

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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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 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.	Date: 02/24/2016 Time: 11:58
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 NORTHWEST COMMUNITY HOSPITAL (14-0252) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 10/01/2014 and ending 09/30/2015, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

**PART III - SETTLEMENT SUMMARY**

		TITLE XVIII						
		TITLE V	PART A	PART B	HIT	TITLE XIX		
		1	2	3	4	5		
1	HOSPITAL		2,804,385	353,766		886,304	1	
2	SUBPROVIDER - IPF		26,881			-909,766	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		2,831,266	353,766		-23,462	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 not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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

**WORKSHEET S-2  
PART I**

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
0	1	2	3	4	5	6	7	8		
3	Hospital	NORTHWEST COMMUNITY HOSPITAL	14-0252	16974	1	07 / 01 / 1966	N	P	O	3
4	Subprovider - IPF	NWCH PSYCHIATRIC UNIT	14-S252	16974	4	11 / 01 / 1985	N	P	O	4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTG									11
12	Hospital-Based HHA	NORTHWEST COMMUNITY HOME CARE SERVIC	14-7094	16974		07 / 01 / 1966	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 10 / 01 / 2014	To: 09 / 30 / 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.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	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.	6,132	3,883				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 is in effect in the cost reporting period.						35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:			36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						37
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
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	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
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
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services 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)	Y			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic 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))		
65	1	2	3	4	5		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))		
67	1	2	3	4	5		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.	Y			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N		71

**Inpatient Rehabilitation Facility PPS**

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	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**

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

**Rural Providers**

		1	2		
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106	
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME 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.	N			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	4,499,357			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

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	N		140

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

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

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

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

Multicampus

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

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

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

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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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	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	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

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

		Y/N	Y/N	
<b>Approved Educational Activities</b>				
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	Y		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see 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.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

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

		Part A		Part B	
		Y/N	Date	Y/N	Date
<b>PS&amp;R Report Data</b>					
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	11/18/2015	Y	11/18/2015
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 relieved 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: GARY	Last name: ZEMAN	Title: VICE PRESIDENT
42	Employer: STRATEGIC REIMBURSEMENT GROUP, LLC		
43	Phone number: 630-530-7100 EXT 112	E-mail Address: GARY.ZEMAN@SRGROUPLCC.COM	

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

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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			Total All Patients	
						Title V	Title XVIII	Title XIX		
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	268	97,820			29,847	4,480	62,044	1
2	HMO and other (see instructions)						3,499	3,883		2
3	HMO IPF Subprovider						172			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)		268	97,820			29,847	4,480	62,044	7
8	Intensive Care Unit	31	60	21,900			4,239	272	8,106	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	NEONATAL INTENSIVE CARE UNIT	35	8	2,920				133	880	12
13	Nursery	43						1,247	8,251	13
14	Total (see instructions)		336	122,640			34,086	6,132	79,281	14
15	CAH Visits									15
16	Subprovider - IPF	40	32	11,680			1,266	1,445	9,587	16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					25,282		39,511	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)		368							27
28	Observation Bed Days								4,631	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)								674	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**

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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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)					7,832	1,947	18,485	1
2	HMO and other (see instructions)					784	985		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	NEONATAL INTENSIVE CARE UNIT								12
13	Nursery								13
14	Total (see instructions)		2,482.17			7,832	1,947	18,485	14
15	CAH Visits								15
16	Subprovider - IPF		66.72			129	214	1,371	16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		60.97						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)		2,609.86						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	Reclassi- fication 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	200	177,687,448	1,664,762	179,352,210	5,428,523.00	33.04	1
2							2
3							3
4							4
4.01							4.01
5							5
6							6
7	21						7
7.01							7.01
8							8
9	44						9
10		11,965,387	886,953	12,852,340	366,127.00	35.10	10
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11		1,919,906		1,919,906	21,236.00	90.41	11
12							12
13							13
14							14
15							15
16							16
<b>WAGE-RELATED COSTS</b>							
17		49,782,882		49,782,882			17
18							18
19		3,225,793		3,225,793			19
20							20
21							21
22							22
22.01							22.01
23							23
24							24
25							25
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26		1,967,641		1,967,641	35,525.00	55.39	26
27		29,239,057	1,664,762	30,903,819	764,708.00	40.41	27
28		6,559,389		6,559,389	49,264.00	133.15	28
29							29
30		2,946,058		2,946,058	95,542.00	30.84	30
31							31
32		3,083,317		3,083,317	223,628.00	13.79	32
33							33
34		2,773,798	-1,484,450	1,289,348	83,905.00	15.37	34
35							35
36			1,484,450	1,484,450	86,554.00	17.15	36
37							37
38		10,098,152		10,098,152	253,923.00	39.77	38
39		1,492,131		1,492,131	86,254.00	17.30	39
40		3,970,878		3,970,878	95,767.00	41.46	40
41		2,355,823		2,355,823	89,874.00	26.21	41
42							42
43							43

**Part III - Hospital Wage Index Summary**

1	Net salaries (see instructions)	184,246,837	1,664,762	185,911,599	5,477,787.00	33.94	1
2	Excluded area salaries (see instructions)	11,965,387	886,953	12,852,340	366,127.00	35.10	2
3	Subtotal salaries (line 1 minus line 2)	172,281,450	777,809	173,059,259	5,111,660.00	33.86	3
4	Subtotal other wages & related costs (see instructions)	1,919,906		1,919,906	21,236.00	90.41	4
5	Subtotal wage-related costs (see instructions)	49,782,882		49,782,882		28.77%	5
6	Total (sum of lines 3 through 5)	223,984,238	777,809	224,762,047	5,132,896.00	43.79	6
7	Total overhead cost (see instructions)	64,486,244	1,664,762	66,151,006	1,864,944.00	35.47	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	7,919,924	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)	651,023	3
4	Qualified Defined Benefit Plan Cost (see instructions)	8,413,423	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)	18,517,382	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	963,685	10
11	Life Insurance (If employee is owner or beneficiary)	78,755	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	620,216	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	2,364,338	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	12,417,520	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	339,126	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	723,284	23
24	Total Wage Related cost (Sum of lines 1-23)	53,008,676	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**

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	Supporting Exhibit for Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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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	09/30/2019	1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)	10/01/2014	09/30/2015
3	Midpoint of Provider's Cost Reporting Period Shown on Line 2, Adjusted to First of Month	4/01/2015	3
4	Date Beginning the 3-Year Averaging Period (subtract 18 months from midpoint shown on Line 3)	10/01/2013	4
5	Date Ending the 3-Year Averaging Period (add 18 months to midpoint shown on Line 3)	10/01/2016	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	10/01/2013	9
10	Ending Date of Averaging Period from Line 5	10/01/2016	10
11	Enter Provider Contributions Made During Averaging Period on Lines 9 & 10	<b>DEPOSIT DATE(S)</b>	<b>CONTRIB-UTION(S)</b>
11.01		09/30/2013	8,400,000
11.02		09/30/2014	8,400,000
11.03		09/30/2015	8,400,000
12	Total Calendar Months Included in Averaging Period (36 unless Step 2 completed)	36	12
13	Total Contributions Made During Averaging Period	25,200,000	13
14	Average Monthly Contribution (Line 13 divided by Line 12)	700,000	14
15	Number of MOonths in Provider Cost Reporting Period on Line 2	12	15
16	Average Pension Contributions (Line 14 times Line 15)	8,400,000	16
<b>STEP 4: TOTAL PENSION COST FOR WAGE INDEX</b>			
17	Annual Prefunding Installment (see instructions)	13,423	17
18	Reportable Prefunding Installment ((Line 17 times Line 15) divided by 12)	13,423	18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	8,413,423	19

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

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

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA**

**HHA CCN: 14-7094**

**WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA

County: **COOK**

	Description	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total 5	
1	Home Health Aide Hours		2,435		1,061	3,496	1
2	Unduplicated Census Count (see instructions)		1,888.00		1,063.00	2,983.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)	1.00		1.00	3
4	Director(s) and Assistant Director(s)				4
5	Other Administrative Personnel		22.37	22.37	5
6	Direct Nursing Service		21.22	21.22	6
7	Nursing Supervisor				7
8	Physical Therapy Service		14.26	14.26	8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service		2.13	2.13	10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service		0.32	0.32	12
13	Speech Pathology Supervisor				13
14	Medical Social Service		1.23	1.23	14
15	Medical Social Service Supervisor				15
16	Home Health Aide		1.60	1.60	16
17	Home Health Aide Supervisor				17
18	CONTINUUM PERSONNEL				18

HOME HEALTH AGENCY CBSA CODES

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

PPS ACTIVITY

		Full Episodes				Total (columns 1 through 4)	
		Without Outliers	With Outliers	LUPA Episodes	PEP only Episodes		
		1	2	3	4		
21	Skilled Nursing Visits	12,129	325	398	275	13,127	21
22	Skilled Nursing Visit Charges	2,237,548	59,786	74,000	50,280	2,421,614	22
23	Physical Therapy Visits	8,800	56	161	187	9,204	23
24	Physical Therapy Visit Charges	2,310,311	14,518	38,883	49,661	2,413,373	24
25	Occupational Therapy Visits	1,329	30	4	23	1,386	25
26	Occupational Therapy Visit Charges	346,422	7,585	1,072	5,057	360,136	26
27	Speech Pathology Visits	219	15	1	1	236	27
28	Speech Pathology Visit Charges	57,621	3,635	268	268	61,792	28
29	Medical Social Service Visits	262	8	2	3	275	29
30	Medical Social Service Visit Charges	61,970	1,880	486	729	65,065	30
31	Home Health Aide Visits	924	106	3	21	1,054	31
32	Home Health Aide Visit Charges	122,148	13,860	405	2,799	139,212	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	23,663	540	569	510	25,282	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	5,136,020	101,264	115,114	108,794	5,461,192	35
36	Total Number of Episodes (standard/non-outlier)	1,814		201	47	2,062	36
37	Total Number of Outlier Episodes		11			11	37
38	Total Non-Routine Medical Supply Charges	207,306		11,399	1,837	220,542	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

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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)		0.230925	1
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### Medicaid (see instructions for each line)

2	Net revenue from Medicaid		11,898,487	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		110,131,630	6
7	Medicaid cost (line 1 times line 6)		25,432,147	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.		13,533,660	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)			13,533,660	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	22,670,900	24,406,209	47,077,109	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	5,235,278	5,636,004	10,871,282	21
22	Partial payment by patients approved for charity care	45,599	229,677	275,276	22
23	Cost of charity care (line 21 minus line 22)	5,189,679	5,406,327	10,596,006	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?				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)			8,260,763	26
27	Medicare bad debts for the entire hospital complex (see instructions)			826,778	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			7,433,985	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			1,716,693	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)			12,312,699	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			25,846,359	31

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

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

**WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		<b>GENERAL SERVICE COST CENTERS</b>								
1	00100	Cap Rel Costs-Bldg & Fixt		59,346,368	59,346,368	-34,235,787	25,110,581	7,367,580	32,478,161	1
2	00200	Cap Rel Costs-Mvble Equip				17,538,341	17,538,341	193,629	17,731,970	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	1,967,641	36,067,437	38,035,078		38,035,078		38,035,078	4
5	00500	Administrative & General	29,239,057	22,883,974	52,123,031	16,671,504	68,794,535	-22,372,358	46,422,177	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	2,946,058	10,174,935	13,120,993	203,409	13,324,402	-5,474	13,318,928	7
8	00800	Laundry & Linen Service								8
9	00900	Housekeeping	3,083,317	3,410,093	6,493,410		6,493,410		6,493,410	9
10	01000	Dietary	2,773,798	3,162,577	5,936,375	-3,134,063	2,802,312	-20,605	2,781,707	10
11	01100	Cafeteria				3,134,063	3,134,063	-1,910,393	1,223,670	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	10,098,152	1,632,457	11,730,609		11,730,609	-245,146	11,485,463	13
14	01400	Central Services & Supply	1,492,131	2,244,018	3,736,149	-1,393,978	2,342,171		2,342,171	14
15	01500	Pharmacy	3,970,878	18,786,367	22,757,245	-18,146,432	4,610,813	-556,869	4,053,944	15
16	01600	Medical Records & Library	2,355,823	2,124,841	4,480,664	-125	4,480,539	105	4,480,644	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	PARAMED ED PRGM-(SPECIFY)				1,132,287	1,132,287	-263,649	868,638	23
		<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	03000	Adults & Pediatrics	31,905,014	6,660,773	38,565,787	-7,253,321	31,312,466	-1,456,444	29,856,022	30
31	03100	Intensive Care Unit	8,064,071	2,608,032	10,672,103	-874,469	9,797,634	-980,880	8,816,754	31
35	02060	NEONATAL INTENSIVE CARE UNIT	2,177,894	835,434	3,013,328	-1,876,776	1,136,552		1,136,552	35
40	04000	Subprovider - IPF	4,379,797	983,905	5,363,702	-406,014	4,957,688	-28,261	4,929,427	40
43	04300	Nursery				1,739,398	1,739,398		1,739,398	43
		<b>ANCILLARY SERVICE COST CENTERS</b>								
50	05000	Operating Room	11,614,981	26,528,817	38,143,798	-22,605,691	15,538,107	-344,736	15,193,371	50
52	05200	Delivery Room & Labor Room				4,660,144	4,660,144		4,660,144	52
53	05300	Anesthesiology	123,687	700,495	824,182	-646,055	178,127		178,127	53
54	05400	Radiology-Diagnostic	12,891,579	7,609,386	20,500,965	-1,459,856	19,041,109	-17,324	19,023,785	54
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	1,740,647	1,505,472	3,246,119	-40,693	3,205,426	-45,461	3,159,965	54.01
56.01	03480	ONCOLOGY	1,270,723	288,626	1,559,349	-86,617	1,472,732	-4,632	1,468,100	56.01
60	06000	Laboratory	5,817,002	6,508,967	12,325,969	-202,007	12,123,962	-2,315	12,121,647	60
62	06200	Whole Blood & Packed Red Blood Cells	509,245	2,027,122	2,536,367	-616	2,535,751		2,535,751	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	2,284,072	909,963	3,194,035	-617,615	2,576,420		2,576,420	65
66	06600	Physical Therapy	6,031,839	2,048,200	8,080,039	-262,930	7,817,109	-259,203	7,557,906	66
69	06900	Electrocardiology	3,706,085	2,316,317	6,022,402	-96,361	5,926,041	-998,041	4,928,000	69
69.01	03630	CARDIAC CATH LAB	1,827,734	7,249,384	9,077,118	-6,495,674	2,581,444	-15,330	2,566,114	69.01
69.02	03160	CARDIAC REHABILITATION	756,135	271,355	1,027,490	-5,923	1,021,567	-86,140	935,427	69.02
71	07100	Medical Supplies Charged to Patients				22,848,426	22,848,426		22,848,426	71
72	07200	Impl. Dev. Charged to Patients				16,396,402	16,396,402		16,396,402	72
73	07300	Drugs Charged to Patients				18,023,186	18,023,186		18,023,186	73
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS				51,009	51,009		51,009	73.01
74	07400	Renal Dialysis		927,913	927,913	-10,773	917,140		917,140	74
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	OUTPATIENT TREATMENT CENTERS	3,716,429	2,405,030	6,121,459	-294,086	5,827,373		5,827,373	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM				715,240	715,240		715,240	90.02
91	09100	Emergency	13,358,069	4,616,504	17,974,573	-3,043,991	14,930,582	-493,597	14,436,985	91
92	09200	Observation Beds (Non-Distinct Part)								92
		<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
101	10100	Home Health Agency	4,952,929	917,444	5,870,373	496	5,870,869		5,870,869	101
		<b>SPECIAL PURPOSE COST CENTERS</b>								
118		SUBTOTALS (sum of lines 1-117)	175,054,787	237,752,206	412,806,993	-75,948	412,731,045	-22,545,544	390,185,501	118
		<b>NONREIMBURSABLE COST CENTERS</b>								
190	19000	Gift, Flower, Coffee Shop & Canteen	159,072	243,458	402,530		402,530		402,530	190
192	19200	Physicians' Private Offices		1,228,817	1,228,817		1,228,817		1,228,817	192
192.01	19201	DAY SURGERY CENTER								192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	460,719	86,746	547,465	-354,703	192,762		192,762	192.02
192.03	19203	MOBILE DENTAL CLINIC	209,452	113,362	322,814		322,814		322,814	192.03
192.04	19204	EMS CONTINUING EDUCATION				430,651	430,651		430,651	192.04

