

ORIGINAL

E-007-14

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION FOR THE
CHANGE OF OWNERSHIP FOR AN EXISTING HEALTH CARE FACILITY

RECEIVED

1. INFORMATION FOR EXISTING FACILITY

FEB 06 2014

Current Facility Name Northwestern Medical Faculty Foundation Dialysis Center
Address 259 East Erie Street—15th Floor
City Chicago, IL Zip Code 60611 County Cook
Name of current licensed entity for the facility Northwestern Medical Faculty Foundation Dialysis Center, LLC
Does the current licensee: own this facility _____ OR lease this facility X (if leased, check if sublease ☐)
Type of ownership of the current licensed entity (check one of the following:) _____ Sole Proprietorship
_____ Not-for-Profit Corporation _____ For Profit Corporation _____ Partnership _____ Governmental
X _____ Limited Liability Company _____ Other, specify _____
Illinois State Senator for the district where the facility is located: Sen. Kwame Raoul
State Senate District Number 13 Mailing address of the State Senator 122 State Capitol Building
Springfield, IL 62706
Illinois State Representative for the district where the facility is located: Rep. Christian Mitchell
State Representative District Number 26 Mailing address of the State Representative _____
240A W Stratton Office Building Springfield, IL 62706

2. **OUTSTANDING PERMITS.** Does the facility have any projects for which the State Board issued a permit that will not be completed (refer to 1130.140 "Completion or Project Completion" for a definition of project completion) by the time of the proposed ownership change? Yes X No ☐. If yes, refer to Section 1130.520(f), and indicate the projects by Project #
12-099

3. **NAME OF APPLICANT** (complete this information for each co-applicant and insert after this page).

Exact Legal Name of Applicant Northwestern Memorial HealthCare
Address 251 East Huron Street
City, State & Zip Code Chicago, IL 60611
Type of ownership of the current licensed entity (check one of the following:) _____ Sole Proprietorship
X _____ Not-for-Profit Corporation _____ For Profit Corporation _____ Partnership _____ Governmental
_____ Limited Liability Company _____ Other, specify _____

4. **NAME OF LEGAL ENTITY THAT WILL BE THE LICENSEE/OPERATING ENTITY OF THE FACILITY NAMED IN THE APPLICATION AS A RESULT OF THIS TRANSACTION.**

Exact Legal Name of Entity to be Licensed Northwestern Medical Faculty Foundation Dialysis Center, LLC
Address c/o Ms. Danae K. Prousis 680 North Lakeshore Drive
City, State & Zip Code Chicago, IL 60611
Type of ownership of the current licensed entity (check one of the following:) _____ Sole Proprietorship
_____ Not-for-Profit Corporation _____ For Profit Corporation _____ Partnership _____ Governmental
X _____ Limited Liability Company _____ Other, specify _____

5. **BUILDING/SITE OWNERSHIP. NAME OF LEGAL ENTITY THAT WILL OWN THE "BRICKS AND MORTAR" (BUILDING) OF THE FACILITY NAMED IN THIS APPLICATION IF DIFFERENT FROM THE OPERATING/LICENSED ENTITY**

Exact Legal Name of Entity That Will Own the Site Northwestern Memorial Hospital
Address 251 East Huron Street
City, State & Zip Code Chicago, IL 60611
Type of ownership of the current licensed entity (check one of the following:) _____ Sole Proprietorship
X _____ Not-for-Profit Corporation _____ For Profit Corporation _____ Partnership _____ Governmental
_____ Limited Liability Company _____ Other, specify _____

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12-099

3. **NAME OF APPLICANT** (complete this information for each co-applicant and insert after this page).

Exact Legal Name of Applicant Northwestern Medical Faculty Foundation Dialysis Center, LLC
Address 680 North lake Shore Drive Suite 1118
City, State & Zip Code Chicago, IL 60611
Type of ownership of the current licensed entity (check one of the following:) _____ Sole Proprietorship
_____ Not-for-Profit Corporation _____ For Profit Corporation _____ Partnership _____ Governmental
X _____ Limited Liability Company _____ Other, specify _____

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_____ Not-for-Profit Corporation _____ For Profit Corporation _____ Partnership _____ Governmental
X _____ Limited Liability Company _____ Other, specify _____

