINE 12 MINUS 13 ± LINE 14) 15
16	INTERIM PAYMENTS 16
17	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY) 17
18	BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS THE SUM OF LINES 16 AND 17) 18
19	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2 19

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART VII

CHECK [ ] TITLE V [XX] HOSPITAL (14-0130) [ ] SNF [ ] PPS  
 APPLICABLE [XX] TITLE XIX [ ] IPF [ ] NF [ ] TEFRA  
 BOXES: [ ] IRF [ ] ICF/MR [XX] OTHER  
 [ ] SUB (OTHER)

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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1 INPATIENT HOSPITAL SNF/NF SERVICES	1,851,417		1
2 MEDICAL AND OTHER SERVICES			2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)			3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)	1,851,417		4
5 INPATIENT PRIMARY PAYER PAYMENTS			5
6 OUTPATIENT PRIMARY PAYER PAYMENTS			6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	1,851,417		7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES			
8 ROUTINE SERVICE CHARGES			8
9 ANCILLARY SERVICE CHARGES			9
10 ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11 INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12 TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)			12
CUSTOMARY CHARGES			
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	1.000000	15
16 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)			16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))			17
18 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	1,851,417		18
19 INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			19
20 COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			20
21 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)			21
PROSPECTIVE PAYMENT AMOUNT			
22 OTHER THAN OUTLIER PAYMENTS			22
23 OUTLIER PAYMENTS			23
24 PROGRAM CAPITAL PAYMENTS			24
25 CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			25
26 ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27 SUBTOTAL (SUM OF LINES 22 THROUGH 26)			27
28 CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)			28
29 SUM OF LINES 27 AND 21			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30 EXCESS OF REASONABLE COST (FROM LINE 18)			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 41)			42
43 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