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

**WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
194	07950	CORPORATE HEALTH	121,997	65,300	187,297		187,297		187,297	194
194.01	07951	MARKETING/COMMUNICATION	612,551	2,533,549	3,146,100		3,146,100		3,146,100	194.01
194.02	07952	FOUNDATION	228	1,095	1,323		1,323		1,323	194.02
194.03	07953	OTHER NRCC	1,068,642	801,643	1,870,285		1,870,285	7,229,677	9,099,962	194.03
200		TOTAL (sum of lines 118-199)	177,687,448	242,826,176	420,513,624		420,513,624	-15,315,867	405,197,757	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	SHARED EXPENSES	A	Cafeteria	11	1,484,450	1,649,613	1
500	Total reclassifications				1,484,450	1,649,613	500
	Code Letter - A						
1	FLOAT POOL	B	Intensive Care Unit	31	22,599	2,046	1
2			Subprovider - IPF	40	7,432	673	2
3			NEONATAL INTENSIVE CARE UNIT	35	1,972	179	3
4			Operating Room	50	455	41	4
5			Emergency	91	2,275	206	5
6			Home Health Agency	101	455	41	6
500	Total reclassifications				35,188	3,186	500
	Code Letter - B						
1	TREATMENT CENTER LEASE EXP	C	Cap Rel Costs-Bldg & Fixt	1		148,496	1
500	Total reclassifications					148,496	500
	Code Letter - C						
1	COST OF MEDICAL SUPPLIES SOLD	D	Medical Supplies Charged to P	71		22,848,426	1
2			Impl. Dev. Charged to Patient	72		16,396,402	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
500	Total reclassifications					39,244,828	500
	Code Letter - D						
1	COST OF DRUGS SOLD	E	Drugs Charged to Patients	73		18,074,195	1
500	Total reclassifications					18,074,195	500
	Code Letter - E						
1	PARAMEDICAL EDUCATION	F	PARAMED ED PRGM-(SPECIFY)	23	218,562	45,195	1
2			EMS CONTINUING EDUCATION	192.04	385,456	45,195	2
500	Total reclassifications				604,018	90,390	500
	Code Letter - F						
1	NON DEPT ITEMS-COST ALLOCATION	G	Cap Rel Costs-Mvble Equip	2		17,493,553	1
2			Administrative & General	5		17,192,984	2
500	Total reclassifications					34,686,537	500
	Code Letter - G						
1	SALT CREEK OCCUPANCY COSTS	H	Cap Rel Costs-Bldg & Fixt	1		26,577	1
2			Operation of Plant	7		203,409	2
500	Total reclassifications					229,986	500
	Code Letter - H						
1	PARTIAL HOSPITALIZATION PROGRAM	I	PARTIAL HOSPITALIZATION PROGR	90.02	553,229	162,011	1
2							2
500	Total reclassifications				553,229	162,011	500
	Code Letter - I						
1	PROPERTY INSURANCE	J	Cap Rel Costs-Bldg & Fixt	1		275,677	1
2			Cap Rel Costs-Mvble Equip	2		44,788	2
3							3
500	Total reclassifications					320,465	500
	Code Letter - J						
1	LDR COST ALLOCATION	K	Nursery	43	1,587,080	152,318	1
2			Delivery Room & Labor Room	52	3,687,953	1,021,824	2
500	Total reclassifications				5,275,033	1,174,142	500
	Code Letter - K						

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

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

EXPLANATION OF RECLASSIFICATION(S)		CODE (1)	INCREASES			
			COST CENTER	LINE #	SALARY	
		1	2	3	4	5
1	OUTCOME BONUS	L	Administrative & General	5	1,664,762	1
500	Total reclassifications				1,664,762	500
	Code Letter - L					
1	VACCINE COST	M	FLU VACCINE DRUGS CHG TO PATI	73.01		51,009
500	Total reclassifications					51,009
	Code Letter - M					
1	EMS CLINICAL EDUCATORS	N	PARAMED ED PRGM-(SPECIFY)	23	868,530	1
2						2
3						3
4						4
5						5
6						6
500	Total reclassifications				868,530	500
	Code Letter - N					
	GRAND TOTAL (Increases)				10,485,210	95,834,858

(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.	
		1	6	7	8	9	10	
1	SHARED EXPENSES	A	Dietary	10	1,484,450	1,649,613	1	
500	Total reclassifications				1,484,450	1,649,613	500	
	Code letter - A							
1	FLOAT POOL	B	Adults & Pediatrics	30	35,188	3,186	1	
2							2	
3							3	
4							4	
5							5	
6							6	
500	Total reclassifications				35,188	3,186	500	
	Code letter - B							
1	TREATMENT CENTER LEASE EXP	C	OUTPATIENT TREATMENT CENTERS	90.01		148,496	10	
500	Total reclassifications					148,496	500	
	Code letter - C							
1	COST OF MEDICAL SUPPLIES SOLD	D	Central Services & Supply	14		1,393,978	1	
2			Pharmacy	15		72,237	2	
3			Medical Records & Library	16		125	3	
4			Adults & Pediatrics	30		2,432,662	4	
5			Intensive Care Unit	31		859,895	5	
6			NEONATAL INTENSIVE CARE UNIT	35		139,529	6	
7			Subprovider - IPF	40		13,329	7	
8			Operating Room	50		22,526,966	8	
9			Anesthesiology	53		646,055	9	
10			Radiology-Diagnostic	54		1,459,856	10	
11			OFFSITE-DIAGNOSTIC SERVICES	54.01		40,693	11	
12			ONCOLOGY	56.01		86,617	12	
13			Laboratory	60		202,007	13	
14			Whole Blood & Packed Red Bloo	62		616	14	
15			Respiratory Therapy	65		617,615	15	
16			Physical Therapy	66		257,882	16	
17			Electrocardiology	69		96,361	17	
18			CARDIAC CATH LAB	69.01		6,495,674	18	
19			CARDIAC REHABILITATION	69.02		5,923	19	
20			Renal Dialysis	74		10,773	20	
21			OUTPATIENT TREATMENT CENTERS	90.01		121,667	21	
22			Emergency	91		1,764,368	22	
500	Total reclassifications					39,244,828	500	
	Code letter - D							
1	COST OF DRUGS SOLD	E	Pharmacy	15		18,074,195	1	
500	Total reclassifications					18,074,195	500	
	Code letter - E							
1	PARAMEDICAL EDUCATION	F	Emergency	91	604,018	90,390	1	
2							2	
500	Total reclassifications				604,018	90,390	500	
	Code letter - F							
1	NON DEPT ITEMS-COST ALLOCATION	G	Cap Rel Costs-Bldg & Fixt	1		34,686,537	9	
2							2	
500	Total reclassifications					34,686,537	500	
	Code letter - G							
1	SALT CREEK OCCUPANCY COSTS	H	Administrative & General	5		26,577	10	
2			Administrative & General	5		203,409	14	
500	Total reclassifications					229,986	500	
	Code letter - H							
1	PARTIAL HOSPITALIZATION PROGRAM	I	Subprovider - IPF	40	254,729	105,808	1	
2			RESIDENTIAL TREATMENT CENTER	192.02	298,500	56,203	2	
500	Total reclassifications				553,229	162,011	500	
	Code letter - I							
1	PROPERTY INSURANCE	J	Administrative & General	5		291,494	12	
2			Physical Therapy	66		5,048	12	
3			OUTPATIENT TREATMENT CENTERS	90.01		23,923	3	
500	Total reclassifications					320,465	500	
	Code letter - J							
1	LDR COST ALLOCATION	K	Adults & Pediatrics	30	3,687,953	1,021,824	1	
2			NEONATAL INTENSIVE CARE UNIT	35	1,587,080	152,318	2	
500	Total reclassifications				5,275,033	1,174,142	500	

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
	Code letter - K							
1	OUTCOME BONUS	L	Administrative & General	5		1,664,762	1	
500	Total reclassifications					1,664,762	500	
	Code letter - L							
1	VACCINE COST	M	Drugs Charged to Patients	73		51,009	1	
500	Total reclassifications					51,009	500	
	Code letter - M							
1	EMS CLINICAL EDUCATORS	N	Adults & Pediatrics	30	72,508		1	
2			Intensive Care Unit	31	39,219		2	
3			Subprovider - IPF	40	40,253		3	
4			Operating Room	50	79,221		4	
5			Delivery Room & Labor Room	52	49,633		5	
6			Emergency	91	587,696		6	
500	Total reclassifications				868,530		500	
	Code letter - N							
	<b>GRAND TOTAL (Decreases)</b>				<b>8,820,448</b>	<b>97,499,620</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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**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	1,789,072					1,789,072		1
2	Land Improvements	14,250,270					14,250,270		2
3	Buildings and Fixtures	326,517,316					326,517,316		3
4	Building Improvements	1,317,195					1,317,195		4
5	Fixed Equipment	206,775,885					206,775,885		5
6	Movable Equipment	120,066,006					120,066,006		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	670,715,744					670,715,744		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	670,715,744					670,715,744		10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	33,063,240		15,508		26,267,620		59,346,368	1	
2	Cap Rel Costs-Mvble Equip								2	
3	Total (sum of lines 1-2)	33,063,240		15,508		26,267,620		59,346,368	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 line 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	550,649,737		550,649,737	0.820988					1
2	Cap Rel Costs-Mvble Equip	120,066,007		120,066,007	0.179012					2
3	Total (sum of lines 1-2)	670,715,744		670,715,744	1.000000					3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	5,822,431	175,073	-62,640	275,677	26,267,620		32,478,161	1	
2	Cap Rel Costs-Mvble Equip	17,687,182			44,788			17,731,970	2	
3	Total (sum of lines 1-2)	23,509,613	175,073	-62,640	320,465	26,267,620		50,210,131	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

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			Wkst. A-7 Ref.
				COST CENTER		LINE#	
				1	2	3	
1	Investment income-buildings & fixtures (chapter 2)	B	-909,807	Cap Rel Costs-Bldg & Fixt	1	9	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)	B	-808,868	Administrative & General	5		3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-42,975	Administrative & General	5		7
8	Television and radio service (chapter 21)	A	-5,474	Operation of Plant	7		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-3,637,940				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-1,910,393	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34							34
35	PHO EXP	A	-2,736,995	Administrative & General	5		35
36	OPERATING REV-OVERHEAD CC	B	23,225	Administrative & General	5		36
36.01	OPERATING REV : OVERHEAD CC	B	-20,605	Dietary	10		36.01
37							37
38	LOBBYING PORTION OF DUES	A	-38,201	Administrative & General	5		38
39	PROVIDER ASSESSMENT REBATE	B	-16,782,682	Administrative & General	5		39
40							40
41							41
41.09	AMORT OF CAPITALIZED INT INCOME	B	-78,148	Cap Rel Costs-Bldg & Fixt	1	11	41.09
41.14	PARAMED EDUCATION TUITION INCOM	B	-263,649	PARAMED ED PRGM-(SPECIFY)	23		41.14
41.71	NC HEALTH COST	A	7,229,677	OTHER NRCC	194.03		41.71
41.88	PIANO DEPRECIATION	A	-1,371	Cap Rel Costs-Mvble Equip	2	9	41.88
42	WELLNESS CENTER RENT TO COST	A	7,534	Physical Therapy	66		42
42.01	WELLNESS CENTER RENT TO COST	A	-76,535	CARDIAC REHABILITATION	69.02		42.01
43	INTERCOMPANY RENT	A	-182,600	Cap Rel Costs-Bldg & Fixt	1	9	43
44	BANK LOAN INTEREST EXP	A	-45,461	OFFSITE-DIAGNOSTIC SERVICES	54.01		44
45							45
45.01	MISC OPERATING INCOME	B	-1,910,393	Administrative & General	5		45.01
45.02	MISC OPERATING INCOME	B	-6,500	Pharmacy	15		45.02
45.03	MISC OPERATING INCOME	B	-245,146	Nursing Administration	13		45.03
45.04	MISC OPERATING INCOME	B	105	Medical Records & Library	16		45.04
45.05	MISC OPERATING INCOME	B	-70,124	Adults & Pediatrics	30		45.05
45.06	MISC OPERATING INCOME	B	-28,261	Subprovider - IPF	40		45.06
45.07	MISC OPERATING INCOME	B	-120,500	Operating Room	50		45.07
45.08	MISC OPERATING INCOME	B	-4,430	Radiology-Diagnostic	54		45.08
45.09	MISC OPERATING INCOME	B	-2,315	Laboratory	60		45.09
45.10	MISC OPERATING INCOME	B	-1,995	Physical Therapy	66		45.10
45.11	MISC OPERATING INCOME	B	-33,270	Electrocardiology	69		45.11
45.12	MISC OPERATING INCOME	B	-550,369	Pharmacy	15		45.12
45.14	MISC OPERATING INCOME	B	-4,632	ONCOLOGY	56.01		45.14
45.15	MISC OPERATING INCOME	B	-493,597	Emergency	91		45.15

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**ADJUSTMENTS TO EXPENSES**

**WORKSHEET A-8**

		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED					
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
45.26	NON ALLOWABLE TRAVEL	A	-31,565	Administrative & General	5		45.26
45.32	CSM AND 901 DEPRECIATION	A	-1,718,816	Cap Rel Costs-Bldg & Fixt	1	9	45.32
45.33	AMORT OF DEPR EXP OF DEMOLISHED	A	68,111	Cap Rel Costs-Bldg & Fixt	1	9	45.33
45.35	MED VS BOOK DEP DIFF	A	10,188,840	Cap Rel Costs-Bldg & Fixt	1	9	45.35
46	MAINFRAME SERVER EDITION-RECORD	A	195,000	Cap Rel Costs-Mvble Equip	2	9	46
47	PT B NON PHY COST	A	-264,742	Physical Therapy	66		47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-15,315,867				50

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

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

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

**WORKSHEET A-8-1**

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

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

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

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

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

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

	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							6
7							7
8							8
9							9
10							10

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

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

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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	5	Administrative & Gen AGGREGATE	66,480		66,480	177,200	265	22,576	1,129	2
3										3
4	30	Adults & Pediatrics AGGREGATE	1,386,320	1,386,320						4
5	31	Intensive Care Unit AGGREGATE	1,014,000	965,847	48,153	165,600	416	33,120	1,656	5
6										6
7	50	Operating Room AGGREGATE	312,836	215,474	97,362	208,000	886	88,600	4,430	7
8	54	Radiology-Diagnostic AGGREGATE	31,850		31,850	225,300	175	18,956	948	8
9										9
10	60	Laboratory AGGREGATE	309,200		309,200	215,700	3,310	343,253	17,163	10
11										11
12										12
13	69	Electrocardiology AGGREGATE	1,070,421	832,126	238,295	165,600	1,327	105,650	5,283	13
14	69.01	CARDIAC CATH LAB AGGREGATE	24,725		24,725	165,600	118	9,395	470	14
15										15
16	69.02	CARDIAC REHABILITATI AGGREGATE	26,563		26,563	165,600	213	16,958	848	16
17										17
18										18
19	91	Emergency AGGREGATE	1,065,431		1,065,431	177,200	21,309	1,815,363	90,768	19
20										20
200		TOTAL	5,307,826	3,399,767	1,908,059		28,019	2,453,871	122,695	200

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

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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	5	Administrative & Gen AGGREGATE					22,576	43,904	43,904	2
3										3
4	30	Adults & Pediatrics AGGREGATE								4
5	31	Intensive Care Unit AGGREGATE					33,120	15,033	980,880	5
6										6
7	50	Operating Room AGGREGATE					88,600	8,762	224,236	7
8	54	Radiology-Diagnostic AGGREGATE					18,956	12,894	12,894	8
9										9
10	60	Laboratory AGGREGATE					343,253			10
11										11
12										12
13	69	Electrocardiology AGGREGATE					105,650	132,645	964,771	13
14	69.01	CARDIAC CATH LAB AGGREGATE					9,395	15,330	15,330	14
15										15
16	69.02	CARDIAC REHABILITATI AGGREGATE					16,958	9,605	9,605	16
17										17
18										18
19	91	Emergency AGGREGATE					1,815,363			19
20										20
200		TOTAL					2,453,871	238,173	3,637,940	200