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Address 252 East Huron Street
City, State & Zip Code Chicago, IL 60611
Type of ownership of the current licensed entity (check one of the following:) _____ Sole Proprietorship
X _____ Not-for-Profit Corporation _____ For Profit Corporation _____ Partnership _____ Governmental
_____ Limited Liability Company _____ Other, specify _____

6. **TRANSACTION TYPE. CHECK THE FOLLOWING THAT APPLY TO THE TRANSACTION:**
- ☐ Purchase resulting in the issuance of a license to an entity different from current licensee;
 - ☐ Lease resulting in the issuance of a license to an entity different from current licensee;
 - ☐ Stock transfer resulting in the issuance of a license to a different entity from current licensee;
 - ☐ Stock transfer resulting in no change from current licensee;
 - ☐ Assignment or transfer of assets resulting in the issuance of a license to an entity different from the current licensee;
 - ☐ Assignment or transfer of assets not resulting in the issuance of a license to an entity different from the current licensee;
 - ☐ Change in membership or sponsorship of a not-for-profit corporation that is the licensed entity;
 - X Change of 50% or more of the voting members of a not-for-profit corporation's board of directors that controls a health care facility's operations, license, certification or physical plant and assets;
 - ☐ Change in the sponsorship or control of the person who is licensed, certified or owns the physical plant and assets of a governmental health care facility;
 - ☐ Sale or transfer of the physical plant and related assets of a health care facility not resulting in a change of current licensee;
 - X Any other transaction that results in a person obtaining control of a health care facility's operation or physical plant and assets, and explain in "Attachment 3 Narrative Description"
7. **APPLICATION FEE.** Submit the application fee in the form of a check or money order for \$2,500 payable to the Illinois Department of Public Health and append as **ATTACHMENT #1.**
8. **FUNDING.** Indicate the type and source of funds which will be used to acquire the facility (e.g., mortgage through Health Facilities Authority; cash gift from parent company, etc.) and append as **ATTACHMENT #2.** not applicable
9. **ANTICIPATED ACQUISITION PRICE:** \$ not applicable
10. **FAIR MARKET VALUE OF THE FACILITY:** \$ 9,007,464 (CON Permit amt.)
(to determine fair market value, refer to 77 IAC 1130.140)
11. **DATE OF PROPOSED TRANSACTION:** September 1, 2013
12. **NARRATIVE DESCRIPTION.** Provide a narrative description explaining the transaction, and append it to the application as **ATTACHMENT #3.**
13. **BACKGROUND OF APPLICANT** (co-applicants must also provide this information); Corporations and Limited Liability Companies must provide a current Certificate of Good Standing from the Illinois Secretary of State. Limited Liability Companies and Partnerships must provide the name and address of each partner/ member and specify the percentage of ownership of each. Append this information to the application as **ATTACHMENT #4.**
14. **TRANSACTION DOCUMENTS.** Provide a copy of the complete transaction document(s) including schedules and exhibits which detail the terms and conditions of the proposed transaction (purchase, lease, stock transfer, etc). Applicants should note that the document(s) submitted should reflect the applicant's (and co-applicant's, if applicable) involvement in the transaction. The document must be signed by both parties and contain language stating that the transaction is contingent upon approval of the Illinois Health Facilities and Services Review Board. Append this document(s) to the application as **ATTACHMENT #5.**
15. **FINANCIAL STATEMENTS.** (Co-applicants must also provide this information) Provide a copy of the applicants latest audited financial statements, and append it to this application as **ATTACHMENT #6.** If the applicant is a newly formed entity and financial statements are not available, please indicate by checking YES , and indicate the date the entity was formed

16. **PRIMARY CONTACT PERSON.** Individual representing the applicant to whom all correspondence and inquiries pertaining to this application are to be directed. (Note: other persons representing the applicant not named below will need written authorization from the applicant stating that such persons are also authorized to represent the applicant in relationship to this application).

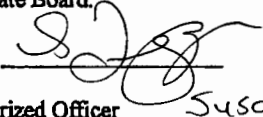
Name: Ms. Danae Prousis
Address: 680 North Lake Shore Drive
City, State & Zip Code: Chicago, IL 60611
Telephone () Ext. (312) 695-8391

17. **ADDITIONAL CONTACT PERSON.** Consultant, attorney, other individual who is also authorized to discuss this application and act on behalf of the applicant.