BALANCE SHEET

WORKSHEET G

ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	24,588,471	3,971,024	25,176,543	1
2 TEMPORARY INVESTMENTS				2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	32,980,915			4
5 OTHER RECEIVABLES				5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7 INVENTORY	4,734,881			7
8 PREPAID EXPENSES				8
9 OTHER CURRENT ASSETS	9,438,752			9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	71,743,019	3,971,024	25,176,543	11
FIXED ASSETS				
12 LAND	55,533,262			12
13 LAND IMPROVEMENTS				13
14 ACCUMULATED DEPRECIATION				14
15 BUILDINGS	160,621,674			15
16 ACCUMULATED DEPRECIATION	-46,714,146			16
17 LEASEHOLD IMPROVEMENTS				17
18 ACCUMULATED AMORTIZATION				18
19 FIXED EQUIPMENT	31,205,334			19
20 ACCUMULATED DEPRECIATION				20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT				23
24 ACCUMULATED DEPRECIATION				24
25 MINOR EQUIPMENT DEPRECIABLE				25
26 ACCUMULATED DEPRECIATION				26
27 HIT DESIGNATED ASSETS				27
28 ACCUMULATED DEPRECIATION				28
29 MINOR EQUIPMENT-NONDEPRECIABLE				29
30 TOTAL FIXED ASSETS (SUM OF LINES 12-29)	200,646,124			30
OTHER ASSETS				
31 INVESTMENTS	145,816,500			31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS	5,381,352			34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	151,197,852			35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	423,586,995	3,971,024	25,176,543	36
LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	8,062,435			37
38 SALARIES, WAGES & FEES PAYABLE	11,660,409			38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)				40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS				43
44 OTHER CURRENT LIABILITIES	39,064,835			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	58,787,679			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE				46
47 NOTES PAYABLE				47
48 UNSECURED LOANS	29,147,567			48
49 OTHER LONG TERM LIABILITIES	91,923,922			49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	121,071,489			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	179,859,168			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	243,727,827			52
53 SPECIFIC PURPOSE FUND BALANCE		3,971,024		53
54 DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED			25,176,543	54
55 DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56 GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57 PLANT FUND BALANCE - INVESTED IN PLANT				57
58 PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59 TOTAL FUND BALANCES (SUM OF LINES 52-58)	243,727,827	3,971,024	25,176,543	59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	423,586,995	3,971,024	25,176,543	60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD	248,965,845			3,857,316		24,869,001			1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)	-7,677,476								2
3 TOTAL (SUM OF LINE 1 AND LINE 2)	241,288,369			3,857,316		24,869,001			3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 ASSETS RELEASED FROM RESTRICTED GIFTS, GRANTS & OTHER REVENUE	673,108								5
6 INVESTMENT INCOME - REALIZED			943,405		307,542				6
7 UNREALIZED GAINS (LOSSES)			398,156						7
8			101,393						8
9			14,815						9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)	673,108			1,457,769		307,542			10
11 SUBTOTAL (LINE 3 PLUS LINE 10)	241,961,477			5,315,085		25,176,543			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 OPERATING EXPENSES			670,953						13
14 PROPERTY ADDITIONS			673,108						14
15 PENSION RELATED CHANGES	13,075,197								15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)	13,075,197			1,344,061					18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)	228,886,280			3,971,024		25,176,543			19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	46,215,365		46,215,365	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY	9,438,122		9,438,122	7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	55,653,487		55,653,487	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	55,653,487		55,653,487	18
19 ANCILLARY SERVICES	193,996,111	433,459,348	627,455,459	19
20 OUTPATIENT SERVICES				20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY		5,159,883	5,159,883	23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
27.01 OTHER (SPECIFY)				27.01
27.02 PROFESSION CHARGES	2,862,815	21,871,607	24,734,422	27.02
28 OCCUPATIONAL MEDICINE		1,920,027	1,920,027	28
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	252,512,413	462,410,865	714,923,278	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		245,066,430	29
30 ADD (SPECIFY)			30
31 BAD DEBT	5,545,217		31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		5,545,217	36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		250,611,647	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	714,923,278	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	492,111,265	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	222,812,013	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	250,611,647	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-27,799,634	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	8,261,000	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	1,229,518	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	422,388	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	6,252,886	22
23	GOVERNMENTAL APPROPRIATIONS	3,956,366	23
24			24
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	20,122,158	25
26	TOTAL (LINE 5 PLUS LINE 25)	-7,677,476	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	-7,677,476	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7045

WORKSHEET H

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR- TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED/ SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF COLS.1-5) 6
GENERAL SERVICE COST CENTER						
1 CAPITAL RELATED-BLDGS & FIXTURES						1
2 CAPITAL RELATED-MOVABLE EQUIPMENT						2
3 PLANT OPERATION & MAINTENANCE						3
4 TRANSPORTATION (SEE INSTRUCTIONS)						4
5 ADMINISTRATIVE AND GENERAL	241,336	24,560			-185,410	80,486
HHA REIMBURSABLE SERVICES						
6 SKILLED NURSING CARE	1,046,686	106,520				1,153,206
7 PHYSICAL THERAPY	492,035	50,074				542,109
8 OCCUPATIONAL THERAPY	156	16				172
9 SPEECH PATHOLOGY						9
10 MEDICAL SOCIAL SERVICES	37,118	3,777				40,895
11 HOME HEALTH AIDE	59,623	6,068				65,691
12 SUPPLIES (SEE INSTRUCTIONS)						12
13 DRUGS						13
14 DME						14
HHA NONREIMBURSABLE SERVICES						
15 HOME DIALYSIS AIDE SERVICES						15
16 RESPIRATORY THERAPY						16
17 PRIVATE DUTY NURSING						17
18 CLINIC						18
19 HEALTH PROMOTION ACTIVITIES						19
20 DAY CARE PROGRAM						20
21 HOME DELIVERED MEALS PROGRAM						21
22 HOMEMAKER SERVICE						22
23 ALL OTHERS						23
24 TOTAL (SUM OF LINES 1-23)	1,876,954	191,015			-185,410	1,882,559

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7045

WORKSHEET H  
 (CONTINUED)