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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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	32,478,161	32,478,161					1
2	Cap Rel Costs-Mvble Equip	17,731,970		17,731,970				2
4	Employee Benefits Department	38,035,078	478,477	13,049	38,526,604			4
5	Administrative & General	46,422,177	7,516,460	9,296,664	6,712,013	69,947,314	69,947,314	5
6	Maintenance & Repairs							6
7	Operation of Plant	13,318,928	4,409,754	102,681	639,863	18,471,226	3,853,874	7
8	Laundry & Linen Service							8
9	Housekeeping	6,493,410		24,416	669,675	7,187,501	1,499,615	9
10	Dietary	2,781,707	389,660	68,266	280,037	3,519,670	734,351	10
11	Cafeteria	1,223,670	256,248		322,412	1,802,330	376,042	11
12	Maintenance of Personnel							12
13	Nursing Administration	11,485,463	318,111	16,887	2,193,248	14,013,709	2,923,848	13
14	Central Services & Supply	2,342,171	580,770	388,591	324,080	3,635,612	758,541	14
15	Pharmacy	4,053,944	231,587	272,711	862,447	5,420,689	1,130,983	15
16	Medical Records & Library	4,480,644	197,100	51,616	511,668	5,241,028	1,093,499	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	868,638	22,649	360	236,109	1,127,756	235,297	23
<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	Adults & Pediatrics	29,856,022	4,825,198	572,076	6,105,157	41,358,453	8,629,099	30
31	Intensive Care Unit	8,816,754	1,202,299	158,005	1,747,850	11,924,908	2,488,037	31
35	NEONATAL INTENSIVE CARE UNIT	1,136,552	93,215	170,688	128,749	1,529,204	319,056	35
40	Subprovider - IPF	4,929,427	795,652	40,263	888,807	6,654,149	1,388,335	40
43	Nursery	1,739,398	189,004		344,703	2,273,105	474,265	43
<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	15,193,371	2,931,834	2,740,456	2,505,585	23,371,246	4,876,224	50
52	Delivery Room & Labor Room	4,660,144	438,420		790,218	5,888,782	1,228,647	52
53	Anesthesiology	178,127	24,427		26,864	229,418	47,866	53
54	Radiology-Diagnostic	19,023,785	1,600,850	1,658,562	2,799,961	25,083,158	5,233,400	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	3,159,965		737,417	378,056	4,275,438	892,036	54.01
56.01	ONCOLOGY	1,468,100	793,827	41,064	275,992	2,578,983	538,084	56.01
60	Laboratory	12,121,647	631,262	255,094	1,263,412	14,271,415	2,977,617	60
62	Whole Blood & Packed Red Blood Cells	2,535,751	43,519	27,648	110,604	2,717,522	566,989	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,576,420	148,012	37,249	496,084	3,257,765	679,707	65
66	Physical Therapy	7,557,906	459,431	235,518	1,310,073	9,562,928	1,995,228	66
69	Electrocardiology	4,928,000	251,382	216,456	804,936	6,200,774	1,293,742	69
69.01	CARDIAC CATH LAB	2,566,114	111,699	421,717	396,971	3,496,501	729,517	69.01
69.02	CARDIAC REHABILITATION	935,427	412,356	12,267	164,227	1,524,277	318,028	69.02
71	Medical Supplies Charged to Patients	22,848,426				22,848,426	4,767,141	71
72	Impl. Dev. Charged to Patients	16,396,402				16,396,402	3,420,978	72
73	Drugs Charged to Patients	18,023,186				18,023,186	3,760,394	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	51,009				51,009	10,643	73.01
74	Renal Dialysis	917,140		3,264		920,404	192,035	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	OUTPATIENT TREATMENT CENTERS	5,827,373	1,010,814	93,782	807,182	7,739,151	1,614,712	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	715,240	227,142		120,157	1,062,539	221,690	90.02
91	Emergency	14,436,985	734,117	33,340	2,642,941	17,847,383	3,723,714	91
92	Observation Beds (Non-Distinct Part)							92
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	5,870,869	242,210	18,361	1,075,840	7,207,280	1,503,741	101
<b>SPECIAL PURPOSE COST CENTERS</b>								
118	SUBTOTALS (sum of lines 1-117)	390,185,501	31,567,486	17,708,468	37,935,921	388,660,641	66,496,975	118
<b>NONREIMBURSABLE COST CENTERS</b>								
190	Gift, Flower, Coffee Shop & Canteen	402,530	265,093	1,080	34,549	703,252	146,728	190
192	Physicians' Private Offices	1,228,817				1,228,817	256,383	192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER	192,762		12,348	35,233	240,343	50,146	192.02
192.03	MOBILE DENTAL CLINIC	322,814		2,399	45,492	370,705	77,345	192.03
192.04	EMS CONTINUING EDUCATION	430,651			83,718	514,369	107,319	192.04
194	CORPORATE HEALTH	187,297	127,329	7,057	26,497	348,180	72,645	194
194.01	MARKETING/COMMUNICATION	3,146,100	94,338	571	133,042	3,374,051	703,969	194.01

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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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)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
194.02	FOUNDATION	1,323	42,069	47	50	43,489	9,074	194.02
194.03	OTHER NRCC	9,099,962	381,846		232,102	9,713,910	2,026,730	194.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	405,197,757	32,478,161	17,731,970	38,526,604	405,197,757	69,947,314	202

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		7	9	10	11	13	14	
	<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
6	Maintenance & Repairs							6
7	Operation of Plant	22,325,100						7
8	Laundry & Linen Service							8
9	Housekeeping		8,687,116					9
10	Dietary	433,368	168,632	4,856,021				10
11	Cafeteria	284,992	110,896		2,574,260			11
12	Maintenance of Personnel							12
13	Nursing Administration	353,793	137,668		168,118	17,597,136		13
14	Central Services & Supply	645,915	251,338		57,109		5,348,515	14
15	Pharmacy	257,564	100,223		63,402	616,668		15
16	Medical Records & Library	219,208	85,298		59,505			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	25,189	9,802		34,235	332,979		23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	5,366,441	2,088,181	3,878,706	594,566	5,782,936	7,739	30
31	Intensive Care Unit	1,337,160	520,314	250,652	144,927	1,409,603	1,830	31
35	NEONATAL INTENSIVE CARE UNIT	103,671	40,340		10,425	101,394	311	35
40	Subprovider - IPF	884,900	344,331	592,895	87,061	846,780	303	40
43	Nursery	210,205	81,795		27,859	270,964		43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	3,260,697	1,268,798		225,612	2,194,368	18,813	50
52	Delivery Room & Labor Room	487,598	189,733		66,570	634,080		52
53	Anesthesiology	27,167	10,571		4,242	41,254		53
54	Radiology-Diagnostic	1,780,416	692,793		245,250		231,395	54
54.01	OFFSITE-DIAGNOSTIC SERVICES						14,848	54.01
56.01	ONCOLOGY	882,870	343,541		21,166	205,869	92	56.01
60	Laboratory	702,070	273,189		152,322			60
62	Whole Blood & Packed Red Blood Cells	48,401	18,834		10,879			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	164,614	64,055		48,516		9,822	65
66	Physical Therapy	510,965	198,826		117,316		73	66
69	Electrocardiology	279,579	108,789		65,234	634,482	47,004	69
69.01	CARDIAC CATH LAB	124,228	48,340		29,305	285,028	12,593	69.01
69.02	CARDIAC REHABILITATION	458,609	178,454		14,776	143,720	1,566	69.02
71	Medical Supplies Charged to Patients						2,696,986	71
72	Impl. Dev. Charged to Patients						2,261,419	72
73	Drugs Charged to Patients							73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OUTPATIENT TREATMENT CENTERS	1,124,197	437,446			526,525	19,888	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	252,620	98,299		10,521	102,332		90.02
91	Emergency	816,462	317,701		272,599	2,651,377	20,062	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	269,378	104,820			816,777	2,447	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	21,312,277	8,293,007	4,722,253	2,531,515	17,597,136	5,347,191	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	294,828	114,723		5,990			190
192	Physicians' Private Offices							192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER			133,768	6,445		1,037	192.02
192.03	MOBILE DENTAL CLINIC						3	192.03
192.04	EMS CONTINUING EDUCATION							192.04
194	CORPORATE HEALTH	141,611	55,104		2,864			194
194.01	MARKETING/COMMUNICATION	104,920	40,826		15,093			194.01
194.02	FOUNDATION	46,787	18,206					194.02
194.03	OTHER NRCC	424,677	165,250		12,353		284	194.03

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		7	9	10	11	13	14	
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	22,325,100	8,687,116	4,856,021	2,574,260	17,597,136	5,348,515	202

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	PARAMED EDUCATION EMS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	24	25	26	
	<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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	7,589,529						15
16	Medical Records & Library		6,698,538					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	12		1,765,270				23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	36,300	529,311	128,718	68,400,450		68,400,450	30
31	Intensive Care Unit	912	151,815	73,553	18,303,711		18,303,711	31
35	NEONATAL INTENSIVE CARE UNIT	367	9,903		2,114,671		2,114,671	35
40	Subprovider - IPF		91,922	73,553	10,964,229		10,964,229	40
43	Nursery		33,090		3,371,283		3,371,283	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	33,154	458,815	147,106	35,854,833		35,854,833	50
52	Delivery Room & Labor Room		31,762	91,941	8,619,113		8,619,113	52
53	Anesthesiology	17,961	115,091		493,570		493,570	53
54	Radiology-Diagnostic	1,695	1,370,340		34,638,447		34,638,447	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	1,038	177,775		5,361,135		5,361,135	54.01
56.01	ONCOLOGY	183	534,905		5,105,693		5,105,693	56.01
60	Laboratory	28	850,859		19,227,500		19,227,500	60
62	Whole Blood & Packed Red Blood Cells		38,406		3,401,031		3,401,031	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	353	78,382		4,303,214		4,303,214	65
66	Physical Therapy	2,389	131,983		12,519,708		12,519,708	66
69	Electrocardiology	8,090	228,298		8,865,992		8,865,992	69
69.01	CARDIAC CATH LAB	288	150,049		4,875,849		4,875,849	69.01
69.02	CARDIAC REHABILITATION	8	7,262		2,646,700		2,646,700	69.02
71	Medical Supplies Charged to Patients		477,138		30,789,691		30,789,691	71
72	Impl. Dev. Charged to Patients		265,938		22,344,737		22,344,737	72
73	Drugs Charged to Patients	7,439,758	393,716		29,617,054		29,617,054	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	21,055	481		83,188		83,188	73.01
74	Renal Dialysis		23,784		1,136,223		1,136,223	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OUTPATIENT TREATMENT CENTERS	21,406	57,263		11,540,588		11,540,588	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM		6,642		1,754,643		1,754,643	90.02
91	Emergency	4,483	449,743	1,250,399	27,353,923		27,353,923	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	49	33,865		9,938,357		9,938,357	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	7,589,529	6,698,538	1,765,270	383,625,533		383,625,533	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen				1,265,521		1,265,521	190
192	Physicians' Private Offices				1,485,200		1,485,200	192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER				431,739		431,739	192.02
192.03	MOBILE DENTAL CLINIC				448,053		448,053	192.03
192.04	EMS CONTINUING EDUCATION				621,688		621,688	192.04
194	CORPORATE HEALTH				620,404		620,404	194
194.01	MARKETING/COMMUNICATION				4,238,859		4,238,859	194.01
194.02	FOUNDATION				117,556		117,556	194.02
194.03	OTHER NRCC				12,343,204		12,343,204	194.03

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	PARAMED EDUCATION EMS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	24	25	26	
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	7,589,529	6,698,538	1,765,270	405,197,757		405,197,757	202

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	3,210	478,477	13,049	494,736	494,736		4
5	Administrative & General	1,049,189	7,516,460	9,296,664	17,862,313	86,202	17,948,515	5
6	Maintenance & Repairs							6
7	Operation of Plant	71,712	4,409,754	102,681	4,584,147	8,217	988,912	7
8	Laundry & Linen Service							8
9	Housekeeping			24,416	24,416	8,599	384,804	9
10	Dietary	1,771	389,660	68,266	459,697	3,596	188,436	10
11	Cafeteria		256,248		256,248	4,140	96,493	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,245	318,111	16,887	336,243	28,164	750,266	13
14	Central Services & Supply	109,555	580,770	388,591	1,078,916	4,162	194,643	14
15	Pharmacy		231,587	272,711	504,298	11,075	290,213	15
16	Medical Records & Library		197,100	51,616	248,716	6,570	280,594	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)		22,649	360	23,009	3,032	60,378	23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	21,896	4,825,198	572,076	5,419,170	78,397	2,214,126	30
31	Intensive Care Unit	1,371	1,202,299	158,005	1,361,675	22,444	638,436	31
35	NEONATAL INTENSIVE CARE UNIT	859	93,215	170,688	264,762	1,653	81,871	35
40	Subprovider - IPF	1,120	795,652	40,263	837,035	11,413	356,250	40
43	Nursery		189,004		189,004	4,426	121,697	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	116,286	2,931,834	2,740,456	5,788,576	32,175	1,251,250	50
52	Delivery Room & Labor Room		438,420		438,420	10,147	315,274	52
53	Anesthesiology		24,427		24,427	345	12,283	53
54	Radiology-Diagnostic	688,955	1,600,850	1,658,562	3,948,367	35,955	1,342,902	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	422,057		737,417	1,159,474	4,855	228,898	54.01
56.01	ONCOLOGY		793,827	41,064	834,891	3,544	138,074	56.01
60	Laboratory	56,540	631,262	255,094	942,896	16,224	764,063	60
62	Whole Blood & Packed Red Blood Cells		43,519	27,648	71,167	1,420	145,491	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	805	148,012	37,249	186,066	6,370	174,414	65
66	Physical Therapy	803,296	459,431	235,518	1,498,245	16,823	511,980	66
69	Electrocardiology	108,548	251,382	216,456	576,386	10,336	331,977	69
69.01	CARDIAC CATH LAB		111,699	421,717	533,416	5,098	187,196	69.01
69.02	CARDIAC REHABILITATION	154,400	412,356	12,267	579,023	2,109	81,607	69.02
71	Medical Supplies Charged to Patients						1,223,259	71
72	Impl. Dev. Charged to Patients						877,831	72
73	Drugs Charged to Patients						964,925	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS						2,731	73.01
74	Renal Dialysis			3,264	3,264		49,277	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OUTPATIENT TREATMENT CENTERS	431,514	1,010,814	93,782	1,536,110	10,365	414,339	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM		227,142		227,142	1,543	56,886	90.02
91	Emergency	2,050	734,117	33,340	769,507	33,938	955,513	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	3,230	242,210	18,361	263,801	13,815	385,863	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	4,049,609	31,567,486	17,708,468	53,325,563	487,152	17,063,152	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen		265,093	1,080	266,173	444	37,651	190
192	Physicians' Private Offices						65,788	192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER			12,348	12,348	452	12,867	192.02
192.03	MOBILE DENTAL CLINIC			2,399	2,399	584	19,847	192.03
192.04	EMS CONTINUING EDUCATION					1,075	27,538	192.04
194	CORPORATE HEALTH		127,329	7,057	134,386	340	18,641	194
194.01	MARKETING/COMMUNICATION		94,338	571	94,909	1,708	180,640	194.01
194.02	FOUNDATION		42,069	47	42,116	1	2,328	194.02
194.03	OTHER NRCC		381,846		381,846	2,980	520,063	194.03

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,049,609	32,478,161	17,731,970	54,259,740	494,736	17,948,515	202