Name: Jacob M. Axel
Address: 675 North Court, Suite 210
City, State & Zip Code: Palatine, IL 60067
Telephone () Ext. (847) 776-7101

18. **CERTIFICATION—Northwestern Medical Faculty Foundation Dialysis Center, LLC**

I certify that the above information and all attached information are true and correct to the best of my knowledge and belief. I certify that the number of beds within the facility will not change as part of this transaction. I certify that no adverse action has been taken against the applicant(s) by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois. I certify that I am fully aware that a change in ownership will void any permits for projects that have not been completed unless such projects will be completed or altered pursuant to the requirements in 77 IAC 1130.520(f) prior to the effective date of the proposed ownership change. I also certify that the applicant has not already acquired the facility named in this application or entered into an agreement to acquire the facility named in the application unless the contract contains a clause that the transaction is contingent upon approval by the State Board.

Signature of Authorized Officer 
Typed or Printed Name of Authorized Officer Susan Quaggin
Title of Authorized Officer: Professor of Medicine
Address: 303 E. Superior St. Suite 10-105
City, State & Zip Code: Chicago, IL
Telephone (312) 503-1531 Date: Jan 30, 2014

NOTE: complete a separate signature page for each co-applicant and insert following this page.

16. **PRIMARY CONTACT PERSON.** Individual representing the applicant to whom all correspondence and inquiries pertaining to this application are to be directed. (Note: other persons representing the applicant not named below will need written authorization from the applicant stating that such persons are also authorized to represent the applicant in relationship to this application).

Name: Ms. Danae Prousis
Address: 680 North Lake Shore Drive
City, State & Zip Code: Chicago, IL 60611
Telephone () Ext. (312) 695-8391

17. **ADDITIONAL CONTACT PERSON.** Consultant, attorney, other individual who is also authorized to discuss this application and act on behalf of the applicant.

Name: Jacob M. Axel
Address: 675 North Court, Suite 210
City, State & Zip Code: Palatine, IL 60067
Telephone () Ext. (847) 776-7101

18. **CERTIFICATION--Northwestern Memorial HealthCare**

I certify that the above information and all attached information are true and correct to the best of my knowledge and belief. I certify that the number of beds within the facility will not change as part of this transaction. I certify that no adverse action has been taken against the applicant(s) by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois. I certify that I am fully aware that a change in ownership will void any permits for projects that have not been completed unless such projects will be completed or altered pursuant to the requirements in 77 IAC 1130.520(f) prior to the effective date of the proposed ownership change. I also certify that the applicant has not already acquired the facility named in this application or entered into an agreement to acquire the facility named in the application unless the contract contains a clause that the transaction is contingent upon approval by the State Board.

Signature of Authorized Officer 

Typed or Printed Name of Authorized Officer Dean M. Harrison

Title of Authorized Officer: President & Chief Executive Officer, NMHC

Address: 251 E. Huron street

City, State & Zip Code: Chicago, IL 60611

Telephone (312) 926-3007 Date: 1/28/14

NOTE: complete a separate signature page for each co-applicant and insert following this page.

NARRATIVE DESCRIPTION

On March 26, 2013 the Illinois Health Facilities and Services Review Board ("IHFSRB") approved Project #12-099, proposing the establishment of a 36-station in-center dialysis facility on the Northwestern Memorial Medical Center campus in Chicago. Project #12-099's sole applicant was, and subsequent Permit Holder is Northwestern Medical Faculty Foundation Dialysis Center, LLC ("the LLC"). Project #12-099 was obligated, consistent with IHFSRB rules on August 27, 2013.

Northwestern Medical Faculty Foundation ("NMFF") held/holds an 80% interest in the LLC, and the remaining 20% was held by Ambulatory Services of America, Inc. ("ASA"). Pursuant to the IHFSRB's definition, NMFF held "control" of the LLC. On August 12, 2013, U. S. Renal Care, Inc. acquired ASA, and, as a result, now holds ASA's 20% interest in the LLC. Pursuant to a technical assistance discussion with IHFSRB staff, it was concluded that ASA's acquisition did not require any IHFSRB action.

On September 1, 2013, NMFF (now doing business as Northwestern Medical Group, or NMG) became a wholly owned subsidiary of Northwestern Memorial HealthCare ("NMHC") pursuant to a clinical affiliation agreement by and between NMHC and NMFF. As a result, and consistent with technical assistance discussions with IHFSRB staff, NMHC is the sole corporate member of NMFF d/b/a NMG, resulting in "ultimate control" over the LLC, necessitating a change of ownership application.

