

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**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. <input checked="" type="checkbox"/> Electronically filed cost report Date: 02/01/2016 Time: 07:51	
	2. <input type="checkbox"/> Manually submitted cost report	
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report	
	4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.	
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN
		10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

**PART III - SETTLEMENT SUMMARY**

	TITLE V	TITLE XVIII		HIT	TITLE XIX	
		PART A	PART B			
	1	2	3	4	5	
1 HOSPITAL		408,583	189,749	-36,718		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		408,583	189,749	-36,718		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. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence

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not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2  
PART I**

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
0	1	2	3	4	5	6	7	8		
3	Hospital	NORTHWESTERN LAKE FOREST HOSPITAL	14-0130	29404	1	07 / 01 / 1966	N	P	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF	NORTHWESTERN LAKE FOREST HOSPITAL	14-5216	29404		07 / 01 / 1970	N	P	N	9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	NORTHWESTERN LAKE FOREST HOME HEALTH	14-7045	29404		07 / 01 / 1966	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 09 / 01 / 2014	To: 08 / 31 / 2015	20
21	Type of control (see instructions)	2		21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	1	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,274	347			1,129		24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

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

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

36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2  
PART I**

		1	2		
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39	
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	Y	40	
		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

		1	2	3	
<b>Teaching Hospitals</b>					
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	Y	Y		57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital 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 Nonprovider Settings**

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63
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**WORKSHEET S-2  
PART I**

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

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)					
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
	1	2	3	4	5
65					65

Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)					
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
	1	2	3	4	5
67					67

**Inpatient Psychiatric Facility PPS**

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

**Inpatient Rehabilitation Facility PPS**

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

**Long Term Care Hospital PPS**

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

**TEFRA Providers**

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

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**WORKSHEET S-2  
PART I**

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

**Rural Providers**

		1	2		
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106	
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108	
		Physical	Occupational	Speech	Respiratory
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.				109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	110

**Miscellaneous Cost Reporting Information**

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	502,354	990,065	48,702	118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121

**Transplant Center Information**

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N			125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				129
130	If this is a Medicare 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

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**WORKSHEET S-2  
PART I**

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 (see instructions)	1 Y	2 HB0640	140
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If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name: NORTHWESTERN MEMORIAL HEALTHCA	Contractor's Name: NGS	Contractor's Number: 06101	141
142	Street: 251 E HURON ST	P.O. Box:		142
143	City: CHICAGO	State: IL	ZIP Code: 60611	143
144	Are provider based physicians' costs included in Worksheet A?	N		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

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

**Multicampus**

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)	0.50			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	09 / 01 / 2014	08 / 31 / 2015		170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N		171

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2  
PART II**

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

**COMPLETED BY ALL HOSPITALS**

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

		Y/N	Type	Date	
<b>Financial Data and Reports</b>		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	11/30/2015	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
<b>Approved Educational Activities</b>		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see 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	
<b>Bad Debts</b>			
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	N	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

		Y/N	
<b>Bed Complement</b>			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B	
		Y/N	Date	Y/N	Date
<b>PS&amp;R Report Data</b>		1	2	3	4
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	
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	11/15/2015	Y	11/15/2015
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	
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	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2  
PART II**

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

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

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

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

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

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

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

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

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3  
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				
						Title V	Title XVIII	Title XIX	Total All Patients	
						5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	107	39,055		8,325	1,215	19,792	1	
2	HMO and other (see instructions)					494	1,129		2	
3	HMO IPF Subprovider								3	
4	HMO IRF Subprovider								4	
5	Hospital Adults & Peds. Swing Bed SNF								5	
6	Hospital Adults & Peds. Swing Bed NF								6	
7	Total Adults & Peds. (exclude observation beds) (see instructions)		107	39,055		8,325	1,215	19,792	7	
8	Intensive Care Unit	31	10	3,650		1,066	145	2,502	8	
9	Coronary Care Unit	32							9	
10	Burn Intensive Care Unit	33							10	
11	Surgical Intensive Care Unit	34							11	
12	Other Special Care (specify)	35							12	
13	Nursery	43					261	3,782	13	
14	Total (see instructions)		117	42,705		9,391	1,621	26,076	14	
15	CAH Visits								15	
16	Subprovider - IPF	40							16	
17	Subprovider - IRF	41							17	
18	Subprovider I	42							18	
19	Skilled Nursing Facility	44		10,950		5,281		7,280	19	
20	Nursing Facility	45							20	
21	Other Long Term Care	46							21	
22	Home Health Agency	101						8,922	22	
23	ASC (Distinct Part)	115							23	
24	Hospice (Distinct Part)	116							24	
24.10	Hospice (non-distinct part)	30							24.10	
25	CMHC	99							25	
26	RHC	88							26	
27	Total (sum of lines 14-26)		117						27	
28	Observation Bed Days							3,746	28	
29	Ambulance Trips								29	
30	Employee discount days (see instructions)							480	30	
31	Employee discount days-IRF								31	
32	Labor & delivery (see instructions)		8	2,920				703	32	
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01	
33	LTCH non-covered days								33	

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3  
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					2,268	551	6,723	1
2	HMO and other (see instructions)					135	44		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)	2.81	1,048.00			2,268	551	6,723	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		32.32						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		26.07						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)	2.81	1,106.39						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL WAGE INDEX INFORMATION**

**WORKSHEET S-3  
PARTS II-III**

**Part II - Wage Data**

		Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
<b>SALARIES</b>								
1	Total salaries (see instructions)	200	77,664,970	-51,250	77,613,720	2,237,039.00	34.69	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B							5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21	253,006		253,006	5,845.00	43.29	7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office personnel							8
9	SNF	44	2,062,648		2,062,648	68,391.00	30.16	9
10	Excluded area salaries (see instructions)		5,042,408	-3	5,042,405	153,390.00	32.87	10
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11	Contract labor (see instructions)							11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		1,125,021		1,125,021	13,103.00	85.86	13
14	Home office salaries & wage-related costs		16,102,109		16,102,109	343,518.00	46.87	14
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
<b>WAGE-RELATED COSTS</b>								
17	Wage-related costs (core)(see instructions)		18,602,538		18,602,538			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		1,912,005		1,912,005			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)		42,374		42,374			25
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26	Employee Benefits Department		69,623	412	70,035	4,350.00	16.10	26
27	Administrative & General		9,447,192	-47,991	9,399,201	199,444.00	47.13	27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		2,930,527		2,930,527	110,254.00	26.58	30
31	Laundry & Linen Service		278,343		278,343	18,791.00	14.81	31
32	Housekeeping		1,538,057	-19,987	1,518,070	99,400.00	15.27	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		5,549		5,549	119.00	46.63	34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel		23,839		23,839	919.00	25.94	37
38	Nursing Administration		2,710,518		2,710,518	51,438.00	52.69	38
39	Central Services and Supply		768,886		768,886	36,713.00	20.94	39
40	Pharmacy		1,732,484		1,732,484	40,243.00	43.05	40
41	Medical Records & Medical Records Library		626,698	2,702	629,400	24,895.00	25.28	41
42	Social Service							42
43	Other General Service							43

**Part III - Hospital Wage Index Summary**

1	Net salaries (see instructions)		77,411,964	-51,250	77,360,714	2,231,194.00	34.67	1
2	Excluded area salaries (see instructions)		7,105,056	-3	7,105,053	221,781.00	32.04	2
3	Subtotal salaries (line 1 minus line 2)		70,306,908	-51,247	70,255,661	2,009,413.00	34.96	3
4	Subtotal other wages & related costs (see instructions)		17,227,130		17,227,130	356,621.00	48.31	4
5	Subtotal wage-related costs (see instructions)		18,602,538		18,602,538		26.48%	5
6	Total (sum of lines 3 through 5)		106,136,576	-51,247	106,085,329	2,366,034.00	44.84	6
7	Total overhead cost (see instructions)		20,131,716	-64,864	20,066,852	586,566.00	34.21	7

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL WAGE RELATED COSTS**

**WORKSHEET S-3  
PART IV**

**Part IV - Wage Related Cost**

**Part A - Core List**

		Amount Reported	
	<b>RETIREMENT COST</b>		
1	401K Employer Contributions	4,577,738	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization):</b>		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	<b>HEALTH AND INSURANCE COST</b>		
8	Health Insurance (Purchased or Self Funded)	7,848,808	8
9	Prescription Drug Plan	967,631	9
10	Dental, Hearing and Vision Plan	297,224	10
11	Life Insurance (If employee is owner or beneficiary)	77,631	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	760,075	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	178,826	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	<b>TAXES</b>		
17	FICA-Employers Portion Only	5,509,260	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	58,815	19
20	State or Federal Unemployment Taxes		20
	<b>OTHER</b>		
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	280,909	23
24	Total Wage Related cost (Sum of lines 1-23)	20,556,917	24

**Part B - Other Than Core Related Cost**

25	OTHER WAGE RELATED COSTS (SPECIFY)		25
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**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	Supporting Exhibit for Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)**

**EXHIBIT 3**

<b>STEP 1: DETERMINE THE 3-YEAR AVERAGING PERIOD</b>			
1	Wage Index Fiscal Year Ending Date		1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)		2
3	Midpoint of Provider's Cost Reporting Period Shown on Line 2, Adjusted to First of Month		3
4	Date Beginning the 3-Year Averaging Period (subtract 18 months from midpoint shown on Line 3)		4
5	Date Ending the 3-Year Averaging Period (add 18 months to midpoint shown on Line 3)		5
<b>STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)</b>			
6	Effective Date of Pension Plan		6
7	First Day of the Provider Cost Reporting Period Containing the Pension Plan Effective Date		7
8	Starting Date of the Adjusted Averaging Period (date on Line 7, adjusted to first of month)		8

**IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS**

<b>STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD</b>			
9	Beginning Date of Averaging Period from Line 4 or Line 8, as Applicable		9
10	Ending Date of Averaging Period from Line 5		10
11	Enter Provider Contributions Made During Averaging Period on Lines 9 & 10	<b>DEPOSIT DATE(S)</b>	<b>CONTRIBUTION(S)</b> 11
12	Total Calendar Months Included in Averaging Period (36 unless Step 2 completed)		12
13	Total Contributions Made During Averaging Period		13
14	Average Monthly Contribution (Line 13 divided by Line 12)		14
15	Number of MOnths in Provider Cost Reporting Period on Line 2		15
16	Average Pension Contributions (Line 14 times Line 15)		16
<b>STEP 4: TOTAL PENSION COST FOR WAGE INDEX</b>			
17	Annual Prefunding Installment (see instructions)		17
18	Reportable Prefunding Installment ((Line 17 times Line 15) divided by 12)		18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**HOSPITAL CONTRACT LABOR AND BENEFIT COST**

**WORKSHEET S-3  
PART V**

**Part V - Contract Labor and Benefit Cost**

**Hospital and Hospital-Based Component Identification:**

	Component	Contract Labor 1	Benefit Cost 2	
	0			
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

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA**

**HHA CCN: 14-7045**

**WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA

County: LAKE

	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 instructions)						2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
		Staff 1	Contract 2	Total 3	
3	Administrator and Assistant Administrator(s)	7.65		7.65	3
4	Director(s) and Assistant Director(s)				4
5	Other Administrative Personnel				5
6	Direct Nursing Service	22.75		22.75	6
7	Nursing Supervisor				7
8	Physical Therapy Service	6.87		6.87	8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service	0.87		0.87	10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service				12
13	Speech Pathology Supervisor				13
14	Medical Social Service	0.02		0.02	14
15	Medical Social Service Supervisor				15
16	Home Health Aide	1.80		1.80	16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

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

PPS ACTIVITY

		Full Episodes		LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		Without Outliers	With Outliers				
		1	2	3	4	5	
21	Skilled Nursing Visits	4,428	198	157	147	4,930	21
22	Skilled Nursing Visit Charges	1,592,007	70,105	61,291	54,161	1,777,564	22
23	Physical Therapy Visits	2,804	77	23	125	3,029	23
24	Physical Therapy Visit Charges	1,036,336	28,510	9,173	46,464	1,120,483	24
25	Occupational Therapy Visits	346	12		5	363	25
26	Occupational Therapy Visit Charges	129,632	4,474		1,912	136,018	26
27	Speech Pathology Visits	20	7			27	27
28	Speech Pathology Visit Charges	7,583	2,603			10,186	28
29	Medical Social Service Visits	133	17	5	11	166	29
30	Medical Social Service Visit Charges	67,633	8,687			76,320	30
31	Home Health Aide Visits	314	69		24	407	31
32	Home Health Aide Visit Charges	67,878	15,042		5,232	88,152	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	8,045	380	185	312	8,922	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	2,901,069	129,421	70,464	107,769	3,208,723	35
36	Total Number of Episodes (standard/non-outlier)	526		67	23	616	36
37	Total Number of Ourlier Episodes		9			9	37
38	Total Non-Routine Medical Supply Charges	40,940	1,251	1,548	1,848	45,587	38

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA**

**WORKSHEET S-5**

**RENAL DIALYSIS STATISTICS**

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

**ESRD PPS**

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

**TRANSPLANT INFORMATION**

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

**EPOETIN**

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

**ARANESP**

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

**PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable method(s))**

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

**KPMG LLP Compu-Max 2552-10**

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**PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA**

**WORKSHEET S-7**

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

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC	323		323	12
13	RUB	1,360		1,360	13
14	RUA	659		659	14
15	RVC	564		564	15
16	RVB	984		984	16
17	RVA	449		449	17
18	RHC	193		193	18
19	RHB	141		141	19
20	RHA	119		119	20
21	RMC	37		37	21
22	RMB	50		50	22
23	RMA	1		1	23
24	RLB	2		2	24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2	26		26	29
30	HE1	18		18	30
31	HD2	51		51	31
32	HD1	3		3	32
33	HC2	20		20	33
34	HC1	20		20	34
35	HB2				35
36	HB1	50		50	36
37	LE2	84		84	37
38	LE1	40		40	38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1	3		3	42
43	LB2				43
44	LB1	11		11	44
45	CE2				45
46	CE1	9		9	46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1	18		18	50
51	CB2				51
52	CB1	9		9	52
53	CA2				53
54	CA1	6		6	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64

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**PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA**

**WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1	6		6	70
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1	17		17	74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA	8		8	199
200	TOTAL	5,281		5,281	200

**SNF SERVICES**

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

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each 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 with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing			Y	202
203	Recruitment				203
204	Retention of employees				204
205	Training			Y	205
206	Other (OTHER (STAFF MEETINGS))			Y	206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	8,008,100			207

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA**

**WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.211865	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		1,579,253	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		59,077,237	6
7	Medicaid cost (line 1 times line 6)		12,516,399	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.		10,937,146	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 fundng 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)		10,937,146	19

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	24,610,791	1,746,349	26,357,140	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	5,214,165	369,990	5,584,155	21
22	Partial payment by patients approved for charity care	359,928	357,397	717,325	22
23	Cost of charity care (line 21 minus line 22)	4,854,237	12,593	4,866,830	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)		22,478,139	26
27	Medicare bad debts for the entire hospital complex (see instructions)		219,297	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		22,258,842	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		4,715,870	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		9,582,700	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		20,519,846	31

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**RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES**

**WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATION S	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		<b>GENERAL SERVICE COST CENTERS</b>								
1	00100	Cap Rel Costs-Bldg & Fixt		17,506,499	17,506,499	259,963	17,766,462	-8,060,268	9,706,194	1
2	00200	Cap Rel Costs-Mvble Equip		4,695,646	4,695,646	124,176	4,819,822		4,819,822	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	69,623	13,557,076	13,626,699	40,433	13,667,132	-37,301	13,629,831	4
5	00500	Administrative & General	9,447,192	57,193,621	66,640,813	-428,614	66,212,199	-7,976,567	58,235,632	5
7	00700	Operation of Plant	2,930,527	7,787,104	10,717,631		10,717,631	-34,555	10,683,076	7
8	00800	Laundry & Linen Service	278,343	168,753	447,096		447,096		447,096	8
9	00900	Housekeeping	1,538,057	1,389,547	2,927,604	-19,987	2,907,617	-40	2,907,577	9
10	01000	Dietary	5,549	4,084,417	4,089,966	-1,844,372	2,245,594	-952,665	1,292,929	10
11	01100	Cafeteria		562,859	562,859	1,190,646	1,753,505	-279,978	1,473,527	11
12	01200	Maintenance of Personnel	23,839	49,320	73,159		73,159	-73,159		12
13	01300	Nursing Administration	2,710,518	698,371	3,408,889		3,408,889		3,408,889	13
14	01400	Central Services & Supply	768,886	258,661	1,027,547	-130,087	897,460		897,460	14
15	01500	Pharmacy	1,732,484	12,617,285	14,349,769	-10,996,236	3,353,533	-2,916	3,350,617	15
16	01600	Medical Records & Library	626,698	60,830	687,528	9,854	697,382		697,382	16
17	01700	Social Service								17
21	02100	I&R Services-Salary & Fringes Apprvd	253,006	436,730	689,736	-347,822	341,914	-244,500	97,414	21
22	02200	I&R Services-Other Prgm Costs Apprvd				396,729	396,729		396,729	22
		<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	03000	Adults & Pediatrics	11,225,091	1,199,809	12,424,900	-1,822,016	10,602,884	-2,297	10,600,587	30
31	03100	Intensive Care Unit	2,060,864	584,668	2,645,532	-20,728	2,624,804		2,624,804	31
43	04300	Nursery	733,436	49,678	783,114	1,407,942	2,191,056		2,191,056	43
44	04400	Skilled Nursing Facility	2,062,648	329,563	2,392,211	4,236	2,396,447		2,396,447	44
45	04500	Nursing Facility	1,456,354	592,794	2,049,148	673,713	2,722,861	-142,103	2,580,758	45
		<b>ANCILLARY SERVICE COST CENTERS</b>								
50	05000	Operating Room	8,230,608	14,974,036	23,204,644	-14,265,951	8,938,693	-57,513	8,881,180	50
52	05200	Delivery Room & Labor Room	2,406,200	478,058	2,884,258	-247,530	2,636,728	-85,792	2,550,936	52
54	05400	Radiology-Diagnostic	5,979,130	3,315,076	9,294,206	-982,617	8,311,589	-21,257	8,290,332	54
55	05500	Radiology-Therapeutic	796,053	495,527	1,291,580		1,291,580		1,291,580	55
57	05700	CT Scan	680,088	142,364	822,452	-107,184	715,268		715,268	57
58	05800	MRI	1,679,934	349,576	2,029,510	-166,022	1,863,488		1,863,488	58
59	05900	Cardiac Catheterization	655,562	1,189,725	1,845,287	-1,084,726	760,561		760,561	59
60	06000	Laboratory	3,021,680	4,192,056	7,213,736	50,560	7,264,296	-430	7,263,866	60
65	06500	Respiratory Therapy	942,844	186,832	1,129,676		1,129,676		1,129,676	65
66	06600	Physical Therapy	3,087,321	53,306	3,140,627	32,307	3,172,934	-11,358	3,161,576	66
68	06800	Speech Pathology	969,598	400,271	1,369,869	-48,727	1,321,142	-37,084	1,284,058	68
69	06900	Electrocardiology	627,605	65,546	693,151	1,130	694,281	-9,954	684,327	69
70	07000	Electroencephalography	122,487	39,294	161,781		161,781		161,781	70
71	07100	Medical Supplies Charged to Patients				7,738,988	7,738,988		7,738,988	71
72	07200	Impl. Dev. Charged to Patients				9,628,702	9,628,702		9,628,702	72
73	07300	Drugs Charged to Patients				12,361,690	12,361,690		12,361,690	73
76.97	07697	CARDIAC REHABILITATION	512,106	37,039	549,145		549,145	-1,750	547,395	76.97
		<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	OP PEDS ONC CLINIC	615,223	121,179	736,402		736,402	-44,736	691,666	90.01
90.02	09002	WOUND CLINIC	382,462	753,809	1,136,271	-134,484	1,001,787		1,001,787	90.02
91	09100	Emergency	4,822,099	896,759	5,718,858	-878,251	4,840,607	-8	4,840,599	91
92	09200	Observation Beds (Non-Distinct Part)								92
92.01	09201	OBSERVATION BEDS-DISTINCT	624,801	39,902	664,703	-1,312	663,391		663,391	92.01
		<b>OTHER REIMBURSABLE COST CENTERS</b>								
101	10100	Home Health Agency	2,708,031	825,822	3,533,853	54,513	3,588,366	-2,526,825	1,061,541	101
		<b>SPECIAL PURPOSE COST CENTERS</b>								
118		SUBTOTALS (sum of lines 1-117)	76,786,947	152,379,408	229,166,355	448,916	229,615,271	-20,603,056	209,012,215	118
		<b>NONREIMBURSABLE COST CENTERS</b>								
190	19000	Gift, Flower, Coffee Shop & Canteen	438,794	440,054	878,848		878,848	-878,848		190
192	19200	Physicians' Private Offices	111,733	2,732,874	2,844,607	-448,916	2,395,691	-2,395,691		192
194	07950	HEALTH & FITNESS CENTER	327,496	921,635	1,249,131		1,249,131	-1,029,000	220,131	194
194.01	07951	OCCUPATIONAL HEALTH		7,789	7,789		7,789		7,789	194.01
200		TOTAL (sum of lines 118-199)	77,664,970	156,481,760	234,146,730		234,146,730	-24,906,595	209,240,135	200

**KPMG LLP Compu-Max 2552-10**

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	IMPLANT RECLASS	A	Impl. Dev. Charged to Patient	72		9,628,702	1
2	IMPLANT RECLASS	A					2
3	IMPLANT RECLASS	A					3
4							4
500	Total reclassifications					9,628,702	500
	Code Letter - A						
1	MED SUPPLY	B	Medical Supplies Charged to P	71		7,738,988	1
2	MED SUPPLY	B					2
3	MED SUPPLY	B					3
4	MED SUPPLY	B					4
5	MED SUPPLY	B					5
6	MED SUPPLY	B					6
7	MED SUPPLY	B					7
8	MED SUPPLY	B					8
9	MED SUPPLY	B					9
10	MED SUPPLY	B					10
11	MED SUPPLY	B					11
12	MED SUPPLY	B					12
13	MED SUPPLY	B					13
14	MED SUPPLY	B					14
500	Total reclassifications					7,738,988	500
	Code Letter - B						
1	DRUG RECLASS	C	Drugs Charged to Patients	73		12,361,690	1
2	DRUG RECLASS	C					2
3	DRUG RECLASS	C					3
4	DRUG RECLASS	C					4
5	DRUG RECLASS	C					5
6	DRUG RECLASS	C					6
7	DRUG RECLASS	C					7
8	DRUG RECLASS	C					8
9	DRUG RECLASS	C					9
10							10
500	Total reclassifications					12,361,690	500
	Code Letter - C						
1	HOUSEKEEPING	D	Nursing Facility	45	19,987		1
500	Total reclassifications				19,987		500
	Code Letter - D						
1	CAPITAL RELATED COSTS RECLASS	E	Pharmacy	15		5,166	1
2	CAPITAL RELATED COSTS RECLASS	E	I&R Services-Salary & Fringes	21		48,907	2
3	CAPITAL RELATED COSTS RECLASS	E	Skilled Nursing Facility	44		4,236	3
4	CAPITAL RELATED COSTS RECLASS	E	Radiology-Diagnostic	54		50,704	4
5	CAPITAL RELATED COSTS RECLASS	E	Cardiac Catheterization	59		4,268	5
6	CAPITAL RELATED COSTS RECLASS	E	Laboratory	60		13,355	6
7	CAPITAL RELATED COSTS RECLASS	E	Electrocardiology	69		1,130	7
8	CAPITAL RELATED COSTS RECLASS	E	Home Health Agency	101		31,769	8
500	Total reclassifications					159,535	500
	Code Letter - E						
1	MOB	G	Administrative & General	5	3,259	111,801	1
2	MOB	G	Medical Records & Library	16	2,702	7,152	2
3	MOB	G	Radiology-Diagnostic	54	245	36,550	3
4	MOB	G	Laboratory	60	2,338	44,419	4
5	MOB	G	Physical Therapy	66	3,584	31,309	5
6	MOB	G	Speech Pathology	68	3,871	96,064	6
7	MOB	G	WOUND CLINIC	90.02	3,098	15,153	7
8	MOB	G	Cardiac Catheterization	59	481	23,713	8
9	MOB	G	Home Health Agency	101	116	22,628	9
10	MOB	G	Employee Benefits Department	4	412	40,021	10
500	Total reclassifications				20,106	428,810	500
	Code Letter - G						
1	NURSERY RECLASS	H	Nursery	43	1,195,804	246,819	1
500	Total reclassifications				1,195,804	246,819	500
	Code Letter - H						
1	RECL NON RESIDENT EXPENSES TO LN 22	I	I&R Services-Other Prgm Costs	22		396,729	1

**KPMG LLP Compu-Max 2552-10**

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
2	RECL SAL TO NON 615201 CC 3037	I	Administrative & General	5		51,250	2
500	Total reclassifications					447,979	500
	Code Letter - I						
1	DIETARY RECLASS	J	Cafeteria	11		1,190,646	1
2			Nursing Facility	45		653,726	2
500	Total reclassifications					1,844,372	500
	Code Letter - J						
1	INTEREST RECLASS	L	Cap Rel Costs-Bldg & Fixt	1		259,963	1
2	INTEREST RECLASS	L	Cap Rel Costs-Mvble Equip	2		124,176	2
500	Total reclassifications					384,139	500
	Code Letter - L						
	<b>GRAND TOTAL (Increases)</b>					<b>1,235,897</b>	<b>33,241,034</b>

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.  
 Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

**KPMG LLP Compu-Max 2552-10**

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref. 10	
		1	6	7	8	9	10	
1	IMPLANT RECLASS	A	Operating Room	50		8,930,233	1	
2	IMPLANT RECLASS	A	Radiology-Diagnostic	54		207,754	2	
3	IMPLANT RECLASS	A	Cardiac Catheterization	59		486,295	3	
4			WOUND CLINIC	90.02		4,420	4	
500	Total reclassifications					9,628,702	500	
	Code letter - A							
1	MED SUPPLY	B	Central Services & Supply	14		130,087	1	
2	MED SUPPLY	B	Adults & Pediatrics	30		379,393	2	
3	MED SUPPLY	B	Intensive Care Unit	31		20,728	3	
4	MED SUPPLY	B	Nursery	43		34,681	4	
5	MED SUPPLY	B	Operating Room	50		4,988,943	5	
6	MED SUPPLY	B	Delivery Room & Labor Room	52		247,530	6	
7	MED SUPPLY	B	Radiology-Diagnostic	54		671,276	7	
8	MED SUPPLY	B	CT Scan	57		3,403	8	
9	MED SUPPLY	B	MRI	58		920	9	
10	MED SUPPLY	B	Cardiac Catheterization	59		615,286	10	
11	MED SUPPLY	B	Physical Therapy	66		2,586	11	
12	MED SUPPLY	B	Speech Pathology	68		148,662	12	
13	MED SUPPLY	B	OBSERVATION BEDS-DISTINCT	92.01		630	13	
14	MED SUPPLY	B	Emergency	91		494,863	14	
500	Total reclassifications					7,738,988	500	
	Code letter - B							
1	DRUG RECLASS	C	Pharmacy	15		11,001,402	1	
2	DRUG RECLASS	C	Operating Room	50		346,775	2	
3	DRUG RECLASS	C	Radiology-Diagnostic	54		191,086	3	
4	DRUG RECLASS	C	CT Scan	57		103,781	4	
5	DRUG RECLASS	C	MRI	58		165,102	5	
6	DRUG RECLASS	C	Cardiac Catheterization	59		11,607	6	
7	DRUG RECLASS	C	Laboratory	60		9,552	7	
8	DRUG RECLASS	C	WOUND CLINIC	90.02		148,315	8	
9	DRUG RECLASS	C	Emergency	91		383,388	9	
10			OBSERVATION BEDS-DISTINCT	92.01		682	10	
500	Total reclassifications					12,361,690	500	
	Code letter - C							
1	HOUSEKEEPING	D	Housekeeping	9	19,987		1	
500	Total reclassifications				19,987		500	
	Code letter - D							
1	CAPITAL RELATED COSTS RECLASS	E	Administrative & General	5		159,535	1	
2	CAPITAL RELATED COSTS RECLASS	E					2	
3	CAPITAL RELATED COSTS RECLASS	E					3	
4	CAPITAL RELATED COSTS RECLASS	E					4	
5	CAPITAL RELATED COSTS RECLASS	E					5	
6	CAPITAL RELATED COSTS RECLASS	E					6	
7	CAPITAL RELATED COSTS RECLASS	E					7	
8	CAPITAL RELATED COSTS RECLASS	E					8	
500	Total reclassifications					159,535	500	
	Code letter - E							
1	MOB	G	Physicians' Private Offices	192	20,106	428,810	1	
2	MOB	G					2	
3	MOB	G					3	
4	MOB	G					4	
5	MOB	G					5	
6	MOB	G					6	
7	MOB	G					7	
8	MOB	G					8	
9	MOB	G					9	
10	MOB	G					10	
500	Total reclassifications				20,106	428,810	500	
	Code letter - G							
1	NURSERY RECLASS	H	Adults & Pediatrics	30	1,195,804	246,819	1	
500	Total reclassifications				1,195,804	246,819	500	
	Code letter - H							

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref. 10	
		1	6	7	8	9	10	
1	RECL NON RESIDENT EXPENSES TO LN 22	I	I&R Services-Salary & Fringes	21		396,729	1	
2	RECL SAL TO NON 615201 CC 3037	I	Administrative & General	5	51,250		2	
500	Total reclassifications				51,250	396,729	500	
	Code letter - I							
1	DIETARY RECLASS	J	Dietary	10		1,844,372	1	
2							2	
500	Total reclassifications					1,844,372	500	
	Code letter - J							
1	INTEREST RECLASS	L	Administrative & General	5		384,139	9	
2	INTEREST RECLASS	L					9	
500	Total reclassifications					384,139	500	
	Code letter - L							
	GRAND TOTAL (Decreases)				1,287,147	33,189,784		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.  
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

**KPMG LLP Compu-Max 2552-10**

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**RECONCILIATION OF CAPITAL COST CENTERS**

**WORKSHEET A-7  
PARTS I, II & III**

**PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	54,698,598				1,475,000	53,223,598		1
2	Land Improvements								2
3	Buildings and Fixtures	169,434,713	3,880,968	168,806	4,049,774	3,401,685	170,082,802		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	36,649,363	6,541,943	177,217	6,719,160	397,858	42,970,665		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	260,782,674	10,422,911	346,023	10,768,934	5,274,543	266,277,065		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	260,782,674	10,422,911	346,023	10,768,934	5,274,543	266,277,065		10

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

	Description	SUMMARY OF CAPITAL								
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	17,506,499						17,506,499	1	
2	Cap Rel Costs-Mvble Equip	4,695,646						4,695,646	2	
3	Total (sum of lines 1-2)	22,202,145						22,202,145	3	

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may

have been included in Worksheet A, column 2, lines 1 and 2.

\* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

**PART III - RECONCILIATION OF CAPITAL COST CENTERS**

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	170,082,801		170,082,801	0.798310					1
2	Cap Rel Costs-Mvble Equ	42,970,655		42,970,655	0.201690					2
3	Total (sum of lines 1-2)	213,053,456		213,053,456	1.000000					3

	Description	SUMMARY OF CAPITAL								
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	10,946,435					-1,240,241	9,706,194	1	
2	Cap Rel Costs-Mvble Equip	4,819,822						4,819,822	2	
3	Total (sum of lines 1-2)	15,766,257					-1,240,241	14,526,016	3	

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications,

Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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**ADJUSTMENTS TO EXPENSES**

**WORKSHEET A-8**

		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED				
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2	2
3	Investment income-other (chapter 2)					3
4	Trade, quantity, and time discounts (chapter 8)					4
5	Refunds and rebates of expenses (chapter 8)					5
6	Rental of provider space by suppliers (chapter 8)					6
7	Telephone services (pay stations excl) (chapter 21)					7
8	Television and radio service (chapter 21)					8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2				10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	4,175,877			12
13	Laundry and linen service					13
14	Cafeteria - employees and guests					14
15	Rental of quarters to employees & others					15
16	Sale of medical and surgical supplies to other than patients					16
17	Sale of drugs to other than patients					17
18	Sale of medical records and abstracts					18
19	Nursing school (tuition,fees,books,etc.)					19
20	Vending machines					20
21	Income from imposition of interest, finance or penalty charges (chapter 21)					21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments					22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65	23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66	24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114	25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1	26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19	28
29	Physicians' assistant					29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67	30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68	31
32	CAH HIT Adj for Depreciation					32
33	FOOD INCOME & MISC ADJ	B	-683,954	Dietary	10	33
33.03	FOOD INCOME & MISC ADJ	B	-279,978	Cafeteria	11	33.03
34	OTHER INCOME	B	-175,858	Administrative & General	5	34
34.01	OTHER INCOME	B	-268,711	Dietary	10	34.01
34.02	OTHER INCOME	B	-143,683	Nursing Facility	45	34.02
34.03	OTHER INCOME	B	-21,257	Radiology-Diagnostic	54	34.03
34.04	OTHER INCOME	B	-2,409	Physical Therapy	66	34.04
34.05	OTHER INCOME	B	-19,555	Speech Pathology	68	34.05
34.06	OTHER INCOME	B	-9,954	Electrocardiology	69	34.06
34.07	OTHER INCOME	B	-40,992	OP PEDS ONC CLINIC	90.01	34.07
34.08	OTHER INCOME	B	-755,310	Gift, Flower, Coffee Shop & Canteen	190	34.08
34.09	OTHER INCOME	B	-26,040	Physicians' Private Offices	192	34.09
34.10	OTHER INCOME	B	-1,029,000	HEALTH & FITNESS CENTER	194	34.10
35	OOB	B	-136,920	Administrative & General	5	35
35.01	OOB	B	-34,555	Operation of Plant	7	35.01
35.02	OOB	B	-40	Housekeeping	9	35.02
35.03	OOB	B	3,853	Maintenance of Personnel	12	35.03
35.04	OOB	B	-2,916	Pharmacy	15	35.04
35.05	OOB	B	-2,297	Adults & Pediatrics	30	35.05
35.06	OOB	B	1,580	Nursing Facility	45	35.06
35.07	OOB	B	13,320	Operating Room	50	35.07
35.08	OOB	B	-85,792	Delivery Room & Labor Room	52	35.08
35.09	OOB	B	-430	Laboratory	60	35.09
35.10	OOB	B	-8,949	Physical Therapy	66	35.10
35.11	OOB	B	-1,750	CARDIAC REHABILITATION	76.97	35.11

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**ADJUSTMENTS TO EXPENSES**

**WORKSHEET A-8**

		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED				
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
35.12	OOB	B	-8	Emergency	91	35.12
35.13	OOB	B	-2,526,825	Home Health Agency	101	35.13
35.14	OOB	B	-164,198	Gift, Flower, Coffee Shop & Canteen	190	35.14
35.15	OOB	B	110,592	Physicians' Private Offices	192	35.15
36	RENTAL INCOME	B	-1,953	Administrative & General	5	36
36.01	RENTAL INCOME	B	-94,135	Maintenance of Personnel	12	36.01
36.02	RENTAL INCOME	B	-5,324,570	Physicians' Private Offices	192	36.02
37						37
38	HAP EXCLUDED	A	-3,147,903	Administrative & General	5	38
39	REAL ESTATE TAX	A	-37,301	Employee Benefits Department	4	39
39.01	REAL ESTATE TAX	A	-11,341	Maintenance of Personnel	12	39.01
39.02	REAL ESTATE TAX	A	-1,263,185	Physicians' Private Offices	192	39.02
40	ADVERTISING	A	-1,000	Administrative & General	5	40
41	PHYSICIAN NO HOURS	A	-4,666,175	Administrative & General	5	41
41.01	PHYSICIAN NO HOURS	A	-244,500	I&R Services-Salary & Fringes Apprvd	21	41.01
41.02	PHYSICIAN NO HOURS	A	-17,529	Speech Pathology	68	41.02
41.03	PHYSICIAN NO HOURS	A	-70,833	Operating Room	50	41.03
41.04	PHYSICIAN NO HOURS	A	-3,744	OP PEDS ONC CLINIC	90.01	41.04
41.05	HO EMPLOYEE INHOUSE CLAIMS EXP	A	-3,245,531	Administrative & General	5	41.05
42						42
43	CAPITAL BUILDING TO MEDICARE BASIS	A	-6,820,027	Cap Rel Costs-Bldg & Fixt	1	9 43
44	INTEREST EXPENSE	A	-777,104	Administrative & General	5	44
45	EXCLUDE LOSS ON DISPOSAL	A	-1,240,241	Cap Rel Costs-Bldg & Fixt	1	14 45
46						46
47	LIMIT OFFSET TO ZERO	A	28,464	Maintenance of Personnel	12	47
47.10	LIMIT OFFSET TO ZERO	A	40,660	Gift, Flower, Coffee Shop & Canteen	190	47.10
47.11	LIMIT OFFSET TO ZERO	A	4,107,512	Physicians' Private Offices	192	47.11
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-24,906,595			50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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**STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS**

**WORKSHEET A-8-1**

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	4	Employee Benefits Department	VARIOUS NMG	22,363	22,363			1
2	4	Employee Benefits Department	VARIOUS HFI	110,610	110,610			2
3	5	Administrative & General	VARIOUS NMHC	226,222	226,222			3
3.01	5	Administrative & General	VARIOUS NMHC	29,371,007	25,195,130	4,175,877		3.01
3.02	5	Administrative & General	VARIOUS NMIC	3,693,489	3,693,489			3.02
3.03	5	Administrative & General	VARIOUS NMG	11,783,925	11,783,925			3.03
3.06	54	Radiology-Diagnostic	VARIOUS NMH	618,849	618,849			3.06
3.08	55	Radiology-Therapeutic	VARIOUS NMH	180,000	180,000			3.08
3.09	58	MRI	VARIOUS NMH	25,474	25,474			3.09
3.10	60	Laboratory	VARIOUS NMH	1,021,825	1,021,825			3.10
3.11	5	Administrative & General	VARIOUS NMH	2,617,836	2,617,836			3.11
3.12	21	I&R Services-Salary & Fringes Apprvd	VARIOUS NMG	320,328	320,328			3.12
3.13	68	Speech Pathology	VARIOUS NMG	17,529	17,529			3.13
3.14	70	Electroencephalography	VARIOUS NMG	10,999	10,999			3.14
3.15	90.01	OP PEDS ONC CLINIC	VARIOUS NMG	11,232	11,232			3.15
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			50,031,688	45,855,811	4,175,877		5

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

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

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

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

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

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

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

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**PROVIDER-BASED PHYSICIANS ADJUSTMENTS**

**WORKSHEET A-8-2**

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

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**PROVIDER-BASED PHYSICIANS ADJUSTMENTS**

**WORKSHEET A-8-2**

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

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
<b>GENERAL SERVICE COST CENTERS</b>								
1	Cap Rel Costs-Bldg & Fixt	9,706,194	9,706,194					1
2	Cap Rel Costs-Mvble Equip	4,819,822		4,819,822				2
4	Employee Benefits Department	13,629,831	135,065		13,764,896			4
5	Administrative & General	58,235,632	1,022,429		1,676,453	60,934,514	60,934,514	5
7	Operation of Plant	10,683,076	2,911,387	102,031	519,858	14,216,352	5,841,124	7
8	Laundry & Linen Service	447,096	38,429	67,795	49,376	602,696	247,630	8
9	Housekeeping	2,907,577	142,946	10,433	269,297	3,330,253	1,368,304	9
10	Dietary	1,292,929	104,489	5,115	984	1,403,517	576,664	10
11	Cafeteria	1,473,527	28,504			1,502,031	617,141	11
12	Maintenance of Personnel		141,211		4,229	145,440	59,757	12
13	Nursing Administration	3,408,889	26,170	4,656	480,830	3,920,545	1,610,838	13
14	Central Services & Supply	897,460	228,744	119,083	136,396	1,381,683	567,693	14
15	Pharmacy	3,350,617	48,482	86,349	307,332	3,792,780	1,558,343	15
16	Medical Records & Library	697,382	57,552	4,843	111,652	871,429	358,045	16
17	Social Service							17
21	I&R Services-Salary & Fringes Apprvd	97,414			44,882	142,296	58,465	21
22	I&R Services-Other Prgm Costs Apprvd	396,729		1,263		397,992	163,523	22
<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	Adults & Pediatrics	10,600,587	371,675	25,359	1,779,156	12,776,777	5,249,607	30
31	Intensive Care Unit	2,624,804	66,817	13,543	365,585	3,070,749	1,261,682	31
43	Nursery	2,191,056	7,910	2,077	342,236	2,543,279	1,044,960	43
44	Skilled Nursing Facility	2,396,447	222,690	5,107	365,901	2,990,145	1,228,564	44
45	Nursing Facility	2,580,758	329,786	2,295	261,894	3,174,733	1,304,406	45
<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	8,881,180	1,080,423	1,457,173	1,460,060	12,878,836	5,291,540	50
52	Delivery Room & Labor Room	2,550,936	123,412	47,282	426,845	3,148,475	1,293,617	52
54	Radiology-Diagnostic	8,290,332	431,036	1,156,659	1,060,705	10,938,732	4,494,408	54
55	Radiology-Therapeutic	1,291,580	207,202	787,555	141,215	2,427,552	997,411	55
57	CT Scan	715,268	15,890	33,532	120,644	885,334	363,758	57
58	MRI	1,863,488	297,781	421,839	298,010	2,881,118	1,183,768	58
59	Cardiac Catheterization	760,561	46,778	66,419	116,378	990,136	406,818	59
60	Laboratory	7,263,866	205,993	139,239	536,443	8,145,541	3,346,767	60
65	Respiratory Therapy	1,129,676	3,017	30,531	167,255	1,330,479	546,655	65
66	Physical Therapy	3,161,576	275,654	321	548,308	3,985,859	1,637,674	66
68	Speech Pathology	1,284,058	258,728	10,743	172,688	1,726,217	709,253	68
69	Electrocardiology	684,327	90,958	121,738	111,333	1,008,356	414,304	69
70	Electroencephalography	161,781	49,691	9,815	21,728	243,015	99,848	70
71	Medical Supplies Charged to Patients	7,738,988				7,738,988	3,179,726	71
72	Impl. Dev. Charged to Patients	9,628,702				9,628,702	3,956,154	72
73	Drugs Charged to Patients	12,361,690				12,361,690	5,079,060	73
76.97	CARDIAC REHABILITATION	547,395	13,519	1,409	90,845	653,168	268,368	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	OP PEDS ONC CLINIC	691,666	136,100	1,457	109,137	938,360	385,545	90.01
90.02	WOUND CLINIC	1,001,787	19,561	5,717	68,396	1,095,461	450,093	90.02
91	Emergency	4,840,599	328,216	25,912	855,411	6,050,138	2,485,826	91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT	663,391	112,008	52,151	110,836	938,386	385,556	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101	Home Health Agency	1,061,541	84,458		480,409	1,626,408	668,244	101
<b>SPECIAL PURPOSE COST CENTERS</b>								
118	SUBTOTALS (sum of lines 1-117)	209,012,215	9,664,711	4,819,441	13,612,707	208,818,162	60,761,139	118
<b>NONREIMBURSABLE COST CENTERS</b>								
190	Gift, Flower, Coffee Shop & Canteen		13,041	381	77,839	91,261	37,496	190
192	Physicians' Private Offices				16,254	16,254	6,678	192
194	HEALTH & FITNESS CENTER	220,131			58,096	278,227	114,315	194
194.01	OCCUPATIONAL HEALTH	7,789	28,442			36,231	14,886	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	209,240,135	9,706,194	4,819,822	13,764,896	209,240,135	60,934,514	202

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant	20,057,476						7
8	Laundry & Linen Service	343,971	1,194,297					8
9	Housekeeping	169,151	597,148	5,464,856				9
10	Dietary	598,394		83,306	2,661,881			10
11	Cafeteria	71,250		22,215		2,212,637		11
12	Maintenance of Personnel	808,665		11,107		1,272	1,026,241	12
13	Nursing Administration	149,860				59,953		13
14	Central Services & Supply	533,459		55,537		43,375		14
15	Pharmacy	154,185		33,323		47,334		15
16	Medical Records & Library	329,602		122,182		29,029		16
17	Social Service							17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	2,128,464	326,599	3,121,187	1,781,428	389,273	513,121	30
31	Intensive Care Unit	382,654	36,156	249,918	225,199	68,110		31
43	Nursery	45,296	82,882	77,752		57,506		43
44	Skilled Nursing Facility	1,275,299	8,795	177,718	655,254	79,793		44
45	Nursing Facility	2,134,282	53,298			77,226		45
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	3,070,284	20,403	577,586		295,301		50
52	Delivery Room & Labor Room	706,737	24,628			79,121		52
54	Radiology-Diagnostic	1,169,591		133,289		192,549		54
55	Radiology-Therapeutic	483,887				23,247		55
57	CT Scan	90,990				24,447		57
58	MRI	399,062				50,620		58
59	Cardiac Catheterization	267,898				17,177		59
60	Laboratory	757,303		166,611		133,364	128,280	60
65	Respiratory Therapy	17,303		49,984		30,012		65
66	Physical Therapy	1,068,061	5,062	61,091		96,371	128,280	66
68	Speech Pathology	463,849				32,795		68
69	Electrocardiology	141,506				20,608		69
70	Electroencephalography	284,554				4,846		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION	77,416	2,459			16,458		76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OP PEDS ONC CLINIC	321,895		261,025		22,167		90.01
90.02	WOUND CLINIC	112,022	36,867			13,195		90.02
91	Emergency	1,136,477		216,595		170,550	256,560	91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT	122,364				24,566		92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency	4,177				81,760		101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	19,819,908	1,194,297	5,420,426	2,661,881	2,182,025	1,026,241	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	74,681		44,430		13,195		190
192	Physicians' Private Offices					4,966		192
194	HEALTH & FITNESS CENTER					12,451		194
194.01	OCCUPATIONAL HEALTH	162,887						194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	20,057,476	1,194,297	5,464,856	2,661,881	2,212,637	1,026,241	202

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	
		13	14	15	16	21	22	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	5,741,196						13
14	Central Services & Supply		2,581,747					14
15	Pharmacy			5,585,965				15
16	Medical Records & Library				1,710,287			16
17	Social Service							17
21	I&R Services-Salary & Fringes Apprvd					200,761		21
22	I&R Services-Other Prgm Costs Apprvd						561,515	22
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	1,962,009	86,394	10,372	102,809	200,761	561,515	30
31	Intensive Care Unit	412,687	23,321	2,995	20,127			31
43	Nursery	162,552	4,279	42	8,727			43
44	Skilled Nursing Facility	376,206	10,503	551	13,830			44
45	Nursing Facility	85,702	9,621	9	6,380			45
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	914,425	833,924	45,573	250,992			50
52	Delivery Room & Labor Room	459,060	34,613	9,872	26,150			52
54	Radiology-Diagnostic	87,972	109,107	10,161	204,924			54
55	Radiology-Therapeutic	20,234	3,139		58,314			55
57	CT Scan		7,189	163	83,864			57
58	MRI		9,624	523	122,292			58
59	Cardiac Catheterization	86,977	61,797	737	22,543			59
60	Laboratory		145,116	4,635	207,791			60
65	Respiratory Therapy		16,736	317	21,267			65
66	Physical Therapy		2,326	3	36,781			66
68	Speech Pathology		36,233		8,189			68
69	Electrocardiology		1,502	302	51,457			69
70	Electroencephalography		1,264		1,896			70
71	Medical Supplies Charged to Patients		1,081,588		76,282			71
72	Impl. Dev. Charged to Patients				33,743			72
73	Drugs Charged to Patients			5,471,290	117,326			73
76.97	CARDIAC REHABILITATION	28,925	1,073	175	3,206			76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OP PEDS ONC CLINIC	42,264	7,662	2,248	11,257			90.01
90.02	WOUND CLINIC	9,334	19,811	4,197	11,793			90.02
91	Emergency	832,147	65,051	21,629	187,373			91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT	42,386	3,140	118	8,128			92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency	201,309	5,382	53	12,846			101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	5,724,189	2,580,395	5,585,965	1,710,287	200,761	561,515	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	17,007	40					190
192	Physicians' Private Offices							192
194	HEALTH & FITNESS CENTER		1,312					194
194.0	OCCUPATIONAL HEALTH							194.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,741,196	2,581,747	5,585,965	1,710,287	200,761	561,515	202