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		7	9	10	11	13	14	
	<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
6	Maintenance & Repairs							6
7	Operation of Plant	5,581,276						7
8	Laundry & Linen Service							8
9	Housekeeping		417,819					9
10	Dietary	108,342	8,111	768,182				10
11	Cafeteria	71,248	5,334		433,463			11
12	Maintenance of Personnel							12
13	Nursing Administration	88,448	6,621		28,308	1,238,050		13
14	Central Services & Supply	161,479	12,088		9,616		1,460,904	14
15	Pharmacy	64,391	4,820		10,676	43,386		15
16	Medical Records & Library	54,802	4,103		10,020			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	6,297	471		5,765	23,427		23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	1,341,610	100,435	613,579	100,117	406,859	2,114	30
31	Intensive Care Unit	334,290	25,025	39,651	24,403	99,173	500	31
35	NEONATAL INTENSIVE CARE UNIT	25,918	1,940		1,755	7,134	85	35
40	Subprovider - IPF	221,225	16,561	93,791	14,660	59,575	83	40
43	Nursery	52,551	3,934		4,691	19,064		43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	815,174	61,025		37,989	154,385	5,139	50
52	Delivery Room & Labor Room	121,899	9,125		11,209	44,611		52
53	Anesthesiology	6,792	508		714	2,902		53
54	Radiology-Diagnostic	445,104	33,321		41,296		63,203	54
54.01	OFFSITE-DIAGNOSTIC SERVICES						4,056	54.01
56.01	ONCOLOGY	220,718	16,523		3,564	14,484	25	56.01
60	Laboratory	175,518	13,139		25,649			60
62	Whole Blood & Packed Red Blood Cells	12,100	906		1,832			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	41,154	3,081		8,169		2,683	65
66	Physical Therapy	127,741	9,563		19,754		20	66
69	Electrocardiology	69,895	5,232		10,984	44,639	12,839	69
69.01	CARDIAC CATH LAB	31,057	2,325		4,934	20,053	3,440	69.01
69.02	CARDIAC REHABILITATION	114,652	8,583		2,488	10,111	428	69.02
71	Medical Supplies Charged to Patients						736,661	71
72	Impl. Dev. Charged to Patients						617,686	72
73	Drugs Charged to Patients							73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS							73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OUTPATIENT TREATMENT CENTERS	281,049	21,040			37,044	5,432	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	63,155	4,728		1,772	7,200		90.02
91	Emergency	204,116	15,280		45,901	186,538	5,480	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	67,345	5,041			57,465	668	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	5,328,070	398,863	747,021	426,266	1,238,050	1,460,542	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	73,707	5,518		1,009			190
192	Physicians' Private Offices							192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER			21,161	1,085		283	192.02
192.03	MOBILE DENTAL CLINIC						1	192.03
192.04	EMS CONTINUING EDUCATION							192.04
194	CORPORATE HEALTH	35,403	2,650		482			194
194.01	MARKETING/COMMUNICATION	26,230	1,964		2,541			194.01
194.02	FOUNDATION	11,697	876					194.02
194.03	OTHER NRCC	106,169	7,948		2,080		78	194.03

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		7	9	10	11	13	14	
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,581,276	417,819	768,182	433,463	1,238,050	1,460,904	202

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	PARAMED EDUCATION EMS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	24	25	26	
	<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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	928,859						15
16	Medical Records & Library		604,805					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	2		122,381				23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	4,443	47,785		10,328,635		10,328,635	30
31	Intensive Care Unit	112	13,706		2,559,415		2,559,415	31
35	NEONATAL INTENSIVE CARE UNIT	45	894		386,057		386,057	35
40	Subprovider - IPF		8,299		1,618,892		1,618,892	40
43	Nursery		2,987		398,354		398,354	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	4,058	41,421		8,191,192		8,191,192	50
52	Delivery Room & Labor Room		2,867		953,552		953,552	52
53	Anesthesiology	2,198	10,390		60,559		60,559	53
54	Radiology-Diagnostic	207	123,787		6,034,142		6,034,142	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	127	16,049		1,413,459		1,413,459	54.01
56.01	ONCOLOGY	22	48,290		1,280,135		1,280,135	56.01
60	Laboratory	3	76,814		2,014,306		2,014,306	60
62	Whole Blood & Packed Red Blood Cells		3,467		236,383		236,383	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	43	7,076		429,056		429,056	65
66	Physical Therapy	292	11,915		2,196,333		2,196,333	66
69	Electrocardiology	990	20,610		1,083,888		1,083,888	69
69.01	CARDIAC CATH LAB	35	13,546		801,100		801,100	69.01
69.02	CARDIAC REHABILITATION	1	656		799,658		799,658	69.02
71	Medical Supplies Charged to Patients		43,075		2,002,995		2,002,995	71
72	Impl. Dev. Charged to Patients		24,008		1,519,525		1,519,525	72
73	Drugs Charged to Patients	910,529	35,544		1,910,998		1,910,998	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	2,577	43		5,351		5,351	73.01
74	Renal Dialysis		2,147		54,688		54,688	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OUTPATIENT TREATMENT CENTERS	2,620	5,170		2,313,169		2,313,169	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM		600		363,026		363,026	90.02
91	Emergency	549	40,602		2,257,424		2,257,424	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	6	3,057		797,061		797,061	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	928,859	604,805		52,009,353		52,009,353	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen				384,502		384,502	190
192	Physicians' Private Offices				65,788		65,788	192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER				48,196		48,196	192.02
192.03	MOBILE DENTAL CLINIC				22,831		22,831	192.03
192.04	EMS CONTINUING EDUCATION				28,613		28,613	192.04
194	CORPORATE HEALTH				191,902		191,902	194
194.01	MARKETING/COMMUNICATION				307,992		307,992	194.01
194.02	FOUNDATION				57,018		57,018	194.02
194.03	OTHER NRCC				1,021,164		1,021,164	194.03

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	PARAMED EDUCATION EMS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	24	25	26	
200	Cross Foot Adjustments			122,381	122,381		122,381	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	928,859	604,805	122,381	54,259,740		54,259,740	202

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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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	694,055						1
2	Cap Rel Costs-Mvble Equip		18,010,841					2
4	Employee Benefits Department	10,225	13,254	177,384,569				4
5	Administrative & General	160,626	9,442,866	30,903,819	-69,947,314	335,250,443		5
6	Maintenance & Repairs							6
7	Operation of Plant	94,236	104,296	2,946,058		18,471,226	428,968	7
8	Laundry & Linen Service							8
9	Housekeeping		24,800	3,083,317		7,187,501		9
10	Dietary	8,327	69,340	1,289,348		3,519,670	8,327	10
11	Cafeteria	5,476		1,484,450		1,802,330	5,476	11
12	Maintenance of Personnel							12
13	Nursing Administration	6,798	17,153	10,098,152		14,013,709	6,798	13
14	Central Services & Supply	12,411	394,703	1,492,131		3,635,612	12,411	14
15	Pharmacy	4,949	277,000	3,970,878		5,420,689	4,949	15
16	Medical Records & Library	4,212	52,428	2,355,823		5,241,028	4,212	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	484	366	1,087,092		1,127,756	484	23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	103,114	581,073	28,109,365		41,358,453	103,114	30
31	Intensive Care Unit	25,693	160,490	8,047,451		11,924,908	25,693	31
35	NEONATAL INTENSIVE CARE UNIT	1,992	173,373	592,786		1,529,204	1,992	35
40	Subprovider - IPF	17,003	40,896	4,092,247		6,654,149	17,003	40
43	Nursery	4,039		1,587,080		2,273,105	4,039	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	62,653	2,783,557	11,536,215		23,371,246	62,653	50
52	Delivery Room & Labor Room	9,369		3,638,320		5,888,782	9,369	52
53	Anesthesiology	522		123,687		229,418	522	53
54	Radiology-Diagnostic	34,210	1,684,647	12,891,579		25,083,158	34,210	54
54.01	OFFSITE-DIAGNOSTIC SERVICES		749,015	1,740,647		4,275,438		54.01
56.01	ONCOLOGY	16,964	41,710	1,270,723		2,578,983	16,964	56.01
60	Laboratory	13,490	259,106	5,817,002		14,271,415	13,490	60
62	Whole Blood & Packed Red Blood Cells	930	28,083	509,245		2,717,522	930	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,163	37,835	2,284,072		3,257,765	3,163	65
66	Physical Therapy	9,818	239,222	6,031,839		9,562,928	9,818	66
69	Electrocardiology	5,372	219,860	3,706,085		6,200,774	5,372	69
69.01	CARDIAC CATH LAB	2,387	428,350	1,827,734		3,496,501	2,387	69.01
69.02	CARDIAC REHABILITATION	8,812	12,460	756,135		1,524,277	8,812	69.02
71	Medical Supplies Charged to Patients					22,848,426		71
72	Impl. Dev. Charged to Patients					16,396,402		72
73	Drugs Charged to Patients					18,023,186		73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS					51,009		73.01
74	Renal Dialysis		3,315			920,404		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OUTPATIENT TREATMENT CENTERS	21,601	95,257	3,716,429		7,739,151	21,601	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	4,854		553,229		1,062,539	4,854	90.02
91	Emergency	15,688	33,864	12,168,630		17,847,383	15,688	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	5,176	18,650	4,953,384		7,207,280	5,176	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	674,594	17,986,969	174,664,952	-69,947,314	318,713,327	409,507	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	5,665	1,097	159,072		703,252	5,665	190
192	Physicians' Private Offices					1,228,817		192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER		12,542	162,219		240,343		192.02
192.03	MOBILE DENTAL CLINIC		2,437	209,452		370,705		192.03
192.04	EMS CONTINUING EDUCATION			385,456		514,369		192.04
194	CORPORATE HEALTH	2,721	7,168	121,997		348,180	2,721	194
194.01	MARKETING/COMMUNICATION	2,016	580	612,551		3,374,051	2,016	194.01
194.02	FOUNDATION	899	48	228		43,489	899	194.02

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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	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
194.03	OTHER NRCC	8,160		1,068,642		9,713,910	8,160	194.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	32,478,161	17,731,970	38,526,604		69,947,314	22,325,100	202
203	Unit Cost Multiplier (Wkst. B, Part I)	46.794794	0.984516	0.217193		0.208642	52.043742	203
204	Cost to be allocated (Per Wkst. B, Part II)			494,736		17,948,515	5,581,276	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.002789		0.053538	13.010938	205

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

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		SQUARE FEET	MEALS SERVED	FTE'S SERVED	FTE'S NRSING HRS	COSTED REQUIS.	COSTED REQUISITION	
		9	10	11	13	14	15	
<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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	428,968						9
10	Dietary	8,327	235,563					10
11	Cafeteria	5,476		186,932				11
12	Maintenance of Personnel							12
13	Nursing Administration	6,798		12,208	131,379			13
14	Central Services & Supply	12,411		4,147		40,142,366		14
15	Pharmacy	4,949		4,604	4,604		18,386,977	15
16	Medical Records & Library	4,212		4,321				16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)	484		2,486	2,486		30	23
<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	Adults & Pediatrics	103,114	188,154	43,175	43,175	58,081	87,942	30
31	Intensive Care Unit	25,693	12,159	10,524	10,524	13,731	2,209	31
35	NEONATAL INTENSIVE CARE UNIT	1,992		757	757	2,331	888	35
40	Subprovider - IPF	17,003	28,761	6,322	6,322	2,273		40
43	Nursery	4,039		2,023	2,023			43
<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	62,653		16,383	16,383	141,199	80,322	50
52	Delivery Room & Labor Room	9,369		4,834	4,734			52
53	Anesthesiology	522		308	308		43,513	53
54	Radiology-Diagnostic	34,210		17,809		1,736,688	4,106	54
54.01	OFFSITE-DIAGNOSTIC SERVICES					111,440	2,515	54.01
56.01	ONCOLOGY	16,964		1,537	1,537	687	444	56.01
60	Laboratory	13,490		11,061			69	60
62	Whole Blood & Packed Red Blood Cells	930		790				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,163		3,523		73,715	854	65
66	Physical Therapy	9,818		8,519		546	5,788	66
69	Electrocardiology	5,372		4,737	4,737	352,783	19,600	69
69.01	CARDIAC CATH LAB	2,387		2,128	2,128	94,518	698	69.01
69.02	CARDIAC REHABILITATION	8,812		1,073	1,073	11,757	19	69.02
71	Medical Supplies Charged to Patients					20,241,814		71
72	Impl. Dev. Charged to Patients					16,972,651		72
73	Drugs Charged to Patients						18,024,132	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS						51,009	73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	OUTPATIENT TREATMENT CENTERS	21,601			3,931	149,265	51,860	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	4,854		764	764			90.02
91	Emergency	15,688		19,795	19,795	150,574	10,861	91
92	Observation Beds (Non-Distinct Part)							92
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	5,176			6,098	18,368	118	101
<b>SPECIAL PURPOSE COST CENTERS</b>								
118	SUBTOTALS (sum of lines 1-117)	409,507	229,074	183,828	131,379	40,132,421	18,386,977	118
<b>NONREIMBURSABLE COST CENTERS</b>								
190	Gift, Flower, Coffee Shop & Canteen	5,665		435				190
192	Physicians' Private Offices							192
192.01	DAY SURGERY CENTER							192.01
192.02	RESIDENTIAL TREATMENT CENTER		6,489	468		7,785		192.02
192.03	MOBILE DENTAL CLINIC					25		192.03
192.04	EMS CONTINUING EDUCATION							192.04
194	CORPORATE HEALTH	2,721		208				194
194.01	MARKETING/COMMUNICATION	2,016		1,096				194.01
194.02	FOUNDATION	899						194.02

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S SERVED	NURSING ADMINISTRATION FTE'S NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUISTION	
		9	10	11	13	14	15	
194.03	OTHER NRCC	8,160		897		2,135		194.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	8,687,116	4,856,021	2,574,260	17,597,136	5,348,515	7,589,529	202
203	Unit Cost Multiplier (Wkst. B, Part I)	20.251198	20.614532	13.771104	133.941772	0.133239	0.412767	203
204	Cost to be allocated (Per Wkst. B, Part II)	417,819	768,182	433,463	1,238,050	1,460,904	928,859	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.974010	3.261047	2.318827	9.423500	0.036393	0.050517	205

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY GROSS REVENUE	PARAMED EDUCATION EMS ASSIGNED TIME					
	16	23					

GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library	1,661,259,199					16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	PARAMED ED PRGM-(SPECIFY)			192			23
INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	131,277,652	14				30
31	Intensive Care Unit	37,652,596	8				31
35	NEONATAL INTENSIVE CARE UNIT	2,456,125					35
40	Subprovider - IPF	22,798,122	8				40
43	Nursery	8,206,920					43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	113,793,471	16				50
52	Delivery Room & Labor Room	7,877,379	10				52
53	Anesthesiology	28,544,274					53
54	Radiology-Diagnostic	339,781,109					54
54.01	OFFSITE-DIAGNOSTIC SERVICES	44,091,060					54.01
56.01	ONCOLOGY	132,664,934					56.01
60	Laboratory	211,026,536					60
62	Whole Blood & Packed Red Blood Cells	9,525,329					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	19,440,088					65
66	Physical Therapy	32,733,933					66
69	Electrocardiology	56,621,540					69
69.01	CARDIAC CATH LAB	37,214,439					69.01
69.02	CARDIAC REHABILITATION	1,801,083					69.02
71	Medical Supplies Charged to Patients	118,337,905					71
72	Impl. Dev. Charged to Patients	65,956,966					72
73	Drugs Charged to Patients	97,647,704					73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	119,352					73.01
74	Renal Dialysis	5,898,746					74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT TREATMENT CENTERS	14,202,210					90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1,647,235					90.02
91	Emergency	111,543,474	136				91
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	Home Health Agency	8,399,017					101
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,661,259,199	192				118
NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192
192.01	DAY SURGERY CENTER						192.01
192.02	RESIDENTIAL TREATMENT CENTER						192.02
192.03	MOBILE DENTAL CLINIC						192.03
192.04	EMS CONTINUING EDUCATION						192.04
194	CORPORATE HEALTH						194