The change of control request is being filed in the form of a "Change of Ownership" Certificate of Exemption application by virtue of Northwestern Memorial HealthCare's AA+ February 5, 2013 bond rating from Standard & Poor's Financial Services, LLC.



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

NORTHWESTERN MEMORIAL HEALTHCARE, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 30, 1981, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1335102330

Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 17TH day of DECEMBER A.D. 2013 .*

Jesse White

SECRETARY OF STATE

ATTACHMENT 4

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To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

NORTHWESTERN MEDICAL FACULTY FOUNDATION DIALYSIS CENTER, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON NOVEMBER 20, 2012, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.



Authentication #: 1334301566

Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 9TH day of DECEMBER A.D. 2013 .

Jesse White

SECRETARY OF STATE

ATTACHMENT 4

TRANSACTION DOCUMENTS

As noted in ATTACHMENT 3/Narrative Description, Northwestern Medical Faculty Foundation ("NMFF") signed an affiliation agreement with Northwestern Memorial HealthCare ("NMHC"), through which NMHC became the "ultimate parent" of NMFF. That affiliation agreement/transaction document does not mention or specifically address Northwestern Medical Faculty Foundation Dialysis Center, LLC or NMFF's ownership interest in or control of the dialysis center. Therefore, and as evidence of NMHC's "ultimate control" of the dialysis center, the following documents are provided: 1) NMHC's original Articles of Incorporation (filed under a prior name), 2) Articles of Amendment to NMHC's Articles of Incorporation (please see Attachment Sheet 1/Article 4), 3) two Medicare Enrollment Applications, and 4) an Enrollment Disclosure Statement for the Illinois Medical Assistance Program.

Articles of Incorporation

Articles of Amendment
to
Articles of Incorporation

Medicare Enrollment Applications

Enrollment Disclosure Statement
Illinois Medical Assistance Program

Northwestern Memorial HealthCare
Audited Financial Statement

Articles of Incorporation

File Number

5357-40-3



To all to whom these Presents Shall Come, Greeting:

ARTICLES OF INCORPORATION, duly signed and verified of

Whereas,

THE NORTHWESTERN MEMORIAL GROUP

incorporated under the laws of the State of ILLINOIS have been filed in the Office of the Secretary of State as provided by The "General Not For Profit Corporation Act" of Illinois, in force January 1, A.D. 1943.

Now Therefore, I, Jim Edgar, Secretary of State of the State of Illinois by virtue of the powers vested in me by law, do hereby issue this certificate and attach thereto a copy of the Application of the aforesaid corporation.

In Testimony Whereof, I thereto set my hand and cause to

be affixed the Great Seal of the State of Illinois

Done at the City of Springfield this 30th

day of November AD 1943 and

of the Independence of the United States

the two hundred and 6th

(SEAL)

Jim Edgar
SECRETARY OF STATE

EXHIBIT 5

File in Duplicate

FORM NP-29

**ARTICLES OF INCORPORATION
UNDER THE
GENERAL NOT FOR PROFIT CORPORATION ACT**

(Please type or print using black ink)

(Do Not Write in This Space)

Date Paid

11-30-81

Filing Fee \$50.00

Clerk

Secretary of State, Springfield, Illinois.

We, the Incorporators (Not less than three)				
Incorporator's Name	Number	Street	Address City	State
Henry K. Gardner	110 N. Michigan Avenue	Chicago	Illinois	
David L. Everhart	250 E. Superior Street	Chicago	Illinois	
William D. Smithburg	The Quaker Oats Co., Merchandise Mart Plaza,	Chicago	Illinois	

being natural persons of the age of twenty-one years or more and citizens of the United States, for the purpose of forming a corporation under the "General Not For Profit Corporation Act" of the State of Illinois, do hereby adopt the following Articles of Incorporation:

- The name of the corporation is: THE NORTHWESTERN MEMORIAL GROUP
- The duration of the corporation is ☒ perpetual OR _____ years.
- The name and address of the initial registered agent and registered office are:

Registered Agent George L. Heidkamp
 Registered Office 216 E. Superior Street
 City, Zip Code, County Chicago, 60611 Cook County
(Do Not Use P. O. Box)

- The first Board of Directors shall be 7 in number, their names and addresses being as follows:
(Not less than three)

Directors' Names	Number	Street	Address City	State
See attached				

- The purposes for which the corporation is organized are:
See attached

(NOTE: Any special provision authorized or permitted by statute to be contained in the Articles of Incorporation, may be inserted above.)