**KPMG LLP Compu-Max 2552-10**

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		24	25	26			
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	Adults & Pediatrics	29,210,316	-762,276	28,448,040			30
31	Intensive Care Unit	5,753,598		5,753,598			31
43	Nursery	4,027,275		4,027,275			43
44	Skilled Nursing Facility	6,816,658		6,816,658			44
45	Nursing Facility	6,845,657		6,845,657			45
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	24,178,864		24,178,864			50
52	Delivery Room & Labor Room	5,782,273		5,782,273			52
54	Radiology-Diagnostic	17,340,733		17,340,733			54
55	Radiology-Therapeutic	4,013,784		4,013,784			55
57	CT Scan	1,455,745		1,455,745			57
58	MRI	4,647,007		4,647,007			58
59	Cardiac Catheterization	1,854,083		1,854,083			59
60	Laboratory	13,035,408		13,035,408			60
65	Respiratory Therapy	2,012,753		2,012,753			65
66	Physical Therapy	7,021,508		7,021,508			66
68	Speech Pathology	2,976,536		2,976,536			68
69	Electrocardiology	1,638,035		1,638,035			69
70	Electroencephalography	635,423		635,423			70
71	Medical Supplies Charged to Patients	12,076,584		12,076,584			71
72	Impl. Dev. Charged to Patients	13,618,599		13,618,599			72
73	Drugs Charged to Patients	23,029,366		23,029,366			73
76.97	CARDIAC REHABILITATION	1,051,248		1,051,248			76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01	OP PEDS ONC CLINIC	1,992,423		1,992,423			90.01
90.02	WOUND CLINIC	1,752,773		1,752,773			90.02
91	Emergency	11,422,346		11,422,346			91
92	Observation Beds (Non-Distinct Part)						92
92.01	OBSERVATION BEDS-DISTINCT	1,524,644		1,524,644			92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
101	Home Health Agency	2,600,179		2,600,179			101
	<b>SPECIAL PURPOSE COST CENTERS</b>						
118	SUBTOTALS (sum of lines 1-117)	208,313,818	-762,276	207,551,542			118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	Gift, Flower, Coffee Shop & Canteen	278,110		278,110			190
192	Physicians' Private Offices	27,898		27,898			192
194	HEALTH & FITNESS CENTER	406,305		406,305			194
194.0	OCCUPATIONAL HEALTH						194.0
1		214,004		214,004			1
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	209,240,135	-762,276	208,477,859			202

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDG & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMEN T	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		135,065		135,065	135,065		4
5	Administrative & General	522,576	1,022,429		1,545,005	16,453	1,561,458	5
7	Operation of Plant	13,333	2,911,387	102,031	3,026,751	5,102	149,635	7
8	Laundry & Linen Service		38,429	67,795	106,224	485	6,346	8
9	Housekeeping		142,946	10,433	153,379	2,643	35,064	9
10	Dietary		104,489	5,115	109,604	10	14,778	10
11	Cafeteria		28,504		28,504		15,815	11
12	Maintenance of Personnel		141,211		141,211	42	1,531	12
13	Nursing Administration		26,170	4,656	30,826	4,719	41,279	13
14	Central Services & Supply	102,972	228,744	119,083	450,799	1,339	14,548	14
15	Pharmacy	80	48,482	86,349	134,911	3,016	39,934	15
16	Medical Records & Library		57,552	4,843	62,395	1,096	9,175	16
17	Social Service							17
21	I&R Services-Salary & Fringes Apprvd					440	1,498	21
22	I&R Services-Other Prgm Costs Apprvd			1,263	1,263		4,190	22
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics		371,675	25,359	397,034	17,433	134,527	30
31	Intensive Care Unit	62,202	66,817	13,543	142,562	3,588	32,332	31
43	Nursery		7,910	2,077	9,987	3,359	26,778	43
44	Skilled Nursing Facility	1,073	222,690	5,107	228,870	3,591	31,483	44
45	Nursing Facility		329,786	2,295	332,081	2,570	33,427	45
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	118,927	1,080,423	1,457,173	2,656,523	14,329	135,601	50
52	Delivery Room & Labor Room	675	123,412	47,282	171,369	4,189	33,150	52
54	Radiology-Diagnostic	499,708	431,036	1,156,659	2,087,403	10,410	115,174	54
55	Radiology-Therapeutic		207,202	787,555	994,757	1,386	25,560	55
57	CT Scan		15,890	33,532	49,422	1,184	9,322	57
58	MRI		297,781	421,839	719,620	2,925	30,335	58
59	Cardiac Catheterization		46,778	66,419	113,197	1,142	10,425	59
60	Laboratory	35,675	205,993	139,239	380,907	5,265	85,764	60
65	Respiratory Therapy		3,017	30,531	33,548	1,641	14,009	65
66	Physical Therapy	580	275,654	321	276,555	5,381	41,967	66
68	Speech Pathology		258,728	10,743	269,471	1,695	18,175	68
69	Electrocardiology		90,958	121,738	212,696	1,093	10,617	69
70	Electroencephalography		49,691	9,815	59,506	213	2,559	70
71	Medical Supplies Charged to Patients						81,484	71
72	Impl. Dev. Charged to Patients						101,381	72
73	Drugs Charged to Patients						130,156	73
76.97	CARDIAC REHABILITATION		13,519	1,409	14,928	892	6,877	76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OP PEDS ONC CLINIC		136,100	1,457	137,557	1,071	9,880	90.01
90.02	WOUND CLINIC		19,561	5,717	25,278	671	11,534	90.02
91	Emergency	40	328,216	25,912	354,168	8,395	63,702	91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT		112,008	52,151	164,159	1,088	9,880	92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency		84,458		84,458	4,715	17,124	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	1,357,841	9,664,711	4,819,441	15,841,993	133,571	1,557,016	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	6,200	13,041	381	19,622	764	961	190
192	Physicians' Private Offices	6,000			6,000	160	171	192
194	HEALTH & FITNESS CENTER					570	2,929	194
194.01	OCCUPATIONAL HEALTH		28,442		28,442		381	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,370,041	9,706,194	4,819,822	15,896,057	135,065	1,561,458	202

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant	3,181,488						7
8	Laundry & Linen Service	54,560	167,615					8
9	Housekeeping	26,831	83,809	301,726				9
10	Dietary	94,916		4,600	223,908			10
11	Cafeteria	11,302		1,227		56,848		11
12	Maintenance of Personnel	128,269		613		33	271,699	12
13	Nursing Administration	23,771				1,540		13
14	Central Services & Supply	84,616		3,066		1,114		14
15	Pharmacy	24,457		1,840		1,216		15
16	Medical Records & Library	52,281		6,746		746		16
17	Social Service							17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	337,614	45,837	172,325	149,847	10,001	135,850	30
31	Intensive Care Unit	60,696	5,074	13,799	18,943	1,750		31
43	Nursery	7,185	11,632	4,293		1,477		43
44	Skilled Nursing Facility	202,286	1,234	9,812	55,118	2,050		44
45	Nursing Facility	338,537	7,480			1,984		45
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	487,001	2,864	31,890		7,587		50
52	Delivery Room & Labor Room	112,102	3,456			2,033		52
54	Radiology-Diagnostic	185,519		7,359		4,947		54
55	Radiology-Therapeutic	76,753				597		55
57	CT Scan	14,433				628		57
58	MRI	63,299				1,301		58
59	Cardiac Catheterization	42,494				441		59
60	Laboratory	120,122		9,199		3,426	33,962	60
65	Respiratory Therapy	2,745		2,760		771		65
66	Physical Therapy	169,414	710	3,373		2,476	33,962	66
68	Speech Pathology	73,575				843		68
69	Electrocardiology	22,446				529		69
70	Electroencephalography	45,136				125		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION	12,280	345			423		76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OP PEDS ONC CLINIC	51,059		14,412		570		90.01
90.02	WOUND CLINIC	17,769	5,174			339		90.02
91	Emergency	180,266		11,959		4,382	67,925	91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT	19,409				631		92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency	662				2,101		101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	3,143,805	167,615	299,273	223,908	56,061	271,699	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	11,846		2,453		339		190
192	Physicians' Private Offices					128		192
194	HEALTH & FITNESS CENTER					320		194
194.0 1	OCCUPATIONAL HEALTH	25,837						194.0 1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,181,488	167,615	301,726	223,908	56,848	271,699	202

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	
		13	14	15	16	21	22	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	102,135						13
14	Central Services & Supply		555,482					14
15	Pharmacy			205,374				15
16	Medical Records & Library				132,439			16
17	Social Service							17
21	I&R Services-Salary & Fringes Apprvd					1,938		21
22	I&R Services-Other Prgm Costs Apprvd						5,453	22
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	34,902	18,588	381	7,949			30
31	Intensive Care Unit	7,342	5,018	110	1,556			31
43	Nursery	2,892	921	2	675			43
44	Skilled Nursing Facility	6,693	2,260	20	1,069			44
45	Nursing Facility	1,525	2,070		493			45
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	16,267	179,423	1,676	19,607			50
52	Delivery Room & Labor Room	8,167	7,447	363	2,022			52
54	Radiology-Diagnostic	1,565	23,475	374	15,845			54
55	Radiology-Therapeutic	360	675		4,509			55
57	CT Scan		1,547	6	6,484			57
58	MRI		2,071	19	9,456			58
59	Cardiac Catheterization	1,547	13,296	27	1,743			59
60	Laboratory		31,222	170	16,066			60
65	Respiratory Therapy		3,601	12	1,644			65
66	Physical Therapy		500		2,844			66
68	Speech Pathology		7,796		633			68
69	Electrocardiology		323	11	3,979			69
70	Electroencephalography		272		147			70
71	Medical Supplies Charged to Patients		232,714		5,898			71
72	Impl. Dev. Charged to Patients				2,609			72
73	Drugs Charged to Patients			201,159	9,072			73
76.97	CARDIAC REHABILITATION	515	231	6	248			76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OP PEDS ONC CLINIC	752	1,648	83	870			90.01
90.02	WOUND CLINIC	166	4,263	154	912			90.02
91	Emergency	14,804	13,996	795	14,488			91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT	754	676	4	628			92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency	3,581	1,158	2	993			101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	101,832	555,191	205,374	132,439			118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	303	9					190
192	Physicians' Private Offices							192
194	HEALTH & FITNESS CENTER		282					194
194.01	OCCUPATIONAL HEALTH							194.01
200	Cross Foot Adjustments					1,938	5,453	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	102,135	555,482	205,374	132,439	1,938	5,453	202

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		24	25	26			
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	Adults & Pediatrics	1,462,288		1,462,288			30
31	Intensive Care Unit	292,770		292,770			31
43	Nursery	69,201		69,201			43
44	Skilled Nursing Facility	544,486		544,486			44
45	Nursing Facility	720,167		720,167			45
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	3,552,768		3,552,768			50
52	Delivery Room & Labor Room	344,298		344,298			52
54	Radiology-Diagnostic	2,452,071		2,452,071			54
55	Radiology-Therapeutic	1,104,597		1,104,597			55
57	CT Scan	83,026		83,026			57
58	MRI	829,026		829,026			58
59	Cardiac Catheterization	184,312		184,312			59
60	Laboratory	686,103		686,103			60
65	Respiratory Therapy	60,731		60,731			65
66	Physical Therapy	537,182		537,182			66
68	Speech Pathology	372,188		372,188			68
69	Electrocardiology	251,694		251,694			69
70	Electroencephalography	107,958		107,958			70
71	Medical Supplies Charged to Patients	320,096		320,096			71
72	Impl. Dev. Charged to Patients	103,990		103,990			72
73	Drugs Charged to Patients	340,387		340,387			73
76.97	CARDIAC REHABILITATION	36,745		36,745			76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01	OP PEDS ONC CLINIC	217,902		217,902			90.01
90.02	WOUND CLINIC	66,260		66,260			90.02
91	Emergency	734,880		734,880			91
92	Observation Beds (Non-Distinct Part)						92
92.01	OBSERVATION BEDS-DISTINCT	197,229		197,229			92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
101	Home Health Agency	114,794		114,794			101
	<b>SPECIAL PURPOSE COST CENTERS</b>						
118	SUBTOTALS (sum of lines 1-117)	15,787,149		15,787,149			118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	Gift, Flower, Coffee Shop & Canteen	36,297		36,297			190
192	Physicians' Private Offices	6,459		6,459			192
194	HEALTH & FITNESS CENTER	4,101		4,101			194
194.0	OCCUPATIONAL HEALTH	54,660		54,660			194.0
1							1
200	Cross Foot Adjustments	7,391		7,391			200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	15,896,057		15,896,057			202

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt	5,909,721						1
2	Cap Rel Costs-Mvble Equip		4,569,403					2
4	Employee Benefits Department	82,236		77,594,935				4
5	Administrative & General	622,517		9,450,451	-60,934,514	148,305,621		5
7	Operation of Plant	1,772,631	96,730	2,930,527		14,216,352	403,399	7
8	Laundry & Linen Service	23,398	64,273	278,343		602,696	6,918	8
9	Housekeeping	87,034	9,891	1,518,070		3,330,253	3,402	9
10	Dietary	63,619	4,849	5,549		1,403,517	12,035	10
11	Cafeteria	17,355				1,502,031	1,433	11
12	Maintenance of Personnel	85,978		23,839		145,440	16,264	12
13	Nursing Administration	15,934	4,414	2,710,518		3,920,545	3,014	13
14	Central Services & Supply	139,273	112,896	768,886		1,381,683	10,729	14
15	Pharmacy	29,519	81,863	1,732,484		3,792,780	3,101	15
16	Medical Records & Library	35,041	4,591	629,400		871,429	6,629	16
17	Social Service							17
21	I&R Services-Salary & Fringes Apprvd			253,006		142,296		21
22	I&R Services-Other Prgm Costs Apprvd		1,197			397,992		22
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	226,298	24,041	10,029,287		12,776,777	42,808	30
31	Intensive Care Unit	40,682	12,839	2,060,864		3,070,749	7,696	31
43	Nursery	4,816	1,969	1,929,240		2,543,279	911	43
44	Skilled Nursing Facility	135,587	4,842	2,062,648		2,990,145	25,649	44
45	Nursing Facility	200,794	2,176	1,476,341		3,174,733	42,925	45
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	657,827	1,381,464	8,230,608		12,878,836	61,750	50
52	Delivery Room & Labor Room	75,141	44,825	2,406,200		3,148,475	14,214	52
54	Radiology-Diagnostic	262,441	1,096,564	5,979,375		10,938,732	23,523	54
55	Radiology-Therapeutic	126,157	746,637	796,053		2,427,552	9,732	55
57	CT Scan	9,675	31,790	680,088		885,334	1,830	57
58	MRI	181,307	399,922	1,679,934		2,881,118	8,026	58
59	Cardiac Catheterization	28,481	62,968	656,043		990,136	5,388	59
60	Laboratory	125,421	132,005	3,024,018		8,145,541	15,231	60
65	Respiratory Therapy	1,837	28,945	942,844		1,330,479	348	65
66	Physical Therapy	167,835	304	3,090,905		3,985,859	21,481	66
68	Speech Pathology	157,529	10,185	973,469		1,726,217	9,329	68
69	Electrocardiology	55,381	115,413	627,605		1,008,356	2,846	69
70	Electroencephalography	30,255	9,305	122,487		243,015	5,723	70
71	Medical Supplies Charged to Patients					7,738,988		71
72	Impl. Dev. Charged to Patients					9,628,702		72
73	Drugs Charged to Patients					12,361,690		73
76.97	CARDIAC REHABILITATION	8,231	1,336	512,106		653,168	1,557	76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OP PEDS ONC CLINIC	82,866	1,381	615,223		938,360	6,474	90.01
90.02	WOUND CLINIC	11,910	5,420	385,560		1,095,461	2,253	90.02
91	Emergency	199,838	24,566	4,822,099		6,050,138	22,857	91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT	68,197	49,441	624,801		938,386	2,461	92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency	51,423		2,708,147		1,626,408	84	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	5,884,464	4,569,042	76,737,018	-60,934,514	147,883,648	398,621	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	7,940	361	438,794		91,261	1,502	190
192	Physicians' Private Offices			91,627		16,254		192
194	HEALTH & FITNESS CENTER			327,496		278,227		194
194.01	OCCUPATIONAL HEALTH	17,317				36,231	3,276	194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	9,706,194	4,819,822	13,764,896		60,934,514	20,057,476	202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.642412	1.054803	0.177394		0.410871	49.721184	203
204	Cost to be allocated (Per Wkst. B, Part II)			135,065		1,561,458	3,181,488	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.001741		0.010529	7.886703	205