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY GROSS REVENUE	PARAMED EDUCATION EMS ASSIGNED TIME					
		16	23					
194.01	MARKETING/COMMUNICATION							194.01
194.02	FOUNDATION							194.02
194.03	OTHER NRCC							194.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	6,698,538	1,765,270					202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.004032	9,194.114583					203
204	Cost to be allocated (Per Wkst. B, Part II)	604,805	122,381					204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000364	637.401042					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	68,400,450		68,400,450		68,400,450	30
31	Intensive Care Unit	18,303,711		18,303,711	15,033	18,318,744	31
35	NEONATAL INTENSIVE CARE UNIT	2,114,671		2,114,671		2,114,671	35
40	Subprovider - IPF	10,964,229		10,964,229		10,964,229	40
43	Nursery	3,371,283		3,371,283		3,371,283	43
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	35,854,833		35,854,833	8,762	35,863,595	50
52	Delivery Room & Labor Room	8,619,113		8,619,113		8,619,113	52
53	Anesthesiology	493,570		493,570		493,570	53
54	Radiology-Diagnostic	34,638,447		34,638,447	12,894	34,651,341	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	5,361,135		5,361,135		5,361,135	54.01
56.01	ONCOLOGY	5,105,693		5,105,693		5,105,693	56.01
60	Laboratory	19,227,500		19,227,500		19,227,500	60
62	Whole Blood & Packed Red Blood Cells	3,401,031		3,401,031		3,401,031	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	4,303,214		4,303,214		4,303,214	65
66	Physical Therapy	12,519,708		12,519,708		12,519,708	66
69	Electrocardiology	8,865,992		8,865,992	132,645	8,998,637	69
69.01	CARDIAC CATH LAB	4,875,849		4,875,849	15,330	4,891,179	69.01
69.02	CARDIAC REHABILITATION	2,646,700		2,646,700	9,605	2,656,305	69.02
71	Medical Supplies Charged to Patients	30,789,691		30,789,691		30,789,691	71
72	Impl. Dev. Charged to Patients	22,344,737		22,344,737		22,344,737	72
73	Drugs Charged to Patients	29,617,054		29,617,054		29,617,054	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	83,188		83,188		83,188	73.01
74	Renal Dialysis	1,136,223		1,136,223		1,136,223	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01	OUTPATIENT TREATMENT CENTERS	11,540,588		11,540,588		11,540,588	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1,754,643		1,754,643		1,754,643	90.02
91	Emergency	27,353,923		27,353,923		27,353,923	91
92	Observation Beds (Non-Distinct Part)	4,750,850		4,750,850		4,750,850	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	Home Health Agency	9,938,357		9,938,357		9,938,357	101
200	Subtotal (sum of lines 30 thru 199)	388,376,383		388,376,383	194,269	388,570,652	200
201	Less Observation Beds	4,750,850		4,750,850		4,750,850	201
202	Total (line 200 minus line 201)	383,625,533		383,625,533		383,819,802	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				
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30	Adults & Pediatrics	126,093,541		126,093,541				30
31	Intensive Care Unit	37,652,596		37,652,596				31
35	NEONATAL INTENSIVE CARE UNIT	2,456,125		2,456,125				35
40	Subprovider - IPF	22,798,122		22,798,122				40
43	Nursery	8,206,920		8,206,920				43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	47,738,690	66,054,781	113,793,471	0.315087	0.315087	0.315164	50
52	Delivery Room & Labor Room	7,705,958	171,421	7,877,379	1.094160	1.094160	1.094160	52
53	Anesthesiology	10,270,287	18,273,987	28,544,274	0.017291	0.017291	0.017291	53
54	Radiology-Diagnostic	95,075,063	244,706,046	339,781,109	0.101943	0.101943	0.101981	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	79,740	44,011,320	44,091,060	0.121592	0.121592	0.121592	54.01
56.01	ONCOLOGY	11,233,886	121,431,048	132,664,934	0.038486	0.038486	0.038486	56.01
60	Laboratory	89,595,488	121,431,048	211,026,536	0.091114	0.091114	0.091114	60
62	Whole Blood & Packed Red Blood Cells	7,211,297	2,314,032	9,525,329	0.357051	0.357051	0.357051	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	16,823,487	2,616,601	19,440,088	0.221358	0.221358	0.221358	65
66	Physical Therapy	7,273,251	25,460,682	32,733,933	0.382469	0.382469	0.382469	66
69	Electrocardiology	11,964,487	44,657,053	56,621,540	0.156583	0.156583	0.158926	69
69.01	CARDIAC CATH LAB	17,879,513	19,334,926	37,214,439	0.131020	0.131020	0.131432	69.01
69.02	CARDIAC REHABILITATION	1,743	1,799,340	1,801,083	1.469505	1.469505	1.474838	69.02
71	Medical Supplies Charged to Patients	65,478,800	52,859,105	118,337,905	0.260185	0.260185	0.260185	71
72	Impl. Dev. Charged to Patients	38,436,995	27,519,971	65,956,966	0.338778	0.338778	0.338778	72
73	Drugs Charged to Patients	57,190,828	40,456,876	97,647,704	0.303305	0.303305	0.303305	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS		119,352	119,352	0.696997	0.696997	0.696997	73.01
74	Renal Dialysis	5,215,115	683,631	5,898,746	0.192621	0.192621	0.192621	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OUTPATIENT TREATMENT CENTERS	244,020	13,958,190	14,202,210	0.812591	0.812591	0.812591	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	366,762	1,280,473	1,647,235	1.065205	1.065205	1.065205	90.02
91	Emergency	32,420,186	79,123,288	111,543,474	0.245231	0.245231	0.245231	91
92	Observation Beds (Non-Distinct Part)		5,184,111	5,184,111	0.916425	0.916425	0.916425	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	60	8,398,957	8,399,017				101
200	Subtotal (sum of lines 30 thru 199)	719,412,960	941,846,239	1,661,259,199				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	719,412,960	941,846,239	1,661,259,199				202

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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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)	
		1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	10,328,635		10,328,635	66,675	154.91	29,847	4,623,599	30
31	Intensive Care Unit	2,559,415		2,559,415	8,106	315.74	4,239	1,338,422	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	NEONATAL INTENSIVE CARE UNIT	386,057		386,057	880	438.70			35
40	Subprovider - IPF	1,618,892		1,618,892	9,587	168.86	1,266	213,777	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	398,354		398,354	8,251	48.28			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	15,291,353		15,291,353	93,499		35,352	6,175,798	200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**

**COMPONENT CCN: 14-0252**

**WORKSHEET D  
PART II**

Check [ ] Title V [XX] Hospital [ ] SUB (Other) [XX] PPS  
 Applicable [XX] 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	8,191,192	113,793,471	0.071983	22,183,514	1,596,836	50
52	Delivery Room & Labor Room	953,552	7,877,379	0.121049			52
53	Anesthesiology	60,559	28,544,274	0.002122	3,723,795	7,902	53
54	Radiology-Diagnostic	6,034,142	339,781,109	0.017759	48,363,396	858,886	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	1,413,459	44,091,060	0.032058			54.01
56.01	ONCOLOGY	1,280,135	132,664,934	0.009649	5,209,897	50,270	56.01
60	Laboratory	2,014,306	211,026,536	0.009545	43,145,992	411,828	60
62	Whole Blood & Packed Red Blood	236,383	9,525,329	0.024816	3,995,487	99,152	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	429,056	19,440,088	0.022071	9,707,032	214,244	65
66	Physical Therapy	2,196,333	32,733,933	0.067097	4,318,816	289,780	66
69	Electrocardiology	1,083,888	56,621,540	0.019143	6,586,703	126,089	69
69.01	CARDIAC CATH LAB	801,100	37,214,439	0.021527	8,155,112	175,555	69.01
69.02	CARDIAC REHABILITATION	799,658	1,801,083	0.443987	270	120	69.02
71	Medical Supplies Charged to Pat	2,002,995	118,337,905	0.016926	32,282,673	546,417	71
72	Impl. Dev. Charged to Patients	1,519,525	65,956,966	0.023038	21,096,813	486,028	72
73	Drugs Charged to Patients	1,910,998	97,647,704	0.019570	25,790,510	504,720	73
73.01	FLU VACCINE DRUGS CHG TO PATIEN	5,351	119,352	0.044834			73.01
74	Renal Dialysis	54,688	5,898,746	0.009271	3,258,935	30,214	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01	OUTPATIENT TREATMENT CENTERS	2,313,169	14,202,210	0.162874	174,358	28,398	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	363,026	1,647,235	0.220385			90.02
91	Emergency	2,257,424	111,543,474	0.020238	14,349,012	290,395	91
92	Observation Beds (Non-Distinct	717,388	5,184,111	0.138382			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	36,638,327	1,455,652,878		252,342,315	5,716,834	200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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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)		128,718			128,718	30
31	Intensive Care Unit		73,553			73,553	31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	NEONATAL INTENSIVE CARE UNIT						35
40	Subprovider - IPF		73,553			73,553	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)		275,824			275,824	200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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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)	66,675	1.93	29,847	57,605	30
31	Intensive Care Unit	8,106	9.07	4,239	38,448	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	NEONATAL INTENSIVE CARE UNIT	880				35
40	Subprovider - IPF	9,587	7.67	1,266	9,710	40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	8,251				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	93,499		35,352	105,763	200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0252**

**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			147,106		147,106	147,106	50
52	Delivery Room & Labor Room			91,941		91,941	91,941	52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	OFFSITE-DIAGNOSTIC SERVICES							54.01
56.01	ONCOLOGY							56.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
69.01	CARDIAC CATH LAB							69.01
69.02	CARDIAC REHABILITATION							69.02
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN							73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OUTPATIENT TREATMENT CENTERS							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM							90.02
91	Emergency			1,250,399		1,250,399	1,250,399	91
92	Observation Beds (Non-Distinct			8,941		8,941	8,941	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Total (sum of lines 50-199)			1,498,387		1,498,387	1,498,387	200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0252**

**WORKSHEET D  
PART IV**

Check [ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [XX] PPS  
 Applicable [XX] 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	113,793,471	0.001293	0.001293	22,183,514	28,683	21,506,875	27,808	50
52	Delivery Room & Labor Room	7,877,379	0.011672	0.011672					52
53	Anesthesiology	28,544,274			3,723,795		5,765,714		53
54	Radiology-Diagnostic	339,781,109			48,363,396		92,104,395		54
54.01	OFFSITE-DIAGNOSTIC SERVICES	44,091,060					10,041,724		54.01
56.01	ONCOLOGY	132,664,934			5,209,897		26,864,862		56.01
60	Laboratory	211,026,536			43,145,992		20,150,588		60
62	Whole Blood & Packed Red Blood	9,525,329			3,995,487		1,358,573		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	19,440,088			9,707,032		965,221		65
66	Physical Therapy	32,733,933			4,318,816		2,290		66
69	Electrocardiology	56,621,540			6,586,703		13,660,408		69
69.01	CARDIAC CATH LAB	37,214,439			8,155,112		9,585,200		69.01
69.02	CARDIAC REHABILITATION	1,801,083			270		858,997		69.02
71	Medical Supplies Charged to Pat	118,337,905			32,282,673		18,439,284		71
72	Impl. Dev. Charged to Patients	65,956,966			21,096,813		13,937,579		72
73	Drugs Charged to Patients	97,647,704			25,790,510		14,815,654		73
73.01	FLU VACCINE DRUGS CHG TO PATIEN	119,352							73.01
74	Renal Dialysis	5,898,746			3,258,935		517,942		74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90.01	OUTPATIENT TREATMENT CENTERS	14,202,210			174,358		2,248,195		90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1,647,235					104,607		90.02
91	Emergency	111,543,474	0.011210	0.011210	14,349,012	160,852	18,938,384	212,299	91
92	Observation Beds (Non-Distinct	5,184,111	0.001725	0.001725			3,247,035	5,601	92
<b>OTHER REIMBURSABLE COST CENTERS</b>									
200	Total (sum of lines 50-199)	1,455,652,878			252,342,315	189,535	275,113,527	245,708	200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS**

**COMPONENT CCN: 14-0252**

**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	0.315087	21,506,875			6,776,537			50
52	Delivery Room & Labor Room	1.094160							52
53	Anesthesiology	0.017291	5,765,714			99,695			53
54	Radiology-Diagnostic	0.101943	92,104,395	1,555		9,389,398	159		54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.121592	10,041,724			1,220,993			54.01
56.01	ONCOLOGY	0.038486	26,864,862			1,033,921			56.01
60	Laboratory	0.091114	20,150,588	24		1,836,001	2		60
62	Whole Blood & Packed Red Blood	0.357051	1,358,573			485,080			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.221358	965,221			213,659			65
66	Physical Therapy	0.382469	2,290			876			66
69	Electrocardiology	0.156583	13,660,408			2,138,988			69
69.01	CARDIAC CATH LAB	0.131020	9,585,200			1,255,853			69.01
69.02	CARDIAC REHABILITATION	1.469505	858,997			1,262,300			69.02
71	Medical Supplies Charged to Pat	0.260185	18,439,284			4,797,625			71
72	Impl. Dev. Charged to Patients	0.338778	13,937,579			4,721,745			72
73	Drugs Charged to Patients	0.303305	14,815,654	145		4,493,662	44		73
73.01	FLU VACCINE DRUGS CHG TO PATIEN	0.696997			61,442			42,825	73.01
74	Renal Dialysis	0.192621	517,942			99,767			74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	OUTPATIENT TREATMENT CENTERS	0.812591	2,248,195			1,826,863			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.065205	104,607			111,428			90.02
91	Emergency	0.245231	18,938,384	74,027		4,644,279	18,154		91
92	Observation Beds (Non-Distinct	0.916425	3,247,035			2,975,664			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Subtotal (see instructions)		275,113,527	75,751	61,442	49,384,334	18,359	42,825	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		275,113,527	75,751	61,442	49,384,334	18,359	42,825	202

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**

**COMPONENT CCN: 14-S252**

**WORKSHEET D  
PART II**

Check [ ] Title V [ ] Hospital [ ] SUB (Other) [XX] PPS  
 Applicable [XX] Title XVIII, Part A [XX] 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	8,191,192	113,793,471	0.071983			50
52	Delivery Room & Labor Room	953,552	7,877,379	0.121049			52
53	Anesthesiology	60,559	28,544,274	0.002122			53
54	Radiology-Diagnostic	6,034,142	339,781,109	0.017759	49,262	875	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	1,413,459	44,091,060	0.032058			54.01
56.01	ONCOLOGY	1,280,135	132,664,934	0.009649	21,342	206	56.01
60	Laboratory	2,014,306	211,026,536	0.009545	168,191	1,605	60
62	Whole Blood & Packed Red Blood	236,383	9,525,329	0.024816			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	429,056	19,440,088	0.022071			65
66	Physical Therapy	2,196,333	32,733,933	0.067097	13,929	935	66
69	Electrocardiology	1,083,888	56,621,540	0.019143	37,388	716	69
69.01	CARDIAC CATH LAB	801,100	37,214,439	0.021527			69.01
69.02	CARDIAC REHABILITATION	799,658	1,801,083	0.443987			69.02
71	Medical Supplies Charged to Pat	2,002,995	118,337,905	0.016926	11,128	188	71
72	Impl. Dev. Charged to Patients	1,519,525	65,956,966	0.023038			72
73	Drugs Charged to Patients	1,910,998	97,647,704	0.019570	143,554	2,809	73
73.01	FLU VACCINE DRUGS CHG TO PATIEN	5,351	119,352	0.044834			73.01
74	Renal Dialysis	54,688	5,898,746	0.009271			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01	OUTPATIENT TREATMENT CENTERS	2,313,169	14,202,210	0.162874			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	363,026	1,647,235	0.220385	46,059	10,151	90.02
91	Emergency	2,257,424	111,543,474	0.020238	196,787	3,983	91
92	Observation Beds (Non-Distinct		5,184,111				92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	35,920,939	1,455,652,878		687,640	21,468	200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-S252**

**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			147,106		147,106	147,106	50
52	Delivery Room & Labor Room			91,941		91,941	91,941	52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	OFFSITE-DIAGNOSTIC SERVICES							54.01
56.01	ONCOLOGY							56.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
69.01	CARDIAC CATH LAB							69.01
69.02	CARDIAC REHABILITATION							69.02
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN							73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OUTPATIENT TREATMENT CENTERS							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM							90.02
91	Emergency			1,250,399		1,250,399	1,250,399	91
92	Observation Beds (Non-Distinct							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Total (sum of lines 50-199)			1,489,446		1,489,446	1,489,446	200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-S252**

**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	113,793,471	0.001293	0.001293					50
52	Delivery Room & Labor Room	7,877,379	0.011672	0.011672					52
53	Anesthesiology	28,544,274							53
54	Radiology-Diagnostic	339,781,109			49,262				54
54.01	OFFSITE-DIAGNOSTIC SERVICES	44,091,060							54.01
56.01	ONCOLOGY	132,664,934			21,342				56.01
60	Laboratory	211,026,536			168,191				60
62	Whole Blood & Packed Red Blood	9,525,329							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	19,440,088							65
66	Physical Therapy	32,733,933			13,929				66
69	Electrocardiology	56,621,540			37,388				69
69.01	CARDIAC CATH LAB	37,214,439							69.01
69.02	CARDIAC REHABILITATION	1,801,083							69.02
71	Medical Supplies Charged to Pat	118,337,905			11,128				71
72	Impl. Dev. Charged to Patients	65,956,966							72
73	Drugs Charged to Patients	97,647,704			143,554				73
73.01	FLU VACCINE DRUGS CHG TO PATIEN	119,352							73.01
74	Renal Dialysis	5,898,746							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	OUTPATIENT TREATMENT CENTERS	14,202,210							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1,647,235			46,059				90.02
91	Emergency	111,543,474	0.011210	0.011210	196,787	2,206			91
92	Observation Beds (Non-Distinct	5,184,111							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	1,455,652,878			687,640	2,206			200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S252