INCORPORATORS MUST SIGN BELOW

(Both copies must contain original signatures)

Henry K. Gardner
Henry K. Gardner
David L. Everhart
David L. Everhart
William D. Smithburg
William D. Smithburg

DEC 2 1981
INCORPORATORS

As the incorporators, we declare that this document has been examined and is, to the best of our knowledge and belief, true, correct and complete.

The registered agent cannot be the corporation itself.

The registered agent may be an individual, resident in this State, or a domestic or foreign corporation, authorized to act as a registered agent.

The registered office may be, but need not be, the same as its principal office.

Form NP-29

ARTICLES OF INCORPORATION

under the

GENERAL NOT FOR PROFIT

CORPORATION ACT

of

FILED

NOV 30 1981

JIM EDGAR
Secretary of State

SECRETARY OF STATE
CORPORATION DEPARTMENT
SPRINGFIELD, ILLINOIS 62756
TELEPHONE (217) 752-7880

See Articles and Fees E: Executed and Filed in Office (Date)
NE Fee 150.00

G-157-A

ATTACHMENT 5

19

ATTACHMENT
TO
ARTICLES OF INCORPORATION
OF
THE NORTHWESTERN MEMORIAL GROUP

Article 4: The first Board of Directors shall be 7 in number,
their names and addresses being as follows:

<u>Name</u>	<u>Number/Street</u>	<u>City</u>	<u>State</u>
Henry K. Gardner	410 N. Michigan Avenue	Chicago	Illinois
Harold G. Bernthal	892 Timber	Lake Forest	Illinois
T. Stanley Armour	1144 Hawkseed	Lake Forest	Illinois
David L. Everhart	250 E. Superior Street	Chicago	Illinois
Dr. Robert Thompson	250 E. Superior Street	Chicago	Illinois
Silas S. Cathcart	701 N. Mayflower Road	Lake Forest	Illinois
William D. Smithburg	The Quaker Oats Company Merchandise Mart Plaza	Chicago	Illinois

ATTACHMENT
TO
ARTICLES OF INCORPORATION
OF
THE NORTHWESTERN MEMORIAL GROUP

Article 5: The purposes of the corporation are:

- (a) To establish, develop, sponsor, promote and/or conduct educational programs, scientific research, treatment facilities, hospitals, rehabilitation centers, housing centers, consulting and management services, human services programs and other charitable activities devoted to improving and protecting the health and welfare of all persons, including providing opportunities to restore, reclaim or aid persons suffering from physical, mental or emotional disabilities, providing access to community resources aimed at promoting life and health, and providing assistance to persons with the aim of leading full and meaningful lives. In no instance, however, will the corporation engage in the practice of medicine.
- (b) To sponsor, develop and promote and encourage public participation in public services and programs in the area surrounding Chicago, Illinois, or in a larger area if feasible, which are charitable, scientific or educational.
- (c) To own or operate facilities or own other assets for public use and the public's health and welfare.
- (d) To solicit support for the corporation's activities from the public generally and through a board of directors which is broadly representative of the public and the community which the corporation serves.
- (e) To promote the interests of any not for profit and federally tax-exempt organizations which are affiliated with the corporation, the purposes of which are not inconsistent with those of the corporation.
- (f) To own, lease or otherwise deal with all property, real and personal, to be used in furtherance of these purposes.
- (g) To contract with other organizations, for profit and not for profit, with individuals, and with governmental agencies in furtherance of these purposes.

(h) To otherwise operate exclusively for charitable, scientific or educational purposes within the meaning of §501(c)(3) of the Internal Revenue Code of 1954, as amended, in the course of which operation:

(i) No part of the net earnings of the corporation shall inure to the benefit of, or be distributable to, its members, trustees, officers, or other persons, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth herein.

(ii) No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office except as authorized under the Internal Revenue Code.

(iii) Notwithstanding any other provisions of these articles, the corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from Federal income tax under §501(c)(3) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law) or (b) by a corporation, contributions to which are deductible under §170(c)(2) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law).