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINISTRATION DIRECT NRSING HRS	
		8	9	10	11	12	13	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
8	Laundry & Linen Service	1,228,810						8
9	Housekeeping	614,405	4,498,489					9
10	Dietary		68,575	88,722				10
11	Cafeteria		18,287		92,229			11
12	Maintenance of Personnel		9,143		53	2,024,160		12
13	Nursing Administration				2,499		1,224,052	13
14	Central Services & Supply		45,716		1,808			14
15	Pharmacy		27,430		1,973			15
16	Medical Records & Library		100,576		1,210			16
17	Social Service							17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	336,037	2,569,258	59,376	16,226	1,012,080	418,310	30
31	Intensive Care Unit	37,201	205,724	7,506	2,839		87,987	31
43	Nursery	85,277	64,003		2,397		34,657	43
44	Skilled Nursing Facility	9,049	146,292	21,840	3,326		80,209	44
45	Nursing Facility	54,838			3,219		18,272	45
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	20,993	475,450		12,309		194,960	50
52	Delivery Room & Labor Room	25,340			3,298		97,874	52
54	Radiology-Diagnostic		109,719		8,026		18,756	54
55	Radiology-Therapeutic				969		4,314	55
57	CT Scan				1,019			57
58	MRI				2,110			58
59	Cardiac Catheterization				716		18,544	59
60	Laboratory		137,149		5,559	253,020		60
65	Respiratory Therapy		41,145		1,251			65
66	Physical Therapy	5,208	50,288		4,017	253,020		66
68	Speech Pathology				1,367			68
69	Electrocardiology				859			69
70	Electroencephalography				202			70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION	2,530			686		6,167	76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OP PEDS ONC CLINIC		214,867		924		9,011	90.01
90.02	WOUND CLINIC	37,932			550		1,990	90.02
91	Emergency		178,294		7,109	506,040	177,418	91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT				1,024		9,037	92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency				3,408		42,920	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	1,228,810	4,461,916	88,722	90,953	2,024,160	1,220,426	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen		36,573		550		3,626	190
192	Physicians' Private Offices				207			192
194	HEALTH & FITNESS CENTER				519			194
194.01	OCCUPATIONAL HEALTH							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,194,297	5,464,856	2,661,881	2,212,637	1,026,241	5,741,196	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.971913	1.214820	30.002491	23.990686	0.506996	4.690320	203
204	Cost to be allocated (Per Wkst. B, Part II)	167,615	301,726	223,908	56,848	271,699	102,135	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.136404	0.067073	2.523703	0.616379	0.134228	0.083440	205

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	
		14	15	16	17	21	22	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	24,539,390						14
15	Pharmacy		12,721,580					15
16	Medical Records & Library			979,640,709				16
17	Social Service				100			17
21	I&R Services-Salary & Fringes Apprvd					100		21
22	I&R Services-Other Prgm Costs Apprvd						100	22
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	821,177	23,622	58,882,579	100	100	100	30
31	Intensive Care Unit	221,668	6,820	11,527,601				31
43	Nursery	40,676	95	4,998,181				43
44	Skilled Nursing Facility	99,834	1,255	7,921,200				44
45	Nursing Facility	91,449	20	3,654,296				45
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	7,926,433	103,788	143,846,004				50
52	Delivery Room & Labor Room	328,995	22,482	14,976,947				52
54	Radiology-Diagnostic	1,037,058	23,141	117,367,817				54
55	Radiology-Therapeutic	29,834		33,398,877				55
57	CT Scan	68,327	371	48,032,265				57
58	MRI	91,476	1,191	70,041,253				58
59	Cardiac Catheterization	587,381	1,678	12,911,241				59
60	Laboratory	1,379,322	10,556	119,009,950				60
65	Respiratory Therapy	159,079	722	12,180,558				65
66	Physical Therapy	22,110	6	21,066,127				66
68	Speech Pathology	344,398		4,690,227				68
69	Electrocardiology	14,273	687	29,471,357				69
70	Electroencephalography	12,016		1,085,665				70
71	Medical Supplies Charged to Patients	10,280,394		43,689,538				71
72	Impl. Dev. Charged to Patients			19,325,906				72
73	Drugs Charged to Patients		12,460,423	67,196,793				73
76.97	CARDIAC REHABILITATION	10,202	398	1,836,239				76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OP PEDS ONC CLINIC	72,824	5,119	6,447,504				90.01
90.02	WOUND CLINIC	188,307	9,558	6,754,193				90.02
91	Emergency	618,307	49,259	107,315,816				91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT	29,846	268	4,655,058				92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency	51,154	121	7,357,517				101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	24,526,540	12,721,580	979,640,709	100	100	100	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	376						190
192	Physicians' Private Offices							192
194	HEALTH & FITNESS CENTER	12,474						194
194.01	OCCUPATIONAL HEALTH							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,581,747	5,585,965	1,710,287		200,761	561,515	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.105208	0.439094	0.001746		2,007.610000	5,615.150000	203
204	Cost to be allocated (Per Wkst. B, Part II)	555,482	205,374	132,439		1,938	5,453	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.022636	0.016144	0.000135		19.380000	54.530000	205

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS							

	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
43	Nursery							43
44	Skilled Nursing Facility							44
45	Nursing Facility							45
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
65	Respiratory Therapy							65
66	Physical Therapy							66
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OP PEDS ONC CLINIC							90.01
90.02	WOUND CLINIC							90.02
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
92.01	OBSERVATION BEDS-DISTINCT							92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency							101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)							118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	HEALTH & FITNESS CENTER							194
194.0	OCCUPATIONAL HEALTH							194.0
1								1
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)							202
203	Unit Cost Multiplier (Wkst. B, Part I)							203
204	Cost to be allocated (Per Wkst. B, Part II)							204
205	Unit Cost Multiplier (Wkst. B, Part II)							205

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**POST STEPDOWN ADJUSTMENTS**

**WORKSHEET B-2**

	WORKSHEET			
DESCRIPTION	PART	LINE NO.	AMOUNT	
1	2	3	4	

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**COMPUTATION OF RATIO OF COST TO CHARGES**

**WORKSHEET C  
PART I**

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30	Adults & Pediatrics	28,448,040		28,448,040		28,448,040	30
31	Intensive Care Unit	5,753,598		5,753,598		5,753,598	31
43	Nursery	4,027,275		4,027,275		4,027,275	43
44	Skilled Nursing Facility	6,816,658		6,816,658		6,816,658	44
45	Nursing Facility	6,845,657		6,845,657		6,845,657	45
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	24,178,864		24,178,864		24,178,864	50
52	Delivery Room & Labor Room	5,782,273		5,782,273		5,782,273	52
54	Radiology-Diagnostic	17,340,733		17,340,733		17,340,733	54
55	Radiology-Therapeutic	4,013,784		4,013,784		4,013,784	55
57	CT Scan	1,455,745		1,455,745		1,455,745	57
58	MRI	4,647,007		4,647,007		4,647,007	58
59	Cardiac Catheterization	1,854,083		1,854,083		1,854,083	59
60	Laboratory	13,035,408		13,035,408		13,035,408	60
65	Respiratory Therapy	2,012,753		2,012,753		2,012,753	65
66	Physical Therapy	7,021,508		7,021,508		7,021,508	66
68	Speech Pathology	2,976,536		2,976,536		2,976,536	68
69	Electrocardiology	1,638,035		1,638,035		1,638,035	69
70	Electroencephalography	635,423		635,423		635,423	70
71	Medical Supplies Charged to Patients	12,076,584		12,076,584		12,076,584	71
72	Impl. Dev. Charged to Patients	13,618,599		13,618,599		13,618,599	72
73	Drugs Charged to Patients	23,029,366		23,029,366		23,029,366	73
76.97	CARDIAC REHABILITATION	1,051,248		1,051,248		1,051,248	76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01	OP PEDS ONC CLINIC	1,992,423		1,992,423		1,992,423	90.01
90.02	WOUND CLINIC	1,752,773		1,752,773		1,752,773	90.02
91	Emergency	11,422,346		11,422,346		11,422,346	91
92	Observation Beds (Non-Distinct Part)	4,527,416		4,527,416		4,527,416	92
92.01	OBSERVATION BEDS-DISTINCT	1,524,644		1,524,644		1,524,644	92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
101	Home Health Agency	2,600,179		2,600,179		2,600,179	101
200	Subtotal (sum of lines 30 thru 199)	212,078,958		212,078,958		212,078,958	200
201	Less Observation Beds	4,527,416		4,527,416		4,527,416	201
202	Total (line 200 minus line 201)	207,551,542		207,551,542		207,551,542	202

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**COMPUTATION OF RATIO OF COST TO CHARGES**

**WORKSHEET C  
PART I**

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30	Adults & Pediatrics	50,034,531		50,034,531				30
31	Intensive Care Unit	11,527,601		11,527,601				31
43	Nursery	4,998,181		4,998,181				43
44	Skilled Nursing Facility	7,921,200		7,921,200				44
45	Nursing Facility	3,654,296		3,654,296				45
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	36,690,046	107,155,958	143,846,004	0.168089	0.168089	0.168089	50
52	Delivery Room & Labor Room	13,807,029	1,169,918	14,976,947	0.386078	0.386078	0.386078	52
54	Radiology-Diagnostic	13,249,063	104,118,754	117,367,817	0.147747	0.147747	0.147747	54
55	Radiology-Therapeutic	340,915	33,057,962	33,398,877	0.120177	0.120177	0.120177	55
57	CT Scan	12,662,932	35,369,333	48,032,265	0.030308	0.030308	0.030308	57
58	MRI	7,077,738	62,963,515	70,041,253	0.066347	0.066347	0.066347	58
59	Cardiac Catheterization	7,718,859	5,192,382	12,911,241	0.143602	0.143602	0.143602	59
60	Laboratory	39,652,802	79,357,148	119,009,950	0.109532	0.109532	0.109532	60
65	Respiratory Therapy	9,993,699	2,186,859	12,180,558	0.165243	0.165243	0.165243	65
66	Physical Therapy	10,191,050	10,875,077	21,066,127	0.333308	0.333308	0.333308	66
68	Speech Pathology	1,097,744	3,592,483	4,690,227	0.634625	0.634625	0.634625	68
69	Electrocardiology	8,089,617	21,381,740	29,471,357	0.055581	0.055581	0.055581	69
70	Electroencephalography	118,335	967,330	1,085,665	0.585285	0.585285	0.585285	70
71	Medical Supplies Charged to Patients	19,662,661	24,026,877	43,689,538	0.276418	0.276418	0.276418	71
72	Impl. Dev. Charged to Patients	13,895,379	5,430,527	19,325,906	0.704681	0.704681	0.704681	72
73	Drugs Charged to Patients	19,038,867	48,157,926	67,196,793	0.342715	0.342715	0.342715	73
76.97	CARDIAC REHABILITATION	1,244	1,834,995	1,836,239	0.572501	0.572501	0.572501	76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OP PEDS ONC CLINIC	23,175	6,424,329	6,447,504	0.309022	0.309022	0.309022	90.01
90.02	WOUND CLINIC	47,904	6,706,289	6,754,193	0.259509	0.259509	0.259509	90.02
91	Emergency	14,496,431	92,819,385	107,315,816	0.106437	0.106437	0.106437	91
92	Observation Beds (Non-Distinct Part)	1,074,616	7,773,432	8,848,048	0.511685	0.511685	0.511685	92
92.01	OBSERVATION BEDS-DISTINCT	527,633	4,127,425	4,655,058	0.327524	0.327524	0.327524	92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	Home Health Agency		7,357,517	7,357,517				101
200	Subtotal (sum of lines 30 thru 199)	307,593,548	672,047,161	979,640,709				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	307,593,548	672,047,161	979,640,709				202

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**

**WORKSHEET D  
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	1,462,288		1,462,288	23,538	62.12	8,325	517,149	30
31	Intensive Care Unit	292,770		292,770	2,502	117.01	1,066	124,733	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	69,201		69,201	3,782	18.30			43
44	Skilled Nursing Facility	544,486		544,486	7,280	74.79	5,281	394,966	44
45	Nursing Facility	720,167		720,167					45
200	Total (lines 30-199)	3,088,912		3,088,912	37,102		14,672	1,036,848	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**

**COMPONENT CCN: 14-0130**

**WORKSHEET D  
PART II**

Check  Title v  Hospital  SUB (Other)  PPS  
 Applicable  Title XVIII, Part A  IPF  TEFRA  
 Boxes:  Title XIX  IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	3,552,768	143,846,004	0.024698	14,614,691	360,954	50
52	Delivery Room & Labor Room	344,298	14,976,947	0.022989	70,822	1,628	52
54	Radiology-Diagnostic	2,452,071	117,367,817	0.020892	6,238,703	130,339	54
55	Radiology-Therapeutic	1,104,597	33,398,877	0.033073	198,921	6,579	55
57	CT Scan	83,026	48,032,265	0.001729	6,029,456	10,425	57
58	MRI	829,026	70,041,253	0.011836	2,963,928	35,081	58
59	Cardiac Catheterization	184,312	12,911,241	0.014275	3,568,837	50,945	59
60	Laboratory	686,103	119,009,950	0.005765	16,392,775	94,504	60
65	Respiratory Therapy	60,731	12,180,558	0.004986	5,414,136	26,995	65
66	Physical Therapy	537,182	21,066,127	0.025500	2,345,119	59,801	66
68	Speech Pathology	372,188	4,690,227	0.079354	374,338	29,705	68
69	Electrocardiology	251,694	29,471,357	0.008540	4,131,667	35,284	69
70	Electroencephalography	107,958	1,085,665	0.099440	66,818	6,644	70
71	Medical Supplies Charged to Pat	320,096	43,689,538	0.007327	7,516,478	55,073	71
72	Impl. Dev. Charged to Patients	103,990	19,325,906	0.005381	6,185,435	33,284	72
73	Drugs Charged to Patients	340,387	67,196,793	0.005066	6,844,147	34,672	73
76.97	CARDIAC REHABILITATION	36,745	1,836,239	0.020011	249	5	76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01	OP PEDS ONC CLINIC	217,902	6,447,504	0.033796	12,291	415	90.01
90.02	WOUND CLINIC	66,260	6,754,193	0.009810	14,740	145	90.02
91	Emergency	734,880	107,315,816	0.006848	6,212,035	42,540	91
92	Observation Beds (Non-Distinct	232,718	8,848,048	0.026302			92
92.01	OBSERVATION BEDS-DISTINCT	197,229	4,655,058	0.042369	199,704	8,461	92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	12,816,161	894,147,383		89,395,290	1,023,479	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**

**WORKSHEET D  
PART III**

Check  Title v  PPS  
 Applicable  Title XVIII, Part A  TEFRA  
 Boxes:  Title XIX  Other

	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	1	2	3	4	5		
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**

**WORKSHEET D  
PART III**

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

		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	23,538		8,325		30
31	Intensive Care Unit	2,502		1,066		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	3,782				43
44	Skilled Nursing Facility	7,280		5,281		44
45	Nursing Facility					45
200	Total (lines 30-199)	37,102		14,672		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0130**

**WORKSHEET D  
PART IV**

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

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

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0130**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	143,846,004			14,614,691		23,238,584		50
52	Delivery Room & Labor Room	14,976,947			70,822		4,773		52
54	Radiology-Diagnostic	117,367,817			6,238,703		23,825,086		54
55	Radiology-Therapeutic	33,398,877			198,921		14,899,250		55
57	CT Scan	48,032,265			6,029,456		10,323,169		57
58	MRI	70,041,253			2,963,928		16,207,242		58
59	Cardiac Catheterization	12,911,241			3,568,837		2,117,000		59
60	Laboratory	119,009,950			16,392,775		12,401,048		60
65	Respiratory Therapy	12,180,558			5,414,136		627,969		65
66	Physical Therapy	21,066,127			2,345,119		138,977		66
68	Speech Pathology	4,690,227			374,338		364,910		68
69	Electrocardiology	29,471,357			4,131,667		6,661,616		69
70	Electroencephalography	1,085,665			66,818		315,495		70
71	Medical Supplies Charged to Pat	43,689,538			7,516,478		5,264,395		71
72	Impl. Dev. Charged to Patients	19,325,906			6,185,435		1,336,194		72
73	Drugs Charged to Patients	67,196,793			6,844,147		15,429,233		73
76.97	CARDIAC REHABILITATION	1,836,239			249		1,113,211		76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	OP PEDS ONC CLINIC	6,447,504			12,291		2,172,265		90.01
90.02	WOUND CLINIC	6,754,193			14,740		3,305,152		90.02
91	Emergency	107,315,816			6,212,035		12,232,184		91
92	Observation Beds (Non-Distinct	8,848,048					4,662,981		92
92.01	OBSERVATION BEDS-DISTINCT	4,655,058			199,704		1,339,282		92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	894,147,383			89,395,290		157,980,016		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS**

**COMPONENT CCN: 14-0130**

**WORKSHEET D  
PART V**

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

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	0.168089	23,238,584			3,906,150		50
52	Delivery Room & Labor Room	0.386078	4,773			1,843		52
54	Radiology-Diagnostic	0.147747	23,825,086	630		3,520,085	93	54
55	Radiology-Therapeutic	0.120177	14,899,250			1,790,547		55
57	CT Scan	0.030308	10,323,169			312,875		57
58	MRI	0.066347	16,207,242			1,075,302		58
59	Cardiac Catheterization	0.143602	2,117,000			304,005		59
60	Laboratory	0.109532	12,401,048	545		1,358,312	60	60
65	Respiratory Therapy	0.165243	627,969			103,767		65
66	Physical Therapy	0.333308	138,977			46,322		66
68	Speech Pathology	0.634625	364,910			231,581		68
69	Electrocardiology	0.055581	6,661,616			370,259		69
70	Electroencephalography	0.585285	315,495			184,654		70
71	Medical Supplies Charged to Pat	0.276418	5,264,395			1,455,174		71
72	Impl. Dev. Charged to Patients	0.704681	1,336,194			941,591		72
73	Drugs Charged to Patients	0.342715	15,429,233	1,014		5,287,830	348	73
76.97	CARDIAC REHABILITATION	0.572501	1,113,211			637,314		76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OP PEDS ONC CLINIC	0.309022	2,172,265	13		671,278	4	90.01
90.02	WOUND CLINIC	0.259509	3,305,152			857,717		90.02
91	Emergency	0.106437	12,232,184	16		1,301,957	2	91
92	Observation Beds (Non-Distinct)	0.511685	4,662,981			2,385,977		92
92.01	OBSERVATION BEDS-DISTINCT	0.327524	1,339,282			438,647		92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Subtotal (see instructions)		157,980,016	2,218		27,183,187	507	200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)		157,980,016	2,218		27,183,187	507	202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-5216**