WORKSHEET D  
PART V

Check [ ] Title V - O/P [ ] Hospital [ ] SUB (Other) [ ] Swing Bed SNF  
 Applicable [XX] Title XVIII, Part B [XX] 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	0.315087						50
52	Delivery Room & Labor Room	1.094160						52
53	Anesthesiology	0.017291						53
54	Radiology-Diagnostic	0.101943						54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.121592						54.01
56.01	ONCOLOGY	0.038486						56.01
60	Laboratory	0.091114						60
62	Whole Blood & Packed Red Blood	0.357051						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.221358						65
66	Physical Therapy	0.382469						66
69	Electrocardiology	0.156583						69
69.01	CARDIAC CATH LAB	0.131020						69.01
69.02	CARDIAC REHABILITATION	1.469505						69.02
71	Medical Supplies Charged to Pat	0.260185						71
72	Impl. Dev. Charged to Patients	0.338778						72
73	Drugs Charged to Patients	0.303305						73
73.01	FLU VACCINE DRUGS CHG TO PATIEN	0.696997						73.01
74	Renal Dialysis	0.192621						74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OUTPATIENT TREATMENT CENTERS	0.812591						90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.065205						90.02
91	Emergency	0.245231						91
92	Observation Beds (Non-Distinct	0.916425						92
	<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**

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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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

(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)	
		1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	10,328,635		10,328,635	66,675	154.91	4,480	693,997	30
31	Intensive Care Unit	2,559,415		2,559,415	8,106	315.74	272	85,881	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	NEONATAL INTENSIVE CARE UNIT	386,057		386,057	880	438.70	133	58,347	35
40	Subprovider - IPF	1,618,892		1,618,892	9,587	168.86	1,445	244,003	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	398,354		398,354	8,251	48.28	1,247	60,205	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	15,291,353		15,291,353	93,499		7,577	1,142,433	200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**

**COMPONENT CCN: 14-0252**

**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	8,191,192	113,793,471	0.071983	1,373,333	98,857	50
52	Delivery Room & Labor Room	953,552	7,877,379	0.121049	1,674,306	202,673	52
53	Anesthesiology	60,559	28,544,274	0.002122	804,222	1,707	53
54	Radiology-Diagnostic	6,034,142	339,781,109	0.017759	3,563,749	63,289	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	1,413,459	44,091,060	0.032058			54.01
56.01	ONCOLOGY	1,280,135	132,664,934	0.009649	420,924	4,061	56.01
60	Laboratory	2,014,306	211,026,536	0.009545	5,336,971	50,941	60
62	Whole Blood & Packed Red Blood	236,383	9,525,329	0.024816	134,241	3,331	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	429,056	19,440,088	0.022071	1,017,327	22,453	65
66	Physical Therapy	2,196,333	32,733,933	0.067097	143,371	9,620	66
69	Electrocardiology	1,083,888	56,621,540	0.019143	526,638	10,081	69
69.01	CARDIAC CATH LAB	801,100	37,214,439	0.021527	449,399	9,674	69.01
69.02	CARDIAC REHABILITATION	799,658	1,801,083	0.443987			69.02
71	Medical Supplies Charged to Pat	2,002,995	118,337,905	0.016926	3,462,541	58,607	71
72	Impl. Dev. Charged to Patients	1,519,525	65,956,966	0.023038			72
73	Drugs Charged to Patients	1,910,998	97,647,704	0.019570	2,646,130	51,785	73
73.01	FLU VACCINE DRUGS CHG TO PATIEN	5,351	119,352	0.044834			73.01
74	Renal Dialysis	54,688	5,898,746	0.009271	165,818	1,537	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01	OUTPATIENT TREATMENT CENTERS	2,313,169	14,202,210	0.162874			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	363,026	1,647,235	0.220385	3,696	815	90.02
91	Emergency	2,257,424	111,543,474	0.020238	130,744	2,646	91
92	Observation Beds (Non-Distinct	717,388	5,184,111	0.138382			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	36,638,327	1,455,652,878		21,853,410	592,077	200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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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)		128,718			128,718	30
31	Intensive Care Unit		73,553			73,553	31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	NEONATAL INTENSIVE CARE UNIT						35
40	Subprovider - IPF		73,553			73,553	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)		275,824			275,824	200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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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	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)	66,675	1.93	4,480	8,646	30
31	Intensive Care Unit	8,106	9.07	272	2,467	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	NEONATAL INTENSIVE CARE UNIT	880		133		35
40	Subprovider - IPF	9,587	7.67	1,445	11,083	40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	8,251		1,247		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	93,499		7,577	22,196	200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0252**

**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	2	3	4	5	6	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room			147,106		147,106	147,106	50
52	Delivery Room & Labor Room			91,941		91,941	91,941	52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	OFFSITE-DIAGNOSTIC SERVICES							54.01
56.01	ONCOLOGY							56.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
69.01	CARDIAC CATH LAB							69.01
69.02	CARDIAC REHABILITATION							69.02
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN							73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OUTPATIENT TREATMENT CENTERS							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM							90.02
91	Emergency			1,250,399		1,250,399	1,250,399	91
92	Observation Beds (Non-Distinct							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Total (sum of lines 50-199)			1,489,446		1,489,446	1,489,446	200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0252**

**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	113,793,471	0.001293	0.001293	1,373,333	1,776			50
52	Delivery Room & Labor Room	7,877,379	0.011672	0.011672	1,674,306	19,542			52
53	Anesthesiology	28,544,274			804,222				53
54	Radiology-Diagnostic	339,781,109			3,563,749				54
54.01	OFFSITE-DIAGNOSTIC SERVICES	44,091,060							54.01
56.01	ONCOLOGY	132,664,934			420,924				56.01
60	Laboratory	211,026,536			5,336,971				60
62	Whole Blood & Packed Red Blood	9,525,329			134,241				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	19,440,088			1,017,327				65
66	Physical Therapy	32,733,933			143,371				66
69	Electrocardiology	56,621,540			526,638				69
69.01	CARDIAC CATH LAB	37,214,439			449,399				69.01
69.02	CARDIAC REHABILITATION	1,801,083							69.02
71	Medical Supplies Charged to Pat	118,337,905			3,462,541				71
72	Impl. Dev. Charged to Patients	65,956,966							72
73	Drugs Charged to Patients	97,647,704			2,646,130				73
73.01	FLU VACCINE DRUGS CHG TO PATIEN	119,352							73.01
74	Renal Dialysis	5,898,746			165,818				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	OUTPATIENT TREATMENT CENTERS	14,202,210							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1,647,235			3,696				90.02
91	Emergency	111,543,474	0.011210	0.011210	130,744	1,466			91
92	Observation Beds (Non-Distinct	5,184,111							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	1,455,652,878			21,853,410	22,784			200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0252

WORKSHEET D  
PART V

Check [ ] Title V - O/P [XX] Hospital [ ] SUB (Other) [ ] Swing Bed SNF  
 Applicable [ ] Title XVIII, Part B [ ] IPF [ ] SNF [ ] Swing Bed NF  
 Boxes: [XX] 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	0.315087							50
52	Delivery Room & Labor Room	1.094160							52
53	Anesthesiology	0.017291							53
54	Radiology-Diagnostic	0.101943							54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.121592							54.01
56.01	ONCOLOGY	0.038486							56.01
60	Laboratory	0.091114							60
62	Whole Blood & Packed Red Blood	0.357051							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.221358							65
66	Physical Therapy	0.382469							66
69	Electrocardiology	0.156583							69
69.01	CARDIAC CATH LAB	0.131020							69.01
69.02	CARDIAC REHABILITATION	1.469505							69.02
71	Medical Supplies Charged to Pat	0.260185							71
72	Impl. Dev. Charged to Patients	0.338778							72
73	Drugs Charged to Patients	0.303305							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN	0.696997							73.01
74	Renal Dialysis	0.192621							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	OUTPATIENT TREATMENT CENTERS	0.812591							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.065205							90.02
91	Emergency	0.245231							91
92	Observation Beds (Non-Distinct	0.916425							92
	<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**

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**

**COMPONENT CCN: 14-S252**

**WORKSHEET D  
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	8,191,192	113,793,471	0.071983			50
52	Delivery Room & Labor Room	953,552	7,877,379	0.121049			52
53	Anesthesiology	60,559	28,544,274	0.002122			53
54	Radiology-Diagnostic	6,034,142	339,781,109	0.017759	50,286	893	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	1,413,459	44,091,060	0.032058			54.01
56.01	ONCOLOGY	1,280,135	132,664,934	0.009649	12,061	116	56.01
60	Laboratory	2,014,306	211,026,536	0.009545	259,384	2,476	60
62	Whole Blood & Packed Red Blood	236,383	9,525,329	0.024816			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	429,056	19,440,088	0.022071			65
66	Physical Therapy	2,196,333	32,733,933	0.067097	1,062	71	66
69	Electrocardiology	1,083,888	56,621,540	0.019143	53,744	1,029	69
69.01	CARDIAC CATH LAB	801,100	37,214,439	0.021527			69.01
69.02	CARDIAC REHABILITATION	799,658	1,801,083	0.443987			69.02
71	Medical Supplies Charged to Pat	2,002,995	118,337,905	0.016926	14,287	242	71
72	Impl. Dev. Charged to Patients	1,519,525	65,956,966	0.023038			72
73	Drugs Charged to Patients	1,910,998	97,647,704	0.019570	65,521	1,282	73
73.01	FLU VACCINE DRUGS CHG TO PATIEN	5,351	119,352	0.044834			73.01
74	Renal Dialysis	54,688	5,898,746	0.009271			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01	OUTPATIENT TREATMENT CENTERS	2,313,169	14,202,210	0.162874			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	363,026	1,647,235	0.220385	66,528	14,662	90.02
91	Emergency	2,257,424	111,543,474	0.020238	1,838	37	91
92	Observation Beds (Non-Distinct		5,184,111				92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	35,920,939	1,455,652,878		524,711	20,808	200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-S252**

**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			147,106		147,106	147,106	50
52	Delivery Room & Labor Room			91,941		91,941	91,941	52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	OFFSITE-DIAGNOSTIC SERVICES							54.01
56.01	ONCOLOGY							56.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
69.01	CARDIAC CATH LAB							69.01
69.02	CARDIAC REHABILITATION							69.02
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN							73.01
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	OUTPATIENT TREATMENT CENTERS							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM							90.02
91	Emergency			1,250,399		1,250,399	1,250,399	91
92	Observation Beds (Non-Distinct							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Total (sum of lines 50-199)			1,489,446		1,489,446	1,489,446	200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-S252**

**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	113,793,471	0.001293	0.001293					50
52	Delivery Room & Labor Room	7,877,379	0.011672	0.011672					52
53	Anesthesiology	28,544,274							53
54	Radiology-Diagnostic	339,781,109			50,286				54
54.01	OFFSITE-DIAGNOSTIC SERVICES	44,091,060							54.01
56.01	ONCOLOGY	132,664,934			12,061				56.01
60	Laboratory	211,026,536			259,384				60
62	Whole Blood & Packed Red Blood	9,525,329							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	19,440,088							65
66	Physical Therapy	32,733,933			1,062				66
69	Electrocardiology	56,621,540			53,744				69
69.01	CARDIAC CATH LAB	37,214,439							69.01
69.02	CARDIAC REHABILITATION	1,801,083							69.02
71	Medical Supplies Charged to Pat	118,337,905			14,287				71
72	Impl. Dev. Charged to Patients	65,956,966							72
73	Drugs Charged to Patients	97,647,704			65,521				73
73.01	FLU VACCINE DRUGS CHG TO PATIEN	119,352							73.01
74	Renal Dialysis	5,898,746							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	OUTPATIENT TREATMENT CENTERS	14,202,210							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1,647,235			66,528				90.02
91	Emergency	111,543,474	0.011210	0.011210	1,838	21			91
92	Observation Beds (Non-Distinct	5,184,111							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	1,455,652,878			524,711	21			200

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S252

WORKSHEET D  
PART V

Check [ ] Title V - O/P [ ] Hospital [ ] SUB (Other) [ ] Swing Bed SNF  
 Applicable [ ] Title XVIII, Part B [XX] IPF [ ] SNF [ ] Swing Bed NF  
 Boxes: [XX] 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	0.315087							50
52	Delivery Room & Labor Room	1.094160							52
53	Anesthesiology	0.017291							53
54	Radiology-Diagnostic	0.101943							54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.121592							54.01
56.01	ONCOLOGY	0.038486							56.01
60	Laboratory	0.091114							60
62	Whole Blood & Packed Red Blood	0.357051							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.221358							65
66	Physical Therapy	0.382469							66
69	Electrocardiology	0.156583							69
69.01	CARDIAC CATH LAB	0.131020							69.01
69.02	CARDIAC REHABILITATION	1.469505							69.02
71	Medical Supplies Charged to Pat	0.260185							71
72	Impl. Dev. Charged to Patients	0.338778							72
73	Drugs Charged to Patients	0.303305							73
73.01	FLU VACCINE DRUGS CHG TO PATIEN	0.696997							73.01
74	Renal Dialysis	0.192621							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	OUTPATIENT TREATMENT CENTERS	0.812591							90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.065205							90.02
91	Emergency	0.245231							91
92	Observation Beds (Non-Distinct	0.916425							92
	<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**

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-0252**

**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)	66,675	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	66,675	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)	62,044	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	29,847	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)	68,400,450	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)	68,400,450	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)	68,400,450	37

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-0252**

**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	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,025.88	38	
39	Program general inpatient routine service cost (line 9 x line 38)					30,619,440	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)					30,619,440	41	
42	Nursery (Titles V and XIX only)	1	2	3	4	5	42	
	<b>Intensive Care Type Inpatient Hospital Units</b>							
43	Intensive Care Unit	18,318,744	8,106	2,259.90	4,239	9,579,716	43	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	NEONATAL INTENSIVE CARE UNIT	2,114,671	880	2,403.04			47	

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					51,123,104	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					91,322,260	49	

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					6,058,074	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					5,906,369	51
52	Total Program excludable cost (sum of lines 50 and 51)					11,964,443	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					79,357,817	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**

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0252

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)	4,631	87				
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,025.88	88				
89	Observation bed cost (line 87 x line 88) (see instructions)	4,750,850	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	10,328,635	68,400,450	0.151002	4,750,850	717,388	90
91	Nursing School						91
92	Allied Health	128,718	68,400,450	0.001882	4,750,850	8,941	92
93	Other Medical Education						93

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-S252**

**WORKSHEET D-1  
PART I**

Check  Title V - I/P  Hospital  SUB (Other)  ICF/IID  PPS  
 Applicable  Title XVIII, Part A  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)	9,587	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,587	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)	9,587	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)	1,266	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

**SWING-BED ADJUSTMENT**

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	10,964,229	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10,964,229	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	10,964,229	37

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-S252**

**WORKSHEET D-1  
PART II**

Check  Title V - I/P  Hospital  SUB (Other)  PPS  
 Applicable  Title XVIII, Part A  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)	1,143.66	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,447,874	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)	1,447,874	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	176,195	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,624,069	49
<b>PASS THROUGH COST ADJUSTMENTS</b>			
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	223,487	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	23,674	51
52	Total Program excludable cost (sum of lines 50 and 51)	247,161	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,376,908	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**

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-0252**

**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)	66,675	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	66,675	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)	62,044	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)	4,480	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)	8,251	15
16	Nursery days (title V or XIX only)	1,247	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)	68,400,450	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)	68,400,450	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)	68,400,450	37

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-0252**

**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)						1,025.88	38
39	Program general inpatient routine service cost (line 9 x line 38)						4,595,942	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)							40
41	Total Program general inpatient routine service cost (line 39 + line 40)						4,595,942	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
42	Nursery (Titles V and XIX only)	3,371,283	8,251	408.59	1,247	509,512		42
	<b>Intensive Care Type Inpatient Hospital Units</b>							
43	Intensive Care Unit	18,303,711	8,106	2,258.04	272	614,187		43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	NEONATAL INTENSIVE CARE UNIT	2,114,671	880	2,403.04	133	319,604		47
							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						5,385,082	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						11,424,327	49