Article 6: The membership of the corporation shall be as follows:

The members shall be those persons from time to time serving as the corporation's directors. In addition, to doing all the things required or allowed by law, the members, acting as such, shall fill all vacancies from time to time existing on the corporation's board of directors.

Article 7: Dissolution shall be as follows:

In the event of the dissolution of the corporation, the board of directors, after paying or making provision for the payment of all of the liabilities of the corporation, shall distribute, in any proportions considered prudent, all of the assets of the corporation to The Northwestern Memorial Foundation, if then in existence and if qualified under §501(c)(3) of the Internal Revenue Code of 1954, as amended, otherwise in such manner, or to such organization or organizations organized and operated exclusively for charitable, educational or scientific purposes as shall at the time qualify as an exempt organization or organizations under §501(c)(3) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law), as the board of directors shall determine. Any such assets not so disposed of shall be disposed of by a court of competent jurisdiction of the county in which the principal office of the corporation is then located, exclusively for such purposes or to such organization or organizations, as said court shall determine, which are organized and operated exclusively for such purposes.

File Number 5257-740-3

To all to whom these Presents Shall Come, Greeting:

Whereas, ARTICLES OF AMENDMENT TO THE ARTICLES OF INCORPORATION OF THE NORTHWESTERN MEMORIAL GROUP INCORPORATED UNDER THE LAWS OF THE STATE OF ILLINOIS HAVE BEEN FILED IN THE OFFICE OF THE SECRETARY OF STATE AS PROVIDED BY THE GENERAL NOT FOR PROFIT CORPORATION ACT OF ILLINOIS, IN FORCE JANUARY 1, A.D. 1944.

Now Therefore, I, Jim Edgar, Secretary of State of the State of Illinois, by virtue of the powers vested in me by law, do hereby issue this certificate and attach hereto a copy of the Application of the aforesaid corporation.

In Testimony Whereof, I hereunto set my hand and cause to be affixed the Great Seal of the State of Illinois, at the City of Springfield, this 12TH day of NOVEMBER AD 1982 and of the Independence of the United States the two hundred and 7TH.

(SEAL)

Jim Edgar
 SECRETARY OF STATE

5257-140-3

To Be Filed
in Duplicate

Filing Fee \$25.00

FORM NP-35

ARTICLES OF AMENDMENT

to the
ARTICLES OF INCORPORATION

under the

GENERAL NOT FOR PROFIT CORPORATION ACT

(DO NOT WRITE IN THIS SPACE)

Date

Filing Fee \$

Clerk

To Jim Edgar
Secretary of State
Springfield, Illinois

The undersigned corporation, for the purpose of amending its Articles of Incorporation and pursuant to the provisions of Section 35 of the "General Not For Profit Corporation Act" of the State of Illinois, hereby executes the following Articles of Amendment:

1. The name of the corporation is: The Northwestern Memorial Group
2. There are some members, having voting rights with respect to amendments:
(Insert "no" or "some")

(Strike paragraphs (a), (b), or (c) that are not applicable)

3. (a) ~~At a meeting of members, at which a quorum was present, held on _____, 19____, same receiving at least two-thirds (2/3) of the votes entitled to be cast by the members of the corporation present or represented by proxy at such meeting;~~
directors
- (b) BY a consent in writing signed by all members of the corporation entitled to vote with respect thereto,
- (c) ~~At a meeting of directors (members having no voting rights with respect to amendments) held on _____, 19____, same receiving the votes of a majority of the directors then in office, the following amendments were adopted in the manner prescribed by the "General Not For Profit Corporation Act" of the State of Illinois:~~

See Attachment.

(over)

ATTACHMENT 5

25

IN WITNESS WHEREOF, the undersigned corporation has caused these Articles of Amendment to be executed in its name by its _____ President, and its _____ Secretary, this 8th day of November, 19 82.

Corporate
Seal

The Northwestern Memorial Group

David L. Everhart
Execut. Corporate Title

By

David L. Everhart

George L. Heidkamp
President

George L. Heidkamp

Its _____ Secretary

As authorized officers, we declare that this document has been examined by us and is to the best of our knowledge and belief, true, correct and complete.