	RECLASS- IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
1					1
2					2
3					3
4					4
5		80,486		80,486	5
6		1,153,206		1,153,206	6
7		542,109		542,109	7
8		172		172	8
9					9
10		40,895		40,895	10
11		65,691		65,691	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		1,882,559		1,882,559	24



COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7045

WORKSHEET H-1  
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT- ATION (MILEAGE) 4	RECONCIL- IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
GENERAL SERVICE COST CENTER							
1 CAPITAL RELATED-BLDGS & FIXT							1
2 CAPITAL RELATED-MOVABLE EQUIP							2
3 PLANT OPERATION & MAINTENANCE							3
4 TRANSPORTATION (SEE INSTR.)							4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES					-80,486	1,802,073	5
6 SKILLED NURSING CARE						1,153,206	6
7 PHYSICAL THERAPY						542,109	7
8 OCCUPATIONAL THERAPY						172	8
9 SPEECH PATHOLOGY							9
10 MEDICAL SOCIAL SERVICES						40,895	10
11 HOME HEALTH AIDE						65,691	11
12 SUPPLIES (SEE INSTRUCTIONS)							12
13 DRUGS							13
14 DME							14
HHA NONREIMBURSABLE SERVICES							
15 HOME DIALYSIS AIDE SERVICES							15
16 RESPIRATORY THERAPY							16
17 PRIVATE DUTY NURSING							17
18 CLINIC							18
19 HEALTH PROMOTION ACTIVITIES							19
20 DAY CARE PROGRAM							20
21 HOME DELIVERED MEALS PROGRAM							21
22 HOMEMAKER SERVICE							22
23 ALL OTHERS							23
23.50 TELEMEDICINE							23.50
24 TOTAL (SUM OF LINES 1-23)					-80,486	1,802,073	24
25 COST TO BE ALLOC (PER W/S H)						80,486	25
26 UNIT COST MULTIPLIER						0.044663	26







ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7045

WORKSHEET H-2  
 PART I

HHA COST CENTER	SUBTOTAL (SUM OF COL.4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (SUM OF COL.4A-23) 26	ALLOCATED HHA A&G (SEE PT.2) 27	TOTAL HHA COSTS 28	
1 ADMINISTRATIVE AND GENERAL	79,259		79,259			1
2 SKILLED NURSING CARE	2,014,947		2,014,947	50,631	2,065,578	2
3 PHYSICAL THERAPY	947,204		947,204	23,800	971,004	3
4 OCCUPATIONAL THERAPY	301		301	8	309	4
5 SPEECH PATHOLOGY						5
6 MEDICAL SOCIAL SERVICES	71,454		71,454	1,795	73,249	6
7 HOME HEALTH AIDE	114,779		114,779	2,884	117,663	7
8 SUPPLIES	5,323		5,323	134	5,457	8
9 DRUGS	296		296	7	303	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 TOTAL (SUM OF LINES 1-19)	3,233,563		3,233,563	79,259	3,233,563	20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.				0.025127		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS  
 STATISTICAL BASIS

HHA NO.: 14-7045

WORKSHEET H-2  
 PART II

HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET
	1	2	3	4	4A	5	6	7
1 ADMINISTRATIVE AND GENERAL				32,407,667		57,135		1
2 SKILLED NURSING CARE				140,553,606		1,452,508		2
3 PHYSICAL THERAPY				66,072,592		682,807		3
4 OCCUPATIONAL THERAPY				20,924		217		4
5 SPEECH PATHOLOGY								5
6 MEDICAL SOCIAL SERVICES				4,984,409		51,509		6
7 HOME HEALTH AIDE				8,006,479		82,740		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 TOTAL (SUM OF LINES 1-19)				252,045,677		2,326,916		20
21 TOTAL COST TO BE ALLOCATED				444,357		901,028		21
22 UNIT COST MULTIPLIER				0.001763		0.387220		22





APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7045

WORKSHEET H-3  
 PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)	4	(COL.3 ÷ COL.4)	
			1	2	3	5		
1	SKILLED NURSING CARE	2	2,065,578		2,065,578	5,276	391.50	1
2	PHYSICAL THERAPY	3	971,004		971,004	3,361	288.90	2
3	OCCUPATIONAL THERAPY	4	309		309	28	11.04	3
4	SPEECH PATHOLOGY	5				72		4
5	MEDICAL SOCIAL SERVICES	6	73,249		73,249	233	314.37	5
6	HOME HEALTH AIDE	7	117,663		117,663	704	167.13	6
7	TOTAL (SUM OF LINES 1-6)		3,227,803		3,227,803	9,674		7
PATIENT SERVICES								
8	SKILLED NURSING CARE							8
8.01	SKILLED NURSING CARE							8.01
9	PHYSICAL THERAPY							9
9.01	PHYSICAL THERAPY							9.01
10	OCCUPATIONAL THERAPY							10
10.01	OCCUPATIONAL THERAPY							10.01
11	SPEECH PATHOLOGY							11
11.01	SPEECH PATHOLOGY							11.01
12	MEDICAL SOCIAL SERVICES							12
12.01	MEDICAL SOCIAL SERVICES							12.01
13	HOME HEALTH AIDE							13
13.01	HOME HEALTH AIDE							13.01
14	TOTAL (SUM OF LINES 8-13)							14
SUPPLIES AND DRUGS COST COMPUTATIONS		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL CHARGES	RATIO	
OTHER PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)	(FROM HHA RECORD)	(COL.3 ÷ COL.4)	
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	5,457		5,457			15
16	COST OF DRUGS	9	303		303			16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7045

WORKSHEET H-3  
 PARTS I & II  
 (CONTINUED)

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			TOTAL PROGRAM COST (SUM OF COLS.9-10)
	PART A		PART B		PART B			
PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR		
1 SKILLED NURSING CARE	3,624	1,652		1,418,796	646,758		2,065,554	
2 PHYSICAL THERAPY	2,483	878		717,339	253,654		970,993	
3 OCCUPATIONAL THERAPY	14	14		155	155		310	
4 SPEECH PATHOLOGY	45	27					4	
5 MEDICAL SOCIAL SERVICES	109	124		34,266	38,982		73,248	
6 HOME HEALTH AIDE	203	501		33,927	83,732		117,659	
7 TOTAL (SUM OF LINES 1-6)	6,478	3,196		2,204,483	1,023,281		3,227,764	

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS				TOTAL
		PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART B	
8 SKILLED NURSING CARE	16974	2	3	4	8	
8.01 SKILLED NURSING CARE	29404	421	98		8.01	
9 PHYSICAL THERAPY	16974	145	56		9	
9.01 PHYSICAL THERAPY	29404	2,338	822		9.01	
10 OCCUPATIONAL THERAPY	16974				10	
10.01 OCCUPATIONAL THERAPY	29404	14	14		10.01	
11 SPEECH PATHOLOGY	16974				11	
11.01 SPEECH PATHOLOGY	29404	45	27		11.01	
12 MEDICAL SOCIAL SERVICES	16974	8	9		12	
12.01 MEDICAL SOCIAL SERVICES	29404	101	115		12.01	
13 HOME HEALTH AIDE	16974	2			13	
13.01 HOME HEALTH AIDE	29404	201	501		13.01	
14 TOTAL (SUM OF LINES 8-13)		6,478	3,196		14	

SUPPLIES AND DRUGS COST COMPUTATIONS	PROGRAM COVERED CHARGES				COST OF SERVICES		
	PART A		PART B		PART B		
OTHER PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
15 COST OF MEDICAL SUPPLIES							15
16 COST OF DRUGS							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 PHYSICAL THERAPY	66	0.445987		COL 2, LINE 2	1
2 OCCUPATIONAL THERAPY	67			COL 2, LINE 3	2
3 SPEECH PATHOLOGY	68	0.466307		COL 2, LINE 4	3
4 MEDICAL SUPPLIES CHRGD TO PAT	71	0.463110		COL 2, LINE 15	4
5 DRUGS CHARGED TO PATIENTS	73	0.270800		COL 2, LINE 16	5