**WORKSHEET D  
PART IV**

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

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

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-5216**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	143,846,004							50
52	Delivery Room & Labor Room	14,976,947							52
54	Radiology-Diagnostic	117,367,817							54
55	Radiology-Therapeutic	33,398,877							55
57	CT Scan	48,032,265							57
58	MRI	70,041,253							58
59	Cardiac Catheterization	12,911,241							59
60	Laboratory	119,009,950							60
65	Respiratory Therapy	12,180,558							65
66	Physical Therapy	21,066,127							66
68	Speech Pathology	4,690,227							68
69	Electrocardiology	29,471,357							69
70	Electroencephalography	1,085,665							70
71	Medical Supplies Charged to Pat	43,689,538							71
72	Impl. Dev. Charged to Patients	19,325,906							72
73	Drugs Charged to Patients	67,196,793							73
76.97	CARDIAC REHABILITATION	1,836,239							76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	OP PEDS ONC CLINIC	6,447,504							90.01
90.02	WOUND CLINIC	6,754,193							90.02
91	Emergency	107,315,816							91
92	Observation Beds (Non-Distinct	8,848,048							92
92.01	OBSERVATION BEDS-DISTINCT	4,655,058							92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	894,147,383							200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS**

**COMPONENT CCN: 14-5216**

**WORKSHEET D  
PART V**

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	0.168089							50
52	Delivery Room & Labor Room	0.386078							52
54	Radiology-Diagnostic	0.147747							54
55	Radiology-Therapeutic	0.120177							55
57	CT Scan	0.030308							57
58	MRI	0.066347							58
59	Cardiac Catheterization	0.143602							59
60	Laboratory	0.109532							60
65	Respiratory Therapy	0.165243							65
66	Physical Therapy	0.333308							66
68	Speech Pathology	0.634625							68
69	Electrocardiology	0.055581							69
70	Electroencephalography	0.585285							70
71	Medical Supplies Charged to Pat	0.276418							71
72	Impl. Dev. Charged to Patients	0.704681							72
73	Drugs Charged to Patients	0.342715							73
76.97	CARDIAC REHABILITATION	0.572501							76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	OP PEDS ONC CLINIC	0.309022							90.01
90.02	WOUND CLINIC	0.259509							90.02
91	Emergency	0.106437							91
92	Observation Beds (Non-Distinct)	0.511685							92
92.01	OBSERVATION BEDS-DISTINCT	0.327524							92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**

**WORKSHEET D  
PART I**

Check  Title v  
 Applicable  Title XVIII, Part A  
 Boxes:  Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	1,462,288		1,462,288	23,538	62.12	1,215	75,476	30
31	Intensive Care Unit	292,770		292,770	2,502	117.01	145	16,966	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	69,201		69,201	3,782	18.30	261	4,776	43
44	Skilled Nursing Facility	544,486		544,486	7,280	74.79			44
45	Nursing Facility	720,167		720,167					45
200	Total (lines 30-199)	3,088,912		3,088,912	37,102		1,621	97,218	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**

**COMPONENT CCN: 14-0130**

**WORKSHEET D  
PART II**

Check  Title v  Hospital  SUB (Other)  
 Applicable  Title XVIII, Part A  IPF  
 Boxes:  Title XIX  IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	3,552,768	143,846,004	0.024698			50
52	Delivery Room & Labor Room	344,298	14,976,947	0.022989			52
54	Radiology-Diagnostic	2,452,071	117,367,817	0.020892			54
55	Radiology-Therapeutic	1,104,597	33,398,877	0.033073			55
57	CT Scan	83,026	48,032,265	0.001729			57
58	MRI	829,026	70,041,253	0.011836			58
59	Cardiac Catheterization	184,312	12,911,241	0.014275			59
60	Laboratory	686,103	119,009,950	0.005765			60
65	Respiratory Therapy	60,731	12,180,558	0.004986			65
66	Physical Therapy	537,182	21,066,127	0.025500			66
68	Speech Pathology	372,188	4,690,227	0.079354			68
69	Electrocardiology	251,694	29,471,357	0.008540			69
70	Electroencephalography	107,958	1,085,665	0.099440			70
71	Medical Supplies Charged to Pat	320,096	43,689,538	0.007327			71
72	Impl. Dev. Charged to Patients	103,990	19,325,906	0.005381			72
73	Drugs Charged to Patients	340,387	67,196,793	0.005066			73
76.97	CARDIAC REHABILITATION	36,745	1,836,239	0.020011			76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01	OP PEDS ONC CLINIC	217,902	6,447,504	0.033796			90.01
90.02	WOUND CLINIC	66,260	6,754,193	0.009810			90.02
91	Emergency	734,880	107,315,816	0.006848			91
92	Observation Beds (Non-Distinct	232,718	8,848,048	0.026302			92
92.01	OBSERVATION BEDS-DISTINCT	197,229	4,655,058	0.042369			92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	12,816,161	894,147,383				200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**

**WORKSHEET D  
PART III**

Check  Title v  PPS  
 Applicable  Title XVIII, Part A  TEFRA  
 Boxes:  Title XIX  Other

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**

**WORKSHEET D  
PART III**

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

		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	23,538		1,215		30
31	Intensive Care Unit	2,502		145		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	3,782		261		43
44	Skilled Nursing Facility	7,280				44
45	Nursing Facility					45
200	Total (lines 30-199)	37,102		1,621		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0130**

**WORKSHEET D  
PART IV**

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

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

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0130**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	143,846,004							50
52	Delivery Room & Labor Room	14,976,947							52
54	Radiology-Diagnostic	117,367,817							54
55	Radiology-Therapeutic	33,398,877							55
57	CT Scan	48,032,265							57
58	MRI	70,041,253							58
59	Cardiac Catheterization	12,911,241							59
60	Laboratory	119,009,950							60
65	Respiratory Therapy	12,180,558							65
66	Physical Therapy	21,066,127							66
68	Speech Pathology	4,690,227							68
69	Electrocardiology	29,471,357							69
70	Electroencephalography	1,085,665							70
71	Medical Supplies Charged to Pat	43,689,538							71
72	Impl. Dev. Charged to Patients	19,325,906							72
73	Drugs Charged to Patients	67,196,793							73
76.97	CARDIAC REHABILITATION	1,836,239							76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	OP PEDS ONC CLINIC	6,447,504							90.01
90.02	WOUND CLINIC	6,754,193							90.02
91	Emergency	107,315,816							91
92	Observation Beds (Non-Distinct	8,848,048							92
92.01	OBSERVATION BEDS-DISTINCT	4,655,058							92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	894,147,383							200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS**

**COMPONENT CCN: 14-0130**

**WORKSHEET D  
PART V**

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	0.168089							50
52	Delivery Room & Labor Room	0.386078							52
54	Radiology-Diagnostic	0.147747							54
55	Radiology-Therapeutic	0.120177							55
57	CT Scan	0.030308							57
58	MRI	0.066347							58
59	Cardiac Catheterization	0.143602							59
60	Laboratory	0.109532							60
65	Respiratory Therapy	0.165243							65
66	Physical Therapy	0.333308							66
68	Speech Pathology	0.634625							68
69	Electrocardiology	0.055581							69
70	Electroencephalography	0.585285							70
71	Medical Supplies Charged to Pat	0.276418							71
72	Impl. Dev. Charged to Patients	0.704681							72
73	Drugs Charged to Patients	0.342715							73
76.97	CARDIAC REHABILITATION	0.572501							76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	OP PEDS ONC CLINIC	0.309022							90.01
90.02	WOUND CLINIC	0.259509							90.02
91	Emergency	0.106437							91
92	Observation Beds (Non-Distinct)	0.511685							92
92.01	OBSERVATION BEDS-DISTINCT	0.327524							92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-0130**

**WORKSHEET D-1  
PART I**

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

**PART I - ALL PROVIDER COMPONENTS**

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	23,538	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	23,538	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	19,792	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8,325	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

**SWING-BED ADJUSTMENT**

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	28,448,040	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	28,448,040	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	28,448,040	37

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-0130**

**WORKSHEET D-1  
PART II**

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

**PART II - HOSPITALS AND SUBPROVIDERS ONLY**

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

38	Adjusted general inpatient routine service cost per diem (see instructions)					1,208.60	38
39	Program general inpatient routine service cost (line 9 x line 38)					10,061,595	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					10,061,595	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	<b>Intensive Care Type Inpatient Hospital Units</b>						
43	Intensive Care Unit	5,753,598	2,502	2,299.60	1,066	2,451,374	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)					17,815,996	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					30,328,965	49

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					641,882	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,023,479	51
52	Total Program excludable cost (sum of lines 50 and 51)					1,665,361	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					28,663,604	53

**TARGET AMOUNT AND LIMIT COMPUTATION**

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63

**PROGRAM INPATIENT ROUTINE SWING BED COST**

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-0130**

**WORKSHEET D-1  
PARTS III & IV**

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

**PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST**

87	Total observation bed days (see instructions)					3,746	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,208.60	88
89	Observation bed cost (line 87 x line 88) (see instructions)					4,527,416	89
		Cost	Routine Cost (from line 27)	col. 1=col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,462,288	28,448,040	0.051402	4,527,416	232,718	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-5216**

**WORKSHEET D-1  
PART I**

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

**PART I - ALL PROVIDER COMPONENTS**

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,280	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,280	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	7,280	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,281	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

**SWING-BED ADJUSTMENT**

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	6,816,658	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,816,658	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,816,658	37

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-5216**

**WORKSHEET D-1  
PARTS III & IV**

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

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

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	6,816,658	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	936.35	71
72	Program routine service cost (line 9 x line 71)	4,944,864	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)	4,944,864	74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)	4,944,864	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)	4,944,864	86

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-0130**

**WORKSHEET D-1  
PART I**

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

**PART I - ALL PROVIDER COMPONENTS**

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	23,538	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	23,538	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	19,792	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,215	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	3,782	15
16	Nursery days (title V or XIX only)	261	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)	28,448,040	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	28,448,040	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	28,448,040	37

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-0130**

**WORKSHEET D-1  
PART II**

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

**PART II - HOSPITALS AND SUBPROVIDERS ONLY**

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,208.60	38
39	Program general inpatient routine service cost (line 9 x line 38)						1,468,449	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)						1,468,449	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)	4,027,275	3,782	1,064.85	261	277,926		42
	<b>Intensive Care Type Inpatient Hospital Units</b>							
43	Intensive Care Unit	5,753,598	2,502	2,299.60	145	333,442		43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)							48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						2,079,817	49

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						97,218	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							51
52	Total Program excludable cost (sum of lines 50 and 51)						97,218	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)							53

**TARGET AMOUNT AND LIMIT COMPUTATION**

54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise 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

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-0130**

**WORKSHEET D-1  
PARTS III & IV**

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

**PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST**

87	Total observation bed days (see instructions)					3,746	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1=col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**INPATIENT ANCILLARY SERVICE COST APPORTIONMENT**

**COMPONENT CCN: 14-0130**

**WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics		19,428,347		30
31	Intensive Care Unit		5,809,507		31
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.168089	14,614,691	2,456,569	50
52	Delivery Room & Labor Room	0.386078	70,822	27,343	52
54	Radiology-Diagnostic	0.147747	6,238,703	921,750	54
55	Radiology-Therapeutic	0.120177	198,921	23,906	55
57	CT Scan	0.030308	6,029,456	182,741	57
58	MRI	0.066347	2,963,928	196,648	58
59	Cardiac Catheterization	0.143602	3,568,837	512,492	59
60	Laboratory	0.109532	16,392,775	1,795,533	60
65	Respiratory Therapy	0.165243	5,414,136	894,648	65
66	Physical Therapy	0.333308	2,345,119	781,647	66
68	Speech Pathology	0.634625	374,338	237,564	68
69	Electrocardiology	0.055581	4,131,667	229,642	69
70	Electroencephalography	0.585285	66,818	39,108	70
71	Medical Supplies Charged to Patients	0.276418	7,516,478	2,077,690	71
72	Impl. Dev. Charged to Patients	0.704681	6,185,435	4,358,759	72
73	Drugs Charged to Patients	0.342715	6,844,147	2,345,592	73
76.97	CARDIAC REHABILITATION	0.572501	249	143	76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.01	OP PEDS ONC CLINIC	0.309022	12,291	3,798	90.01
90.02	WOUND CLINIC	0.259509	14,740	3,825	90.02
91	Emergency	0.106437	6,212,035	661,190	91
92	Observation Beds (Non-Distinct Part)	0.511685			92
92.01	OBSERVATION BEDS-DISTINCT	0.327524	199,704	65,408	92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		89,395,290	17,815,996	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		89,395,290		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**INPATIENT ANCILLARY SERVICE COST APPORTIONMENT**

**COMPONENT CCN: 14-5216**

**WORKSHEET D-3**

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.168089			50
52	Delivery Room & Labor Room	0.386078			52
54	Radiology-Diagnostic	0.147747			54
55	Radiology-Therapeutic	0.120177			55
57	CT Scan	0.030308			57
58	MRI	0.066347			58
59	Cardiac Catheterization	0.143602			59
60	Laboratory	0.109532			60
65	Respiratory Therapy	0.165243			65
66	Physical Therapy	0.333308			66
68	Speech Pathology	0.634625			68
69	Electrocardiology	0.055581			69
70	Electroencephalography	0.585285			70
71	Medical Supplies Charged to Patients	0.276418			71
72	Impl. Dev. Charged to Patients	0.704681			72
73	Drugs Charged to Patients	0.342715			73
76.97	CARDIAC REHABILITATION	0.572501			76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.01	OP PEDS ONC CLINIC	0.309022			90.01
90.02	WOUND CLINIC	0.259509			90.02
91	Emergency	0.106437			91
92	Observation Beds (Non-Distinct Part)	0.511685			92
92.01	OBSERVATION BEDS-DISTINCT	0.327524			92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**INPATIENT ANCILLARY SERVICE COST APPORTIONMENT**

**COMPONENT CCN: 14-0130**

**WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
43	Nursery				43
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.168089			50
52	Delivery Room & Labor Room	0.386078			52
54	Radiology-Diagnostic	0.147747			54
55	Radiology-Therapeutic	0.120177			55
57	CT Scan	0.030308			57
58	MRI	0.066347			58
59	Cardiac Catheterization	0.143602			59
60	Laboratory	0.109532			60
65	Respiratory Therapy	0.165243			65
66	Physical Therapy	0.333308			66
68	Speech Pathology	0.634625			68
69	Electrocardiology	0.055581			69
70	Electroencephalography	0.585285			70
71	Medical Supplies Charged to Patients	0.276418			71
72	Impl. Dev. Charged to Patients	0.704681			72
73	Drugs Charged to Patients	0.342715			73
76.97	CARDIAC REHABILITATION	0.572501			76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.01	OP PEDS ONC CLINIC	0.309022			90.01
90.02	WOUND CLINIC	0.259509			90.02
91	Emergency	0.106437			91
92	Observation Beds (Non-Distinct Part)	0.511685			92
92.01	OBSERVATION BEDS-DISTINCT	0.327524			92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**WORKSHEET E  
PART A**

**PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,593,564			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	17,529,205			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	786,435			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments	1,040,016			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	114.74			4
	<b>Indirect Medical Education Adjustment Calculation for Hospitals</b>				
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)	2.81			6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)	2.81			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	2.81			10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)	2.81			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	0.94			15
16	Adjustment for residents in initial years of the program	1.87			16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count	2.81			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.024490			19
20	Prior year resident to bed ratio (see instructions)	0.024071			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.024071			21
22	IME payment adjustment (see instructions)	263,487			22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)	263,487			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	<b>Disproportionate Share Adjustment</b>				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0171			30
31	Percentage of Medicaid patient days to total patient days (see instructions)				31
32	Sum of lines 30 and 31				32
33	Allowable disproportionate share percentage (see instructions)				33
34	Disproportionate share adjustment (see instructions)				34
		<b>Prior to October 1</b>	<b>On or after October 1</b>		
	<b>Uncompensated Care Adjustment</b>				
35	Total uncompensated care amount (see instructions)				35
35.01	Factor 3 (see instructions)				35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)				35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)				35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)				36
	<b>Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)</b>				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40