FORM NP-35

File No. _____

ARTICLES OF AMENDMENT

to file

ARTICLES OF INCORPORATION

SECRETARY OF STATE
CORPORATION DEPARTMENT
SPRINGFIELD, ILLINOIS 62756
TELEPHONE (217) 782-6951

PAID

File in Duplicate
Filing Fee \$25.00

ATTACHMENT 5

ATTACHMENT
TO
ARTICLES OF AMENDMENT
TO
ARTICLES OF INCORPORATION
OF
THE NORTHWESTERN MEMORIAL GROUP

Article 5 is revised to read as follows:

Article 5. The purposes for which the corporation is organized are exclusively charitable, scientific or educational within the meaning of §501(c)(3) of the Internal Revenue Code of 1954, as amended, and, in furtherance of these purposes, the corporation may:

- (a) Promote and support the interests and purposes of organizations which provide health care, education or research and which fall within the categories of §501(c)(3) and §509(a)(1) or §509(a)(2) of the Internal Revenue Code of 1954, as amended.
- (b) Raise funds for any or all of the organizations described in subparagraph (a) of this Article from the public and from all other sources available; receive and maintain such funds and to expend principle and income therefrom in furtherance of these purposes.
- (c) Establish, develop, sponsor, promote and/or conduct educational programs, scientific research, treatment facilities, hospitals, rehabilitation centers, housing centers, management services, human services programs and other charitable activities, all in promotion and support of the interests and purposes of the organizations described in subparagraph (a) of this Article.
- (d) Own, lease or otherwise deal with all property, real and personal, to be used in furtherance of these purposes.
- (e) Contract with other organizations for-profit and not-for-profit, with individuals, and with governmental agencies in furtherance of these purposes.
- (f) Otherwise operate exclusively for charitable, scientific or educational purposes within the

meaning of §501(c)(3) of the Internal Revenue Code of 1954, as amended, in the course of which operation:

- (i) No part of the net earnings of the corporation shall inure to the benefit of, or be distributable to, its members, trustees, officers, or other persons, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth herein.
- (ii) No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office except as authorized under the Internal Revenue Code.
- (iii) Notwithstanding any other provisions of these articles, the corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from Federal income tax under §501(c)(3) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law) or (b) by a corporation, contributions to which are deductible under §170(c)(2) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law).

FURTHER RESOLVED, that the appropriate officers of the corporation be, and hereby are, authorized to execute Articles of Amendment to Articles of Incorporation as required by the Secretary of State of Illinois, to file such Articles of Amendment with the Secretary of State and to file such Articles of Amendment for record with the Office of the Recorder of Deeds of Cook County, Illinois.

File Number 5252 740 3

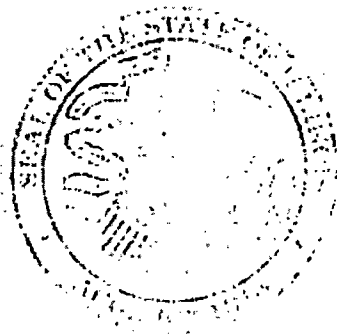
Whereas, ARTICLES OF AMENDMENT TO THE ARTICLES OF
INCORPORATION OF
THE NORTHWESTERN MEMORIAL GROUP

INCORPORATED UNDER THE LAWS OF THE STATE OF ILLINOIS HAVE BEEN
FILED IN THE OFFICE OF THE SECRETARY OF STATE AS PROVIDED BY THE
GENERAL NOT FOR PROFIT CORPORATION ACT OF ILLINOIS, IN FORCE
JANUARY 1, A.D. 1987.

*Now Therefore, I, Jim Edgar, Secretary of State of the State
of Illinois, by virtue of the powers vested in me by law, do hereby
issue this certificate and attach hereto a copy of the Application
of the aforesaid corporation.*

In Testimony Whereof, I hereto set my hand and cause to
be affixed the Great Seal of the State of Illinois.

at the City of Springfield, this 3rd
day of FEBRUARY AD 1987 and
of the Independence of the United States
the two hundred and 11th



Jim Edgar

SECRETARY OF STATE

ATTACHMENT 5

NFP - 110.30
(Rev. Jan., 1987)

Submit in Duplicate

Remit payment in Check or Money
Order, payable to "Secretary of
State".

DO NOT SEND CASH!