CALCULATION OF HHA REMBURSEMENT SETTLEMENT

HHA NO.: 14-7045

WORKSHEET H-4  
 PARTS I & II

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

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

DESCRIPTION	PART A 1	----- PART B -----		
		NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3	
1 REASONABLE COST OF PART A & PART B SERVICES				1
2 REASONABLE COST OF SERVICES (SEE INSTRUCTIONS)				2
3 TOTAL CHARGES				3
CUSTOMARY CHARGES				
4 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (FROM YOUR RECORDS)				4
5 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)				5
6 RATIO OF LINE 3 TO LINE 4 (NOT TO EXCEED 1.000000)				6
7 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)				7
8 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 1)				8
9 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 1 EXCEEDS LINE 6)				9
PRIMARY PAYER PAYMENTS				

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10 TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	1,165,508	488,324	11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	5,127	10,215	12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	26,329	16,741	13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES	3,889	10,400	14
15 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	716	1,149	15
16 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES		57	16
17 TOTAL OTHER PAYMENTS			17
18 DME PAYMENTS			18
19 OXYGEN PAYMENTS			19
20 PROSTHETIC AND ORTHOTIC PAYMENTS			20
21 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
22 SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	1,201,569	526,886	22
23 EXCESS REASONABLE COST (FROM LINE 8)			23
24 SUBTOTAL (LINE 22 MINUS LINE 23)	1,201,569	526,886	24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26 NET COST (LINE 24 MINUS LINE 25)	1,201,569	526,886	26
27 REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
28 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
29 TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	1,201,569	526,886	29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	1,201,569	526,886	31
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)	1,201,569	526,886	32
33 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 32 AND 33)			34
35 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			35

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHA'S  
 FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

HHA NO.: 14-7045

WORKSHEET H-5

DESCRIPTION	PART A		PART B	
	MO/DAY/YR 1	AMOUNT 2	MO/DAY/YR 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,201,569		526,886
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.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE		NONE
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				NONE
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)		1,201,569		526,886
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		NONE
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				NONE
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.)	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM			
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		1,201,569		526,886
8 NAME OF CONTRACTOR:	CONTRACTOR NUMBER:		NPR DATE:	

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [ ] TITLE V [XX] HOSPITAL ((14-013) [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] SUB (OTHER) [ ] COST METHOD  
 BOXES [ ] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT				
2	CAPITAL DRG OTHER THAN OUTLIER		1,592,564		1
3	CAPITAL DRG OUTLIER PAYMENTS		35,302		2
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		72.20		3
5	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)				4
6	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)				5
7	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)				6
8	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)				7
9	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)				8
10	SUM OF LINES 7 AND 8				9
11	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)				10
12	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)				11
13	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)		1,627,866		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 FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)				3
4	APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)				4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)				5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)				6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)				7
8	CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (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 FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST 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 CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					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 SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
46 OTHER LONG TERM CARE					46
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
52 DELIVERY ROOM & LABOR ROOM					52
54 RADIOLOGY-DIAGNOSTIC					54
55 RADIOLOGY-THERAPEUTIC					55
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
58 MAGNETIC RESONANCE IMAGING (MR					58
59 CARDIAC CATHETERIZATION					59
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
70 ELECTROENCEPHALOGRAPHY					70
71 MEDICAL SUPPLIES CHRGED TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90.01 OP PEDS ONC CLINIC					90.01
90.02 WOUND CLINIC					90.02
91 EMERGENCY					91
92 OBSERVATION BEDS					92
92.01 OBSERVATION BEDS-DISTINCT					92.01
OTHER REIMBURSABLE COST CENTERS					
101 HOME HEALTH AGENCY					101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
192 PHYSICIANS' PRIVATE OFFICES					192
194 HEALTH & FITNESS CENTER					194
194.01 OCCUPATIONAL HEALTH					194.01
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204