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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**WORKSHEET E  
PART A**

**PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46
47	Subtotal (see instructions)	20,172,691			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	20,172,691			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,600,626			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)	54,661			52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies	5,115			54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	21,833,093			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	21,833,093			61
62	Deductibles billed to program beneficiaries	23,907			62
63	Coinsurance billed to program beneficiaries	2,123,144			63
64	Allowable bad debts (see instructions)	107,278			64
65	Adjusted reimbursable bad debts (see instructions)	69,731			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	60,378			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	19,755,773			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	-314,843			70.93
70.94	HRR adjustment amount (see instructions)	-42,528			70.94
70.99	HAC adjustment amount (see instructions)	196,360			70.99
71	Amount due provider (see instructions)	19,202,042			71
71.01	Sequestration adjustment (see instructions)	384,041			71.01
72	Interim payments	18,409,418			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	408,583			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	38,245			75

**TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)**

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

**HSP Bonus Payment Amount**

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

**HVBP Adjustment for HSP Bonus Payment**

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

**HRR Adjustment for HSP Bonus Payment**

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

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**HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION**

**EXHIBIT 5**

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to 10/1	(2.01)	On or after 10/1	(3.01)	Total (cols. 2 and 3)	
		(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments							1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1,593,564	1,593,564				1,593,564	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	17,529,205			17,529,205		17,529,205	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1							1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1							1.04
2	Outlier payments for discharges	786,435	65,536		720,899		786,435	2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments	1,040,016	86,668		953,348		1,040,016	4
	<b>Indirect Medical Education Adjustment</b>							
5	Amount from Worksheet E Part A, line 21	0.024071	0.024071		0.024071			5
6	IME payment adjustment	263,487	21,957		241,530		263,487	6
6.01	IME payment adjustment for managed care							6.01
	<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>							
7	IME payment adjustment factor							7
8	IME add-on adjustment amount							8
8.01	IME payment adjustment add-on for managed care							8.01
9	Total IME payment (sum of lines 6 and 8)	263,487	21,957		241,530		263,487	9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)							9.01
	<b>Disproportionate Share Adjustment</b>							
10	Allowable disproportionate share percentage							10
11	Disproportionate share adjustment							11
11.01	Uncompensated care payments							11.01
	<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
12	Total ESRD additional payment							12
13	Subtotal	20,172,691	1,681,057		18,491,634		20,172,691	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)							14
15	Total payment for inpatient operating costs SCH and MDH only	20,172,691	1,681,057		18,491,634		20,172,691	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	1,600,626	133,386		1,467,240		1,600,626	16
17	Special add-on payments for new technologies	5,115	426		4,689		5,115	17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)							17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG							17.02
18	Capital outlier reconciliation adjustment amount							18
19	<b>SUBTOTAL</b>		1,814,869		19,963,563		21,778,432	19
20	Capital DRG other than outlier	1,528,736	127,395		1,401,341		1,528,736	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	15,939	1,328		14,611		15,939	21
21.01	Model 4 BPCI Capital DRG outlier payments							21.01
22	Indirect medical education percentage	1.2400	1.2400		1.2400			22
23	Indirect medical education adjustment	18,956	1,580		17,376		18,956	23
24	Allowable disproportionate share percentage	0.0242	0.0242		0.0242			24
25	Disproportionate share adjustment	36,995	3,083		33,912		36,995	25
26	Total prospective capital payments	1,600,626	133,386		1,467,240		1,600,626	26
27								27
28	Low volume adjustment prior to October 1							28
29	Low volume adjustment on or after October 1							29
30	HVBP payment adjustment	-314,843	-26,237		-288,606		-314,843	30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment	-42,528	-3,544		-38,984		-42,528	31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment				196,360		196,360	32

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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**COMPONENT CCN: 14-0130**

**WORKSHEET E  
PART B**

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

**PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)	507			1
2	Medical and other services reimbursed under OPPS (see instructions)	27,183,187			2
3	PPS payments	21,090,943			3
4	Outlier payment (see instructions)	39,003			4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	507			11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	<b>REASONABLE CHARGES</b>				
12	Ancillary service charges	2,218			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	2,218			14
	<b>CUSTOMARY CHARGES</b>				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	2,218			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions))	1,711			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions))				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	507			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	21,129,946			24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	4,507,032			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	16,623,421			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	42,124			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	16,665,545			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	16,665,545			32
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	230,102			34
35	Adjusted reimbursable bad debts (see instructions)	149,566			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	149,447			36
37	Subtotal (see instructions)	16,815,111			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	16,815,111			40
40.01	Sequestration adjustment (see instructions)	336,302			40.01
41	Interim payments	16,289,060			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	189,749			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

**TO BE COMPLETED BY CONTRACTOR**

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**COMPONENT CCN: 14-5216**

**WORKSHEET E  
PART B**

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

**PART B - MEDICAL AND OTHER HEALTH SERVICES**

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

**TO BE COMPLETED BY CONTRACTOR**

90	Original outlier amount (see instructions)			90
91	Outlier reconciliation adjustment amount (see instructions)			91
92	The rate used to calculate the Time Value of Money			92
93	Time Value of Money (see instructions)			93
94	Total (sum of lines 91 and 93)			94

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED**

**COMPONENT CCN: 14-0130**

**WORKSHEET E-1  
PART I**

Check  Hospital       SUB (Other)  
 Applicable  IPF                       SNF  
 Boxes:  IRF                               Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		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		18,409,418		16,289,060	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. (1)					
		.01				3.01
		.02				3.02
	Program	.03				3.03
	to	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	to	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		18,409,418		16,289,060	4
<b>TO BE COMPLETED BY CONTRACTOR</b>						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	Program	.03				5.03
	to	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	to	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	408,583		189,749	6.01
		.02				6.02
7	Total Medicare program liability (see instructions)		18,818,001		16,478,809	7
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)		8

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

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**CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT****WORKSHEET E-1  
PART II**

Check  Hospital  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 (Wkst. S-3, Pt. I, col. 15, line 14)	6,723	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	9,391	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	494	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	22,294	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	979,640,709	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	26,357,140	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	709,707	8
9	Sequestration adjustment amount (see instructions)	14,194	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	695,513	10

**INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH**

30	Initial/interim HIT payment(s)	732,231	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-36,718	32

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

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**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**

<b>PROSPECTIVE PAYMENT AMOUNT (see instructions)</b>		
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
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>		
5	Medical and other services. Do not use this line. (see instructions)	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	Adjusted reimbursable bad debts (see instructions)	10
11	Utilization review	11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)	12
13	Inpatient primary payer payments	13
14	Other adjustments (specify) (see instructions)	14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	14.50
15	Subtotal (see instructions)	15
15.01	Sequestration adjustment (see instructions)	15.01
16	Interim payments	16
17	Tentative settlement (for contractor use only)	17
18	Balance due provider/program (line 15 minus lines 15.01, 16 and 17)	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	19

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**COMPONENT CCN: 14-0130**

**WORKSHEET E-3  
PART VII**

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1	Inpatient hospital/SNF/NF services	2,079,817		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	2,079,817		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	2,079,817		7
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>REASONABLE CHARGES</b>				
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
<b>CUSTOMARY CHARGES</b>				
13	Amount actually collected from patients liable for payment for services on a cahрге 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)	2,079,817		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
<b>PROSPECTIVE PAYMENT AMOUNT</b>				
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30	Excess of reasonable cost (from line 18)	2,079,817		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS**

**WORKSHEET E-4**

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

<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>				
		Primary Care	Other	Total
		1	2	3
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)			2
3	Amount of reduction to Direct GME cap under §422 of MMA			3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			4
4.01	ACA §5503 increase to the direct GME FTE cal (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			5
6	Unweighted resident FTE count for allopathic and osteopathic programs for teh current year from your records (see instructions)			2.76
7	Enter the lesser of line 5 or line 6			7
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	1.53	1.22	2.75
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00
10	Weighted dental and podiatric resident FTE count for the current year		0.00	
11	Total weighted FTE count	0.00	0.00	
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00	
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00	
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00	
15	Adjustment for residents in initial years of new programs	1.53	1.22	
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00	
17	Adjusted rolling average FTE count	1.53	1.22	
18	Per resident amount	82,461.00	82,461.00	
19	Approved amount for resident costs	126,165	100,602	226,767
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)			
21	Direct GME FTE unweighted resident count over cap (see instructions)			2.76
22	Allowable additional direct GME FTE resident count (see instructions)			
23	Enter the locality adjustment national average per resident amount (see instructions)			
24	Multiply line 22 times line 23			
25	Total direct GME amount (sum of lines 19 and 24)			226,767
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>				
		Inpatient Part A	Managed Care	
26	Inpatient days (see instructions)	9,391	494	26
27	Total inpatient days (see instructions)	22,997	22,997	27
28	Ratio of inpatient days to total inpatient days	0.408358	0.021481	28
29	Program direct GME amount	92,602	4,871	29
30	Reduction for direct GME payments for Medicare Advantage		688	30
31	Net Program direct GME amount			96,785
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)</b>				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			34
35	Medicare outpatient ESRD charges (see instructions)			35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			36
<b>APPORTIONMENT OF MEDICARE REASONABLE COST OF GME</b>				
<b>Part A Reasonable Cost</b>				
37	Reasonable cost (see instructions)			35,273,829
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)			38
39	Cost of physicians' services in a teaching hospital (see instructions)			39
40	Primary payer payments (see instructions)			40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			35,273,829
<b>Part B Reasonable Cost</b>				
42	Reasonable cost (see instructions)			27,183,694
43	Primary payer payments (see instructions)			43
44	Total Part B reasonable cost (line 42 minus line 43)			27,183,694
45	Total reasonable cost (sum of lines 41 and 44)			62,457,523
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.564765
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.435235
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48	Total program GME payment (line 31)			96,785
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			54,661
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			42,124

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**DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS**

**WORKSHEET E-4**

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

<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>				
		Primary Care	Other	Total
		1	2	3
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)			2
3	Amount of reduction to Direct GME cap under §422 of MMA			3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			4
4.01	ACA §5503 increase to the direct GME FTE cal (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			5
6	Unweighted resident FTE count for allopathic and osteopathic programs for teh current year from your records (see instructions)			6
7	Enter the lesser of line 5 or line 6			7
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00 8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00 9
10	Weighted dental and podiatric resident FTE count for the current year		0.00	10
11	Total weighted FTE count	0.00	0.00	11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00	12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00	13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00	14
15	Adjustment for residents in initial years of new programs	0.00	0.00	15
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00	16
17	Adjusted rolling average FTE count	0.00	0.00	17
18	Per resident amount	0.00	0.00	18
19	Approved amount for resident costs			19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)			20
21	Direct GME FTE unweighted resident count over cap (see instructions)			21
22	Allowable additional direct GME FTE resident count (see instructions)			22
23	Enter the locality adjustment national average per resident amount (see instructions)			23
24	Multiply line 22 times line 23			24
25	Total direct GME amount (sum of lines 19 and 24)			25
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>				
		Inpatient Part A	Managed Care	
26	Inpatient days (see instructions)	1,360	1,129	26
27	Total inpatient days (see instructions)	22,997	22,997	27
28	Ratio of inpatient days to total inpatient days	0.059138	0.049093	28
29	Program direct GME amount			29
30	Reduction for direct GME payments for Medicare Advantage			30
31	Net Program direct GME amount			31
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)</b>				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			34
35	Medicare outpatient ESRD charges (see instructions)			35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			36
<b>APPORTIONMENT OF MEDICARE REASONABLE COST OF GME</b>				
<b>Part A Reasonable Cost</b>				
37	Reasonable cost (see instructions)			37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)			38
39	Cost of physicians' services in a teaching hospital (see instructions)			39
40	Primary payer payments (see instructions)			40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			41
<b>Part B Reasonable Cost</b>				
42	Reasonable cost (see instructions)			42
43	Primary payer payments (see instructions)			43
44	Total Part B reasonable cost (line 42 minus line 43)			44
45	Total reasonable cost (sum of lines 41 and 44)			45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			47
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48	Total program GME payment (line 31)			48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			50

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**BALANCE SHEET**

**WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
<b>Assets</b> (Omit Cents)		1	2	3	4	
<b>CURRENT ASSETS</b>						
1	Cash on hand and in banks	5,802,359	27,146,644	26,272,955		1
2	Temporary investments	3,736,535				2
3	Notes receivable					3
4	Accounts receivable	38,225,339				4
5	Other receivables	6,115,012				5
6	Allowances for uncollectible notes and accounts receivable	-11,996,491				6
7	Inventory	5,531,939				7
8	Prepaid expenses	396,456				8
9	Other current assets	1,735,927				9
10	Due from other funds	101,884				10
11	Total current assets (sum of lines 1-10)	49,648,960	27,146,644	26,272,955		11
<b>FIXED ASSETS</b>						
12	Land	53,223,598				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	170,082,801				15
16	Accumulated depreciation	-73,394,659				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	42,970,665				19
20	Accumulated depreciation	-27,044,865				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment					23
24	Accumulated depreciation					24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	165,837,540				30
<b>OTHER ASSETS</b>						
31	Investments	93,392,985				31
32	Deposits on leases	1				32
33	Due from owners/officers	13,968,035				33
34	Other assets	131,540,709				34
35	Total other assets (sum of lines 31-34)	238,901,730				35
36	Total assets (sum of lines 11, 30 and 35)	454,388,230	27,146,644	26,272,955		36
<b>Liabilities and Fund Balances</b> (Omit Cents)						
		1	2	3	4	
<b>CURRENT LIABILITIES</b>						
37	Accounts payable	31,321,301				37
38	Salaries, wages and fees payable	10,079,478				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	2,257,554				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	45,027,850				43
44	Other current liabilities	3,293,499				44
45	Total current liabilities (sum of lines 37 thru 44)	91,979,682				45
<b>LONG TERM LIABILITIES</b>						
46	Mortgage payable					46
47	Notes payable	665,142				47
48	Unsecured loans					48
49	Other long term liabilities	75,789,153				49
50	Total long term liabilities (sum of lines 46 thru 49)	76,454,295				50
51	Total liabilities (sum of lines 45 and 50)	168,433,977				51
<b>CAPITAL ACCOUNTS</b>						
52	General fund balance	285,954,253				52
53	Specific purpose fund		27,146,644			53
54	Donor created - endowment fund balance - restricted			26,272,955		54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**BALANCE SHEET**

**WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	<b>Assets</b>	1	2	3	4	
	(Omit Cents)					
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	285,954,253	27,146,644	26,272,955		59
60	Total liabilities and fund balances (sum of lines 51 and 59)	454,388,230	27,146,644	26,272,955		60

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**STATEMENT OF CHANGES IN FUND BALANCES**

**WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		272,601,768		16,095,277
2	Net income (loss) (from Worksheet G-3, line 29)		12,858,871		
3	Total (sum of line 1 and line 2)		285,460,639		16,095,277
4	Additions (credit adjustments) (specify)				
5	ASSETS RELEASED FROM RESTRICTIONS				
6	GIFTS, GRANTS & OTHER REVENUE			18,311,218	
7	INVESTMENT INCOME - REALIZED GAINS			394,035	
8	RECLASSIFICATION	493,614		-1	
9					
10	Total additions (sum of lines 4-9)		493,614		18,705,252
11	Subtotal (line 3 plus line 10)		285,954,253		34,800,529
12	Deductions (debit adjustments) (specify)				
13	OPERATING EXPENSES			1,406,927	
14	PROPERTY ADDITIONS			6,242,002	
15	CHNG IN VALUE OF SPLIT INT AGREEMNT			4,956	
16					
17					
18	Total deductions (sum of lines 12-17)				7,653,885
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		285,954,253		27,146,644

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	Fund balances at beginning of period		25,251,130		
2	Net income (loss) (from Worksheet G-3, line 29)				
3	Total (sum of line 1 and line 2)		25,251,130		
4	Additions (credit adjustments) (specify)				
5	ASSETS RELEASED FROM RESTRICTIONS				
6	GIFTS, GRANTS & OTHER REVENUE	1,021,825			
7	INVESTMENT INCOME - REALIZED GAINS				
8	RECLASSIFICATION				
9					
10	Total additions (sum of lines 4-9)		1,021,825		
11	Subtotal (line 3 plus line 10)		26,272,955		
12	Deductions (debit adjustments) (specify)				
13	OPERATING EXPENSES				
14	PROPERTY ADDITIONS				
15	CHNG IN VALUE OF SPLIT INT AGREEMNT				
16					
17					
18	Total deductions (sum of lines 12-17)				
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		26,272,955		