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						909,543	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						614,861	51
52	Total Program excludable cost (sum of lines 50 and 51)						1,524,404	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**

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0252

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)	4,631	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**

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S252

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,587	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,587	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)	9,587	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)	1,445	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

**SWING-BED ADJUSTMENT**

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	10,964,229	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10,964,229	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	10,964,229	37

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S252

WORKSHEET D-1  
PART II

Check  Title V - I/P  Hospital  SUB (Other)  PPS  
 Applicable  Title XVIII, Part A  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)	1,143.66	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,652,589	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)	1,652,589	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	132,952	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,785,541	49

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	255,086	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	20,829	51
52	Total Program excludable cost (sum of lines 50 and 51)	275,915	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**

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0252

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/ID                       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		60,041,743		30
31	Intensive Care Unit		19,018,703		31
35	NEONATAL INTENSIVE CARE UNIT				35
40	Subprovider - IPF				40
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.315164	22,183,514	6,991,445	50
52	Delivery Room & Labor Room	1.094160			52
53	Anesthesiology	0.017291	3,723,795	64,388	53
54	Radiology-Diagnostic	0.101981	48,363,396	4,932,147	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.121592			54.01
56.01	ONCOLOGY	0.038486	5,209,897	200,508	56.01
60	Laboratory	0.091114	43,145,992	3,931,204	60
62	Whole Blood & Packed Red Blood Cells	0.357051	3,995,487	1,426,593	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.221358	9,707,032	2,148,729	65
66	Physical Therapy	0.382469	4,318,816	1,651,813	66
69	Electrocardiology	0.158926	6,586,703	1,046,798	69
69.01	CARDIAC CATH LAB	0.131432	8,155,112	1,071,843	69.01
69.02	CARDIAC REHABILITATION	1.474838	270	398	69.02
71	Medical Supplies Charged to Patients	0.260185	32,282,673	8,399,467	71
72	Impl. Dev. Charged to Patients	0.338778	21,096,813	7,147,136	72
73	Drugs Charged to Patients	0.303305	25,790,510	7,822,391	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	0.696997			73.01
74	Renal Dialysis	0.192621	3,258,935	627,739	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.01	OUTPATIENT TREATMENT CENTERS	0.812591	174,358	141,682	90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.065205			90.02
91	Emergency	0.245231	14,349,012	3,518,823	91
92	Observation Beds (Non-Distinct Part)	0.916425			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		252,342,315	51,123,104	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		252,342,315		202

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S252

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
35	NEONATAL INTENSIVE CARE UNIT				35
40	Subprovider - IPF		3,021,621		40
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.315164			50
52	Delivery Room & Labor Room	1.094160			52
53	Anesthesiology	0.017291			53
54	Radiology-Diagnostic	0.101981	49,262	5,024	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.121592			54.01
56.01	ONCOLOGY	0.038486	21,342	821	56.01
60	Laboratory	0.091114	168,191	15,325	60
62	Whole Blood & Packed Red Blood Cells	0.357051			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.221358			65
66	Physical Therapy	0.382469	13,929	5,327	66
69	Electrocardiology	0.158926	37,388	5,942	69
69.01	CARDIAC CATH LAB	0.131432			69.01
69.02	CARDIAC REHABILITATION	1.474838			69.02
71	Medical Supplies Charged to Patients	0.260185	11,128	2,895	71
72	Impl. Dev. Charged to Patients	0.338778			72
73	Drugs Charged to Patients	0.303305	143,554	43,541	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	0.696997			73.01
74	Renal Dialysis	0.192621			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.01	OUTPATIENT TREATMENT CENTERS	0.812591			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.065205	46,059	49,062	90.02
91	Emergency	0.245231	196,787	48,258	91
92	Observation Beds (Non-Distinct Part)	0.916425			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		687,640	176,195	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		687,640		202

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0252

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		5,519,401		30
31	Intensive Care Unit		1,858,425		31
35	NEONATAL INTENSIVE CARE UNIT		1,206,349		35
40	Subprovider - IPF				40
43	Nursery		2,622,421		43
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.315087	1,373,333	432,719	50
52	Delivery Room & Labor Room	1.094160	1,674,306	1,831,959	52
53	Anesthesiology	0.017291	804,222	13,906	53
54	Radiology-Diagnostic	0.101943	3,563,749	363,299	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.121592			54.01
56.01	ONCOLOGY	0.038486	420,924	16,200	56.01
60	Laboratory	0.091114	5,336,971	486,273	60
62	Whole Blood & Packed Red Blood Cells	0.357051	134,241	47,931	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.221358	1,017,327	225,193	65
66	Physical Therapy	0.382469	143,371	54,835	66
69	Electrocardiology	0.156583	526,638	82,463	69
69.01	CARDIAC CATH LAB	0.131020	449,399	58,880	69.01
69.02	CARDIAC REHABILITATION	1.469505			69.02
71	Medical Supplies Charged to Patients	0.260185	3,462,541	900,901	71
72	Impl. Dev. Charged to Patients	0.338778			72
73	Drugs Charged to Patients	0.303305	2,646,130	802,584	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	0.696997			73.01
74	Renal Dialysis	0.192621	165,818	31,940	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.01	OUTPATIENT TREATMENT CENTERS	0.812591			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.065205	3,696	3,937	90.02
91	Emergency	0.245231	130,744	32,062	91
92	Observation Beds (Non-Distinct Part)	0.916425			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		21,853,410	5,385,082	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		21,853,410		202

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S252

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/ID  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
35	NEONATAL INTENSIVE CARE UNIT				35
40	Subprovider - IPF		3,203,790		40
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.315087			50
52	Delivery Room & Labor Room	1.094160			52
53	Anesthesiology	0.017291			53
54	Radiology-Diagnostic	0.101943	50,286	5,126	54
54.01	OFFSITE-DIAGNOSTIC SERVICES	0.121592			54.01
56.01	ONCOLOGY	0.038486	12,061	464	56.01
60	Laboratory	0.091114	259,384	23,634	60
62	Whole Blood & Packed Red Blood Cells	0.357051			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.221358			65
66	Physical Therapy	0.382469	1,062	406	66
69	Electrocardiology	0.156583	53,744	8,415	69
69.01	CARDIAC CATH LAB	0.131020			69.01
69.02	CARDIAC REHABILITATION	1.469505			69.02
71	Medical Supplies Charged to Patients	0.260185	14,287	3,717	71
72	Impl. Dev. Charged to Patients	0.338778			72
73	Drugs Charged to Patients	0.303305	65,521	19,873	73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS	0.696997			73.01
74	Renal Dialysis	0.192621			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.01	OUTPATIENT TREATMENT CENTERS	0.812591			90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM	1.065205	66,528	70,866	90.02
91	Emergency	0.245231	1,838	451	91
92	Observation Beds (Non-Distinct Part)	0.916425			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		524,711	132,952	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		524,711		202

(A) Worksheet A line numbers

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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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)				1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	68,766,250			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	1,126,470			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	6,677,060			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	323.31			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)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	<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)				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)	0.0249			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1253			31
32	Sum of lines 30 and 31	0.1502			32
33	Allowable disproportionate share percentage (see instructions)	0.0252			33
34	Disproportionate share adjustment (see instructions)	433,228			34
		<b>Prior to</b>	<b>On or after</b>		
		<b>October 1</b>	<b>October 1</b>		
	<b>Uncompensated Care Adjustment</b>				
35	Total uncompensated care amount (see instructions)		7,647,644,885		35
35.01	Factor 3 (see instructions)		0.000268497		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		2,053,370		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		2,053,370		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,053,370			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
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

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**WORKSHEET E  
PART A**

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

		1	1.01	1.02	
47	Subtotal (see instructions)	72,379,318			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)	72,379,318			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	5,948,101			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment	4,409			53
54	Special add-on payments for new technologies	5,274			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).	96,053			57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)	189,535			58
59	Total (sum of amounts on lines 49 through 58)	78,622,690			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	78,622,690			61
62	Deductibles billed to program beneficiaries	7,122,924			62
63	Coinsurance billed to program beneficiaries	136,797			63
64	Allowable bad debts (see instructions)	605,200			64
65	Adjusted reimbursable bad debts (see instructions)	393,380			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	513,697			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	71,756,349			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (OTHER ADJ-ALLIED HEALTH A&G)				70
70.93	HVBP payment adjustment amount (see instructions)	-178,665			70.93
70.94	HRR adjustment amount (see instructions)	-268,209			70.94
70.99	HAC adjustment amount (see instructions)	778,858			70.99
71	Amount due provider (see instructions)	70,530,617			71
71.01	Sequestration adjustment (see instructions)	1,410,612			71.01
72	Interim payments	66,315,620			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	2,804,385			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	1			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
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**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

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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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		On or after 10/1		Total (cols. 2 and 3)	
		(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments							1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1							1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	68,766,250			68,766,250		68,766,250	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1							1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1							1.04
2	Outlier payments for discharges	1,126,470			1,126,470		1,126,470	2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments	6,677,060			6,677,060		6,677,060	4
	<b>Indirect Medical Education Adjustment</b>							
5	Amount from Worksheet E Part A, line 21							5
6	IME payment adjustment							6
6.01	IME payment adjustment for managed care							6.01
	<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)							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	0.0252	0.0252	0.0252	0.0252	0.0252		10
11	Disproportionate share adjustment	433,228			433,228		433,228	11
11.01	Uncompensated care payments	2,053,370			2,053,370		2,053,370	11.01
	<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
12	Total ESRD additional payment							12
13	Subtotal	72,379,318			72,379,318		72,379,318	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	72,379,318			72,379,318		72,379,318	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	5,948,101			5,948,101		5,948,101	16
17	Special add-on payments for new technologies	5,274			5,274		5,274	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>				78,332,693		78,332,693	19
20	Capital DRG other than outlier	5,497,842			5,497,842		5,497,842	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	280,376			280,376		280,376	21
21.01	Model 4 BPCI Capital DRG outlier payments							21.01
22	Indirect medical education percentage							22
23	Indirect medical education adjustment							23
24	Allowable disproportionate share percentage	0.0309	0.0309		0.0309			24
25	Disproportionate share adjustment	169,883			169,883		169,883	25
26	Total prospective capital payments	5,948,101			5,948,101		5,948,101	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	-178,665			-178,665		-178,665	30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment	-268,209			-268,209		-268,209	31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment				778,858		778,858	32

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0252

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)	61,184			1
2	Medical and other services reimbursed under OPPTS (see instructions)	49,138,626			2
3	PPS payments	44,242,102			3
4	Outlier payment (see instructions)	22,889			4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.899			5
6	Line 2 times line 5	44,175,625			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	245,708			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	61,184			11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	<b>REASONABLE CHARGES</b>				
12	Ancillary service charges	137,193			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)	137,193			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)	137,193			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	76,009			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)	61,184			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)	44,510,699			24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	Deductibles and coinsurance (see instructions)	15,117			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	9,354,950			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)	35,201,816			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)	35,201,816			30
31	Primary payer payments	1,005			31
32	Subtotal (line 30 minus line 31)	35,200,811			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)	642,912			34
35	Adjusted reimbursable bad debts (see instructions)	417,893			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	526,581			36
37	Subtotal (see instructions)	35,618,704			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ( )				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	35,618,704			40
40.01	Sequestration adjustment (see instructions)	712,374			40.01
41	Interim payments	34,552,564			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	353,766			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**

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S252

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 OPPTS (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 ( )				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**

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0252

WORKSHEET E-1  
PART I

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

		INPATIENT PART A		PART B	
DESCRIPTION		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	Total interim payments paid to provider		65,979,539		34,265,140
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		336,081		287,424
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)		66,315,620		34,552,564
<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	2,804,385		353,766
		.02			6.02
7	Total Medicare program liability (see instructions)		69,120,005		34,906,330
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.

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-S252

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		920,108		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				2
3	List separately each retroactive lump sum adjustment 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)	Program	.01		3.01
		to	.02		3.02
		Provider	.03		3.03
			.04		3.04
			.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)				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)		920,108		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)	Program	.01		5.01
		to	.02		5.02
		Provider	.03		5.03
			.04		5.04
			.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)				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)		26,881		6.01
					6.02
7	Total Medicare program liability (see instructions)		946,989		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.

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT**

**WORKSHEET E-1  
PART II**

Check applicable box:             Hospital             CAH

**TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS**

**HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION**

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	18,485	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	34,086	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	3,499	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	71,030	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	1,661,259,199	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	47,077,109	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

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

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

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

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S252

WORKSHEET E-3  
PART II

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

**PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS**

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	1,047,256	1
2	Net IPF PPS Outlier payment	17,197	2
3	Net IPF PPS ECT payment		3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)		4
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	New teaching program adjustment (see instructions)		5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)		6
7	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)		7
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)		8
9	Average daily census (see instructions)	26,265,753	9
10	Teaching adjustment factor $\{((1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1)\}$		10
11	Teaching adjustment (line 1 multiplied by line 10)		11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,064,453	12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	1,064,453	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	1,064,453	18
19	Deductibles	104,696	19
20	Subtotal (line 18 minus line 19)	959,757	20
21	Coinsurance	20,863	21
22	Subtotal (line 20 minus line 21)	938,894	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	23,854	23
24	Adjusted reimbursable bad debts (see instructions)	15,505	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,104	25
26	Subtotal (sum of lines 22 and 24)	954,399	26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (for freestanding IPF only)		27
28	Other pass through costs (see instructions)	11,916	28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions)		30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	966,315	31
31.01	Sequestration adjustment (see instructions)	19,326	31.01
32	Interim payments	920,108	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	26,881	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35

**TO BE COMPLETED BY CONTRACTOR**

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

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0252

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	11,424,327		1
2			2
3			3
4	11,424,327		4
5			5
6			6
7	11,424,327		7
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
<b>REASONABLE CHARGES</b>			
8	11,206,595		8
9	21,853,410		9
10			10
11			11
12	33,060,005		12
<b>CUSTOMARY CHARGES</b>			
13			13
14			14
15	1.000000	1.000000	15
16	33,060,005		16
17	21,635,678		17
18			18
19			19
20			20
21	11,424,327		21
<b>PROSPECTIVE PAYMENT AMOUNT</b>			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29	11,424,327		29
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
30			30
31	11,424,327		31
32			32
33			33
34			34
35			35
36	11,424,327		36
37			37
38	11,424,327		38
39			39
40	11,424,327		40
41	10,538,023		41
42	886,304		42
43			43



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

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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	2,398,569				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	65,022,151				4
5	Other receivables	20,720,360				5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	11,526,693				7
8	Prepaid expenses					8
9	Other current assets	97				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	99,667,870				11
<b>FIXED ASSETS</b>						
12	Land	1,789,072				12
13	Land improvements	12,624,310				13
14	Accumulated depreciation					14
15	Buildings	303,921,767				15
16	Accumulated depreciation	-312,839,846				16
17	Leasehold improvements	3,283,780				17
18	Accumulated depreciation					18
19	Fixed equipment	208,231,980				19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	200,420,258				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)	417,431,321				30
<b>OTHER ASSETS</b>						
31	Investments	70,096,536				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	26,044,190				34
35	Total other assets (sum of lines 31-34)	96,140,726				35
36	Total assets (sum of lines 11, 30 and 35)	613,239,917				36
<b>Liabilities and Fund Balances</b> (Omit Cents)						
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
<b>CURRENT LIABILITIES</b>						
37	Accounts payable	51,845,650				37
38	Salaries, wages and fees payable	12,715,704				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	6,705,000				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	58,767				43
44	Other current liabilities	48,009,705				44
45	Total current liabilities (sum of lines 37 thru 44)	119,334,826				45
<b>LONG TERM LIABILITIES</b>						
46	Mortgage payable					46
47	Notes payable	294,946,480				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	294,946,480				50
51	Total liabilities (sum of lines 45 and 50)	414,281,306				51
<b>CAPITAL ACCOUNTS</b>						
52	General fund balance	198,958,611				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	198,958,611				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	613,239,917				60

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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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		174,663,904			1
2	Net income (loss) (from Worksheet G-3, line 29)		24,294,707			2
3	Total (sum of line 1 and line 2)		198,958,611			3
4	Additions (credit adjustments) (specify)					4
5	RESTRICTED NET ASSETS TRANSFER					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		198,958,611			11
12	Deductions (debit adjustments) (specify)					12
13	RESTRICTED NET ASSETS TRANSFER					13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		198,958,611			19