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**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	
	<b>GENERAL INPATIENT ROUTINE CARE SERVICES</b>				
1	Hospital	42,866,796		42,866,796	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	8,008,100		8,008,100	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	50,874,896		50,874,896	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
11	Intensive Care Unit	11,428,482		11,428,482	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	11,428,482		11,428,482	16
17	Total inpatient routine care services (sum of lines 10 and 16)	62,303,378		62,303,378	17
18	Ancillary services	236,450,297	683,602,353	920,052,650	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	298,753,675	683,602,353	982,356,028	28

**PART II - OPERATING EXPENSES**

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		234,146,730	29
30	Add (specify)			30
31	BAD DEBT			31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		234,146,730	43

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**STATEMENT OF REVENUES AND EXPENSES****WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	982,356,028	1
2	Less contractual allowances and discounts on patients' accounts	755,597,841	2
3	Net patient revenues (line 1 minus line 2)	226,758,187	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	234,146,730	4
5	Net income from service to patients (line 3 minus line 4)	-7,388,543	5

**OTHER INCOME**

6	Contributions, donations, bequests, etc.		6
7	Income from investments	-1,996,659	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	963,932	14
15	Revenue from rental of living quarters	-897	15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	5,418,907	22
23	Governmental appropriations	1,013,585	23
24	Other (HAP REVENUE)	4,407,841	24
24.0	Other (OTHER INCOME)	10,440,705	24.0
1			1
25	Total other income (sum of lines 6-24)	20,247,414	25
26	Total (line 5 plus line 25)	12,858,871	26
29	Net income (or loss) for the period (line 26 minus line 28)	12,858,871	29

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**

**HHA CCN: 14-7045**

**WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	513,738					5
	<b>HHA REIMBURSABLE SERVICES</b>						
6	Skilled Nursing Care	1,461,260					6
7	Physical Therapy	554,589					7
8	Occupational Therapy	66,017					8
9	Speech Pathology						9
10	Medical Social Services	47,490					10
11	Home Health Aide	64,937					11
12	Supplies (see instructions)						12
13	Drugs						13
14	DME						14
	<b>HHA NONREIMBURSABLE SERVICES</b>						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	2,708,031					24

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**

**HHA CCN: 14-7045**

**WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENT S	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	513,738		513,738	-312,354	201,384	5
	<b>HHA REIMBURSABLE SERVICES</b>						
6	Skilled Nursing Care	1,461,260		1,461,260	-888,449	572,811	6
7	Physical Therapy	554,589		554,589	-337,191	217,398	7
8	Occupational Therapy	66,017		66,017	-40,138	25,879	8
9	Speech Pathology						9
10	Medical Social Services	47,490		47,490	-28,874	18,616	10
11	Home Health Aide	64,937		64,937	-39,484	25,453	11
12	Supplies (see instructions)						12
13	Drugs						13
14	DME						14
	<b>HHA NONREIMBURSABLE SERVICES</b>						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	2,708,031		2,708,031	-1,646,490	1,061,541	24

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

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**

**HHA CCN: 14-7045**

**WORKSHEET H-1  
PART I**

		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	CAPITAL RELATED COSTS			
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANC E	
		0	1	2	3	
<b>GENERAL SERVICE COST CENTERS</b>						
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	201,384				5
<b>HHA REIMBURSABLE SERVICES</b>						
6	Skilled Nursing Care	572,811				6
7	Physical Therapy	217,398				7
8	Occupational Therapy	25,879				8
9	Speech Pathology					9
10	Medical Social Services	18,616				10
11	Home Health Aide	25,453				11
12	Supplies (see instructions)					12
13	Drugs					13
14	DME					14
<b>HHA NONREIMBURSABLE SERVICES</b>						
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	1,061,541				24

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**

**HHA CCN: 14-7045**

**WORKSHEET H-1  
PART I**

		TRANSPORTATION	SUBTOTAL (cols. 0-4)	ADMINISTRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	<b>GENERAL SERVICE COST CENTERS</b>					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		201,384	201,384		5
	<b>HHA REIMBURSABLE SERVICES</b>					
6	Skilled Nursing Care		572,811	46,020	618,831	6
7	Physical Therapy		217,398	17,466	234,864	7
8	Occupational Therapy		25,879	2,079	27,958	8
9	Speech Pathology					9
10	Medical Social Services		18,616	1,496	20,112	10
11	Home Health Aide		25,453	2,045	27,498	11
12	Supplies (see instructions)					12
13	Drugs					13
14	DME					14
	<b>HHA NONREIMBURSABLE SERVICES</b>					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others			132,278	132,278	23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		1,061,541		1,061,541	24

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**COST ALLOCATION - HHA STATISTICAL BASIS**

**HHA CCN: 14-7045**

**WORKSHEET H-1  
PART II**

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORTATION (Mileage)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
<b>GENERAL SERVICE COST CENTERS</b>								
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-201,384	2,506,647	5
<b>HHA REIMBURSABLE SERVICES</b>								
6	Skilled Nursing Care						572,811	6
7	Physical Therapy						217,398	7
8	Occupational Therapy						25,879	8
9	Speech Pathology							9
10	Medical Social Services						18,616	10
11	Home Health Aide						25,453	11
12	Supplies (see instructions)							12
13	Drugs							13
14	DME							14
<b>HHA NONREIMBURSABLE SERVICES</b>								
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others					1,646,490	1,646,490	23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					1,445,106	2,506,647	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						201,384	25
26	Unit Cost Multiplier						0.080340	26

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**

**HHA CCN: 14-7045**

**WORKSHEET H-2  
PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	Administrative and General		21,570		129,638	151,208	62,127	1
2	Skilled Nursing Care	618,831	39,098		218,082	876,011	359,927	2
3	Physical Therapy	234,864	18,295		102,047	355,206	145,944	3
4	Occupational Therapy	27,958	2,033		11,340	41,331	16,982	4
5	Speech Pathology							5
6	Medical Social Services	20,112	1,462		8,158	29,732	12,216	6
7	Home Health Aide	27,498	2,000		11,144	40,642	16,699	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	132,278				132,278	54,349	19
20	Totals (sum of lines 1-19)(2)	1,061,541	84,458		480,409	1,626,408	668,244	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

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

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**

**HHA CCN: 14-7045**

**WORKSHEET H-2  
PART I**

	HHA COST CENTER (omit cents)	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
1	Administrative and General					21,376		1
2	Skilled Nursing Care	4,177				37,546		2
3	Physical Therapy					17,561		3
4	Occupational Therapy					1,943		4
5	Speech Pathology							5
6	Medical Social Services					1,415		6
7	Home Health Aide					1,919		7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	4,177				81,760		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**

**HHA CCN: 14-7045**

**WORKSHEET H-2  
PART I**

	HHA COST CENTER (omit cents)	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	SOCIAL SERVICE 17	I&R SALARY & FRINGES 21	
1	Administrative and General	102,760	5,016		6,423			1
2	Skilled Nursing Care	61,270	227	53	3,854			2
3	Physical Therapy	28,667	106		2,569			3
4	Occupational Therapy	3,185	12					4
5	Speech Pathology							5
6	Medical Social Services	2,294	9					6
7	Home Health Aide	3,133	12					7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	201,309	5,382	53	12,846			20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

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

**KPMG LLP Compu-Max 2552-10**

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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**

**HHA CCN: 14-7045**

**WORKSHEET H-2  
PART I**

	HHA COST CENTER (omit cents)	I&R PROGRAM COSTS 22	SUBTOTAL (sum of col.4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (cols 23 +/- 24) 26	ALLOCATED HHA A&G (see PtII) 27	TOTAL HHA COSTS 28	
1	Administrative and General		348,910		348,910			1
2	Skilled Nursing Care		1,343,065		1,343,065	208,154	1,551,219	2
3	Physical Therapy		550,053		550,053	85,249	635,302	3
4	Occupational Therapy		63,453		63,453	9,834	73,287	4
5	Speech Pathology							5
6	Medical Social Services		45,666		45,666	7,077	52,743	6
7	Home Health Aide		62,405		62,405	9,672	72,077	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		186,627		186,627	28,924	215,551	19
20	Totals (sum of lines 1-19)(2)		2,600,179		2,600,179	348,910	2,600,179	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.154984		21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

**KPMG LLP Compu-Max 2552-10**

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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 14-7045**

**WORKSHEET H-2  
PART II**

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT  SQUARE FEET	
		1	2	4	4A	5	7	
1	Administrative and General	13,133		730,790		151,208		1
2	Skilled Nursing Care	23,805		1,229,364		876,011	84	2
3	Physical Therapy	11,139		575,255		355,206		3
4	Occupational Therapy	1,238		63,928		41,331		4
5	Speech Pathology							5
6	Medical Social Services	890		45,988		29,732		6
7	Home Health Aide	1,218		62,822		40,642		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					132,278		19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	51,423		2,708,147		1,626,408	84	20
21	Total cost to be allocated	84,458		480,409		668,244	4,177	21
22	Unit Cost Multiplier	1.642417		0.177394		0.410871		22
22	Unit Cost Multiplier						49.726190	22

**KPMG LLP Compu-Max 2552-10**

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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 14-7045**

**WORKSHEET H-2  
PART II**

	HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINISTRATION DIRECT NRSING HRS	
		8	9	10	11	12	13	
1	Administrative and General				891		21,909	1
2	Skilled Nursing Care				1,565		13,063	2
3	Physical Therapy				732		6,112	3
4	Occupational Therapy				81		679	4
5	Speech Pathology							5
6	Medical Social Services				59		489	6
7	Home Health Aide				80		668	7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)				3,408		42,920	20
21	Total cost to be allocated				81,760		201,309	21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier				23.990610		4.690331	22

**KPMG LLP Compu-Max 2552-10**

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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 14-7045**

**WORKSHEET H-2  
PART II**

	HHA COST CENTER	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	
		14	15	16	17	21	22	
1	Administrative and General	47,680		3,678,758				1
2	Skilled Nursing Care	2,160	121	2,207,255				2
3	Physical Therapy	1,011		1,471,504				3
4	Occupational Therapy	112						4
5	Speech Pathology							5
6	Medical Social Services	81						6
7	Home Health Aide	110						7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	51,154	121	7,357,517				20
21	Total cost to be allocated	5,382	53	12,846				21
22	Unit Cost Multiplier	0.105212		0.001746				22
22	Unit Cost Multiplier		0.438017					22

**KPMG LLP Compu-Max 2552-10**

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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 14-7045**

**WORKSHEET H-2  
PART II**

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

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**APPORTIONMENT OF PATIENT SERVICE COSTS**

**HHA CCN: 14-7045**

**WORKSHEET H-3  
PARTS I & II**

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

**PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST**

Cost Per Visit Computation								
	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	Skilled Nursing Care	2	1,551,219		1,551,219	4,930	314.65	1
2	Physical Therapy	3	635,302		635,302	3,029	209.74	2
3	Occupational Therapy	4	73,287		73,287	363	201.89	3
4	Speech Pathology	5				27		4
5	Medical Social Services	6	52,743		52,743	166	317.73	5
6	Home Health Aide	7	72,077		72,077	407	177.09	6
7	Total (sum of lines 1-6)		2,384,628		2,384,628	8,922		7

Limitation Cost Computation						
			Program Visits			
			PART B			
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	16974		46		8
8.01	Skilled Nursing Care	29404		4,884		8.01
9	Physical Therapy	16974		35		9
9.01	Physical Therapy	29404		2,994		9.01
10	Occupational Therapy	16974		2		10
10.01	Occupational Therapy	29404		361		10.01
11	Speech Pathology	16974				11
11.01	Speech Pathology	29404		27		11.01
12	Medical Social Services	16974				12
12.01	Medical Social Services	29404		166		12.01
13	Home Health Aide	16974				13
13.01	Home Health Aide	29404		407		13.01
14	Total (sum of lines 8-13)			8,922		14

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

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

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	66	0.333308			col. 2, line 2	1
2	Occupational Therapy	67				col. 2, line 3	2
3	Speech Pathology	68	0.634625			col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.276418			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.342715			col. 2, line 16	5

**KPMG LLP Compu-Max 2552-10**

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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7045

WORKSHEET H-3  
PARTS I & II

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

**PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST**

Cost Per Visit Computation		Program Visits			Cost of Services				
		Part B			Part B				
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		4,930			1,551,225		1,551,225	1
2	Physical Therapy		3,029			635,302		635,302	2
3	Occupational Therapy		363			73,286		73,286	3
4	Speech Pathology		27						4
5	Medical Social Services		166			52,743		52,743	5
6	Home Health Aide		407			72,076		72,076	6
7	Total (sum of lines 1-6)		8,922			2,384,632		2,384,632	7

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

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**CALCULATION OF HHA REIMBURSEMENT SETTLEMENT**

**HHA CCN: 14-7045**

**WORKSHEET H-4  
PARTS I & II**

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

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

	Description	Part A 1	Part B		
			Not Subject to Deductibles & Coinsurance 2	Subject to Deductibles & Coinsurance 3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)				4
5	Ratio of line 3 to line 4 (not to exceed 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts				9

**PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT**

	Description	Part A Services 1	Part B Services 2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers		1,520,693	11
12	Total PPS Reimbursement - Full Episodes with Outliers		30,568	12
13	Total PPS Reimbursement - LUPA Episodes		30,777	13
14	Total PPS Reimbursement - PEP Episodes		26,379	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		3,757	15
16	Total PPS Outlier Reimbursement - PSP Episodes			16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)		1,612,174	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		1,612,174	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		1,612,174	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		1,612,174	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		1,612,174	31
31.01	Sequestration adjustment (see instructions)			31.01
32	Interim payments (see instructions)		1,612,174	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

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**ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES**

**HHa CCN: 14-7045**

**WORKSHEET H-5**

DESCRIPTION		Part A		Part B		
		mm/dd/yyyy 1	Amount 2	mm/dd/yyyy 3	Amount 4	
1	Total interim payments paid to provider				1,612,174	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.					2
3	List separately each retroactive lump sum adjustment 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. (1)	.01				3.01
		.02				3.02
	Program	.03				3.03
	To	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	To	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				1,612,174	4
<b>TO BE COMPLETED BY CONTRACTOR</b>						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01				5.01
		.02				5.02
	Program	.03				5.03
	To	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	To	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions)	.01				6.01
		.02				6.02
7	<b>TOTAL MEDICARE PROGRAM LIABILITY</b> (see instructions)				1,612,174	7
8	Name of Contractor	Contractor Number		NPR Date: Month, Day, Year		8

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

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**CALCULATION OF CAPITAL PAYMENT**

**COMPONENT CCN: 14-0130**

**WORKSHEET L**

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

**PART I - FULLY PROSPECTIVE METHOD**

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	1,528,736	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	15,939	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	64.32	3
4	Number of interns & residents (see instructions)	2.81	4
5	Indirect medical education percentage (see instructions)	1.24	5
6	Indirect medical education adjustment (see instructions)	18,956	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0171	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.1009	8
9	Sum of lines 7 and 8	0.1180	9
10	Allowable disproportionate share percentage (see instructions)	0.0242	10
11	Disproportionate share adjustment (see instructions)	36,995	11
12	Total prospective capital payments (see instructions)	1,600,626	12

**PART II - PAYMENT UNDER REASONABLE COST**

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

**PART III - COMPUTATION OF EXCEPTION PAYMENTS**

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

**KPMG LLP Compu-Max 2552-10**

NORTHWESTERN LAKE FOREST HOSPITAL Provider CCN: 14-0130	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 09/01/2014 To: 08/31/2015	Run Date: 02/01/2016 Run Time: 07:51 Version: 2015.10 (12/23/2015)
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**ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES**

**WORKSHEET L-1  
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30	Adults & Pediatrics						30
31	Intensive Care Unit						31
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room						50
52	Delivery Room & Labor Room						52
54	Radiology-Diagnostic						54
55	Radiology-Therapeutic						55
57	CT Scan						57
58	MRI						58
59	Cardiac Catheterization						59
60	Laboratory						60
65	Respiratory Therapy						65
66	Physical Therapy						66
68	Speech Pathology						68
69	Electrocardiology						69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
76.97	CARDIAC REHABILITATION						76.97
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01	OP PEDS ONC CLINIC						90.01
90.02	WOUND CLINIC						90.02
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
92.01	OBSERVATION BEDS-DISTINCT						92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
101	Home Health Agency						101
	<b>SPECIAL PURPOSE COST CENTERS</b>						
118	SUBTOTALS (sum of lines 1-117)						118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192
194	HEALTH & FITNESS CENTER						194
194.0	OCCUPATIONAL HEALTH						194.0
1							1
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)						202