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

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2  
PARTS I & II**

**PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	<b>GENERAL INPATIENT ROUTINE CARE SERVICES</b>				
1	Hospital	149,674,563		149,674,563	1
2	Subprovider IPF	23,164,865		23,164,865	2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	172,839,428		172,839,428	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
11	Intensive Care Unit	39,305,309		39,305,309	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	NEONATAL INTENSIVE CARE UNIT	11,262,068		11,262,068	15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	50,567,377		50,567,377	16
17	Total inpatient routine care services (sum of lines 10 and 16)	223,406,805		223,406,805	17
18	Ancillary services	495,538,426	866,645,422	1,362,183,848	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		8,398,957	8,398,957	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	OTHER PATIENT REVENUES		916,355	916,355	27
			805,612	805,612	
		3,531,251	198	3,531,449	
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	722,476,482	876,766,544	1,599,243,026	28

**PART II - OPERATING EXPENSES**

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		420,513,624	29
30	MISC WORKSHEET A-8 ADJUSTMENT			30
31				31
32				32
33				33
34				34
35	OTHER			35
36	Total additions (sum of lines 30-35)			36
37	PROVISION FOR BA DEBT - MISC RECEIP			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		420,513,624	43

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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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)	1,599,243,026	1
2	Less contractual allowances and discounts on patients' accounts	1,166,391,766	2
3	Net patient revenues (line 1 minus line 2)	432,851,260	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	420,513,624	4
5	Net income from service to patients (line 3 minus line 4)	12,337,636	5

**OTHER INCOME**

6	Contributions, donations, bequests, etc.	781,493	6
7	Income from investments	640,961	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	1,910,393	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	2,548,548	22
23	Governmental appropriations		23
24	Other (CAPITATION)		24
24.01	Other (OTHER REVENUE - ACCT 533990)	1,920,084	24.01
24.02		1,814,067	24.02
24.03	Other (NON OPERATING)	580,903	24.03
24.04	Other (MEANINGFUL USE)	1,760,622	24.04
25	Total other income (sum of lines 6-24)	11,957,071	25
26	Total (line 5 plus line 25)	24,294,707	26
29	Net income (or loss) for the period (line 26 minus line 28)	24,294,707	29

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**

**HHA CCN: 14-7094**

**WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	<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	1,642,824	119,353			557,608	5
	<b>HHA REIMBURSABLE SERVICES</b>						
6	Skilled Nursing Care	1,702,850	123,714				6
7	Physical Therapy	1,246,136	90,534				7
8	Occupational Therapy	177,274	12,879				8
9	Speech Pathology	27,850	2,023				9
10	Medical Social Services	96,782	7,031				10
11	Home Health Aide	59,213	4,302				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)	4,952,929	359,836			557,608	24

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**

**HHA CCN: 14-7094**

**WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	<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	2,319,785	496	2,320,281		2,320,281	5
	<b>HHA REIMBURSABLE SERVICES</b>						
6	Skilled Nursing Care	1,826,564		1,826,564		1,826,564	6
7	Physical Therapy	1,336,670		1,336,670		1,336,670	7
8	Occupational Therapy	190,153		190,153		190,153	8
9	Speech Pathology	29,873		29,873		29,873	9
10	Medical Social Services	103,813		103,813		103,813	10
11	Home Health Aide	63,515		63,515		63,515	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)	5,870,373	496	5,870,869		5,870,869	24

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

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**

**HHA CCN: 14-7094**

**WORKSHEET H-1  
PART I**

		CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE
		0	1	2	3
<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	2,320,281			5
<b>HHA REIMBURSABLE SERVICES</b>					
6	Skilled Nursing Care	1,826,564			6
7	Physical Therapy	1,336,670			7
8	Occupational Therapy	190,153			8
9	Speech Pathology	29,873			9
10	Medical Social Services	103,813			10
11	Home Health Aide	63,515			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)	5,870,869			24

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**

**HHA CCN: 14-7094**

**WORKSHEET H-1  
PART I**

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	<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		2,320,281	2,320,281		5
	<b>HHA REIMBURSABLE SERVICES</b>					
6	Skilled Nursing Care		1,826,564	1,138,667	2,965,231	6
7	Physical Therapy		1,336,670	834,780	2,171,450	7
8	Occupational Therapy		190,153	105,888	296,041	8
9	Speech Pathology		29,873	16,012	45,885	9
10	Medical Social Services		103,813	83,301	187,114	10
11	Home Health Aide		63,515	36,797	100,312	11
12	Supplies (see instructions)			13,162	13,162	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			91,674	91,674	23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		5,870,869		5,870,869	24

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 14-7094

WORKSHEET H-1  
PART II

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	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					-2,320,281	17,980,192	5
<b>HHA REIMBURSABLE SERVICES</b>								
6	Skilled Nursing Care					6,997,162	8,823,726	6
7	Physical Therapy					5,132,137	6,468,807	7
8	Occupational Therapy					630,388	820,541	8
9	Speech Pathology					94,207	124,080	9
10	Medical Social Services					541,695	645,508	10
11	Home Health Aide					221,630	285,145	11
12	Supplies (see instructions)					101,991	101,991	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					710,394	710,394	23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					12,109,323	17,980,192	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						2,320,281	25
26	Unit Cost Multiplier						0.129047	26

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**

**HHA CCN: 14-7094**

**WORKSHEET H-2  
PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	Administrative and General		242,210	18,361	356,908	617,479	128,832	1
2	Skilled Nursing Care	2,965,231			369,847	3,335,078	695,837	2
3	Physical Therapy	2,171,450			270,652	2,442,102	509,525	3
4	Occupational Therapy	296,041			38,503	334,544	69,800	4
5	Speech Pathology	45,885			6,049	51,934	10,836	5
6	Medical Social Services	187,114			21,020	208,134	43,425	6
7	Home Health Aide	100,312			12,861	113,173	23,613	7
8	Supplies	13,162				13,162	2,746	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	91,674				91,674	19,127	19
20	Totals (sum of lines 1-19)(2)	5,870,869	242,210	18,361	1,075,840	7,207,280	1,503,741	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**

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**

**HHA CCN: 14-7094**

**WORKSHEET H-2  
PART I**

	HHA COST CENTER (omit cents)	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	Administrative and General		269,378		104,820			1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)		269,378		104,820			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**

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**

**HHA CCN: 14-7094**

**WORKSHEET H-2  
PART I**

	HHA COST CENTER (omit cents)	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	Administrative and General		816,777			33,865		1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies			2,447				8
9	Drugs				49			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)		816,777	2,447	49	33,865		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**

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**

**HHA CCN: 14-7094**

**WORKSHEET H-2  
PART I**

	HHA COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION EMS	SUBTOTAL (sum of col.4A-23)	
		19	20	21	22	23	24	
1	Administrative and General						1,971,151	1
2	Skilled Nursing Care						4,030,915	2
3	Physical Therapy						2,951,627	3
4	Occupational Therapy						404,344	4
5	Speech Pathology						62,770	5
6	Medical Social Services						251,559	6
7	Home Health Aide						136,786	7
8	Supplies						18,355	8
9	Drugs						49	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						110,801	19
20	Totals (sum of lines 1-19)(2)						9,938,357	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**

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**

**HHA CCN: 14-7094**

**WORKSHEET H-2  
PART I**

	HHA COST CENTER (omit cents)	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL (cols 23 +/- 24)	ALLOCATED HHA A&G (see PtII)	TOTAL HHA COSTS		
		25	26	27	28		
1	Administrative and General		1,971,151				1
2	Skilled Nursing Care		4,030,915	997,281	5,028,196		2
3	Physical Therapy		2,951,627	730,256	3,681,883		3
4	Occupational Therapy		404,344	100,038	504,382		4
5	Speech Pathology		62,770	15,530	78,300		5
6	Medical Social Services		251,559	62,238	313,797		6
7	Home Health Aide		136,786	33,842	170,628		7
8	Supplies		18,355	4,541	22,896		8
9	Drugs		49	12	61		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		110,801	27,413	138,214		19
20	Totals (sum of lines 1-19)(2)		9,938,357	1,971,151	9,938,357		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.			0.247408			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**

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7094

WORKSHEET H-2  
PART II

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	MAINTENANCE & REPAIRS SQUARE FEET	
		1	2	4	4A	5	6	
1	Administrative and General	5,176	18,650	1,643,278		617,479		1
2	Skilled Nursing Care			1,702,850		3,335,078		2
3	Physical Therapy			1,246,136		2,442,102		3
4	Occupational Therapy			177,274		334,544		4
5	Speech Pathology			27,850		51,934		5
6	Medical Social Services			96,782		208,134		6
7	Home Health Aide			59,214		113,173		7
8	Supplies					13,162		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					91,674		19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	5,176	18,650	4,953,384		7,207,280		20
21	Total cost to be allocated	242,210	18,361	1,075,840		1,503,741		21
22	Unit Cost Multiplier	46.794822		0.217193		0.208642		22
22	Unit Cost Multiplier		0.984504					22

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7094

WORKSHEET H-2  
PART II

	HHA COST CENTER	OPERATION OF PLANT  SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING  SQUARE FEET	DIETARY  MEALS SERVED	CAFETERIA  FTE'S SERVED	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED	
		7	8	9	10	11	12	
1	Administrative and General	5,176		5,176				1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	5,176		5,176				20
21	Total cost to be allocated	269,378		104,820				21
22	Unit Cost Multiplier	52.043663		20.251159				22
22	Unit Cost Multiplier							22

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS**

**HHA CCN: 14-7094**

**WORKSHEET H-2  
PART II**

	HHA COST CENTER	NURSING ADMINIS- TRATION FTE'S NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY  COSTED REQUISTION	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE  TIME SPENT	NONPHYSIC. ANESTHET.  ASSIGNED TIME	
		13	14	15	16	17	19	
1	Administrative and General	6,098			8,399,017			1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies		18,368					8
9	Drugs			118				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)	6,098	18,368	118	8,399,017			20
21	Total cost to be allocated	816,777	2,447	49	33,865			21
22	Unit Cost Multiplier	133.941784		0.415254				22
22	Unit Cost Multiplier		0.133221		0.004032			22

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7094

WORKSHEET H-2  
PART II

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

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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**APPORTIONMENT OF PATIENT SERVICE COSTS**

**HHA CCN: 14-7094**

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

Check applicable box:         Title V         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	5,028,196		5,028,196	20,600	244.09	1
2	Physical Therapy	3	3,681,883		3,681,883	14,757	249.50	2
3	Occupational Therapy	4	504,382		504,382	1,957	257.73	3
4	Speech Pathology	5	78,300		78,300	305	256.72	4
5	Medical Social Services	6	313,797		313,797	379	827.96	5
6	Home Health Aide	7	170,628		170,628	1,513	112.77	6
7	Total (sum of lines 1-6)		9,777,186		9,777,186	39,511		7

Limitation Cost Computation				Program Visits		
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	11340		260		8
8.01	Skilled Nursing Care	16974		12,864		8.01
8.02	Skilled Nursing Care	20994		3		8.02
9	Physical Therapy	11340		146		9
9.01	Physical Therapy	16974		9,057		9.01
9.02	Physical Therapy	20994		1		9.02
10	Occupational Therapy	11340		29		10
10.01	Occupational Therapy	16974		1,357		10.01
10.02	Occupational Therapy	20994				10.02
11	Speech Pathology	11340		8		11
11.01	Speech Pathology	16974		228		11.01
11.02	Speech Pathology	20994				11.02
12	Medical Social Services	11340		6		12
12.01	Medical Social Services	16974		269		12.01
12.02	Medical Social Services	20994				12.02
13	Home Health Aide	11340		28		13
13.01	Home Health Aide	16974		1,026		13.01
13.02	Home Health Aide	20994				13.02
14	Total (sum of lines 8-13)			25,282		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	22,896	57,382	80,278	220,542	0.364003
16	Cost of Drugs	9	61		61		

**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	5
1	Physical Therapy	66	0.382469			col. 2, line 2
2	Occupational Therapy	67				col. 2, line 3
3	Speech Pathology	68				col. 2, line 4
4	Medical Supplies Charged to Pat	71	0.260185	220,542	57,382	col. 2, line 15
5	Drugs Charged to Patients	73	0.303305			col. 2, line 16
5.01	FLU VACCINE DRUGS CHG TO PATIEN	73.01	0.696997			col. 2, line 16

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

NORTHWEST COMMUNITY HOSPITAL Provider CCN: 14-0252	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/24/2016 Run Time: 11:58 Version: 2015.10 (02/18/2016)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7094

WORKSHEET H-3  
PARTS I & II

Check applicable box:         Title V         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			Total Program Cost (sum of cols 9-10)	
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	12		
1 Skilled Nursing Care		13,127			3,204,169		3,204,169	1	
2 Physical Therapy		9,204			2,296,398		2,296,398	2	
3 Occupational Therapy		1,386			357,214		357,214	3	
4 Speech Pathology		236			60,586		60,586	4	
5 Medical Social Services		275			227,689		227,689	5	
6 Home Health Aide		1,054			118,860		118,860	6	
7 Total (sum of lines 1-6)		25,282			6,264,916		6,264,916	7	

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services				
		Part B			Part B			Total Program Cost (sum of cols 9-10)	
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	12		
15 Cost of Medical Supplies								15	
16 Cost of Drugs		176,699						16	

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**CALCULATION OF HHA REIMBURSEMENT SETTLEMENT**

**HHA CCN: 14-7094**

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

Check applicable box:         Title V         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		176,699		2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)		5,692,817		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)		176,699		6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)		176,699		7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts		7,876		9

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

	Description	Part A Services	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)		-7,876	10
11	Total PPS Reimbursement - Full Episodes without Outliers		5,248,706	11
12	Total PPS Reimbursement - Full Episodes with Outliers		39,373	12
13	Total PPS Reimbursement - LUPA Episodes		86,635	13
14	Total PPS Reimbursement - PEP Episodes		47,452	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		8,971	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)		5,423,261	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		5,423,261	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		5,423,261	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)		5,423,261	29
30	Other adjustments (see instructions) (specify)		-93	30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		5,423,168	31
31.01	Sequestration adjustment (see instructions)		108,465	31.01
32	Interim payments (see instructions)		5,314,703	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

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

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

**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					5,314,703	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)					5,314,703	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 (see instructions)</b>					5,314,703	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.

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

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**CALCULATION OF CAPITAL PAYMENT**

**COMPONENT CCN: 14-0252**

**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	5,497,842	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	280,376	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)	196.45	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0249	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.1253	8
9	Sum of lines 7 and 8	0.1502	9
10	Allowable disproportionate share percentage (see instructions)	0.0309	10
11	Disproportionate share adjustment (see instructions)	169,883	11
12	Total prospective capital payments (see instructions)	5,948,101	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

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**ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES**

**WORKSHEET L-1  
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDINARY 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
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	PARAMED ED PRGM-(SPECIFY)						23
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30	Adults & Pediatrics						30
31	Intensive Care Unit						31
35	NEONATAL INTENSIVE CARE UNIT						35
40	Subprovider - IPF						40
43	Nursery						43
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room						50
52	Delivery Room & Labor Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
54.01	OFFSITE-DIAGNOSTIC SERVICES						54.01
56.01	ONCOLOGY						56.01
60	Laboratory						60
62	Whole Blood & Packed Red Blood Cells						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
69	Electrocardiology						69
69.01	CARDIAC CATH LAB						69.01
69.02	CARDIAC REHABILITATION						69.02
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
73.01	FLU VACCINE DRUGS CHG TO PATIENTS						73.01
74	Renal Dialysis						74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01	OUTPATIENT TREATMENT CENTERS						90.01
90.02	PARTIAL HOSPITALIZATION PROGRAM						90.02
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	Home Health Agency						101
	<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
192.01	DAY SURGERY CENTER						192.01
192.02	RESIDENTIAL TREATMENT CENTER						192.02
192.03	MOBILE DENTAL CLINIC						192.03
192.04	EMS CONTINUING EDUCATION						192.04
194	CORPORATE HEALTH						194
194.01	MARKETING/COMMUNICATION						194.01
194.02	FOUNDATION						194.02
194.03	OTHER NRCC						194.03

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