JIM EDGAR
Secretary of State
State of Illinois

ARTICLES OF AMENDMENT
under the

GENERAL NOT FOR PROFIT CORPORATION ACT

File # 5257-740-

This Space For Use By
Secretary of State

Date 2-3-87

Filing Fee 25-

Clerk [Signature]

Pursuant to the provisions of "The General Not For Profit Corporation Act of 1986", the undersigned corporation hereby adopts these Articles of Amendment to its Articles of Incorporation.

ARTICLE ONE The name of the corporation is The Northwestern Memorial Group

(Note 1)

ARTICLE TWO The following amendment to the Articles of Incorporation was adopted on January
19 87 in the manner indicated below ("X" one box only.)

- ☐ By the affirmative vote of a majority of the directors in office, at a meeting of the board of directors, in accordance with Section 110.15. (Note 2)
- ☐ By written consent, signed by all the directors in office, in compliance with Sections 110.15 and 108.45 of this Act. (Note 3)
- ☒ By the members at a meeting of members entitled to vote by the affirmative vote of the members having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the articles of incorporation or the bylaws, in accordance with Section 110.20. (Note 4)
- ☐ By written consent signed by members entitled to vote having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the articles of incorporation, or the bylaws, in compliance with Sections 107.10 and 110.20 of this Act. (Note 4)

(INSERT RESOLUTION)

See attachment

0757 10219

(If space is insufficient, attach additional pages size 8 1/2 x 11)

The undersigned corporation has caused these articles to be signed by its duly authorized officers, each of whom affirm, under penalties of perjury, that the facts stated herein are true.

Dated January 26, 19 87

The Northwestern Memorial Group

attested by Ralph M. Weber
(Signature of Secretary or Assistant Secretary)

by David L. Everhart
(Signature of President or Vice President)

RALPH M. WEBER SECRETARY
(Type or Print Name and Title)

David L. Everhart, President
(Type or Print Name and Title)

NOTES AND INSTRUCTIONS

- NOTE 1:** State the true exact corporate name as it appears on the records of the Office of the Secretary of State, BEFORE any amendments herein reported.
- NOTE 2:** Directors may adopt amendments without member approval only when the corporation has no members, or no members entitled to vote.
- NOTE 3:** Director approval may be (1) by vote at a director's meeting (either annual or special) or (2) by consent, in writing, without a meeting.
- NOTE 4:** All amendments not adopted under Sec. 110.15 require (1) that the board of directors adopt a resolution setting forth the proposed amendment and (2) that the members approve the amendment.
- Member approval may be (1) by vote at a members meeting (either annual or special) or (2) by consent, in writing, without a meeting.
- To be adopted, the amendment must receive the affirmative vote or consent of the holders of at least 2/3 of the outstanding members entitled to vote on the amendment, (but if class voting applies, then also at least a 2/3 vote within each class is required).
- The articles of incorporation may supercede the 2/3 vote requirement by specifying any smaller or larger vote requirement not less than a majority of the outstanding votes of such members entitled to vote and not less than a majority within each when class voting applies. (Sec. 110.20)
- NOTE 5:** When a member approval is by written consent, all members must be given notice of the proposed amendment at least 5 days before the consent is signed. If the amendment is adopted, members who have not signed the consent must be promptly notified of the passage of the amendment. (Sec. 107.10 & 110.20)

FORM NFP-110.30

File No. _____

ARTICLES OF AMENDMENT
under the
GENERAL NOT FOR PROFIT
CORPORATION ACT

Filing Fee \$25

Filing Fee for Re-Filed Articles \$100

FILED

FEB 3 - 1987

JIM EDGAR
Secretary of State

RETURN TO
FEB 17 1987

Corporation Department
Secretary of State
Springfield, Illinois 62756
Telephone (217) 782-8961

ATTACHMENT 5

ATTACHMENT
TO
ARTICLES OF AMENDMENT
TO
ARTICLES OF INCORPORATION
OF
THE NORTHWESTERN MEMORIAL GROUP

Article 1 is revised to read as follows:

Article 1: The name of the corporation is NORTHWESTERN
MEMORIAL CORPORATION. *NR*

Article 4 is deleted in its entirety.

Article 5 is deleted in its entirety.

Article 6 is deleted in its entirety.

Article 7 is deleted in its entirety.

The following provisions are added:

Article 4: The corporation is organized and shall be operated exclusively for charitable, scientific or educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue Law (the "Internal Revenue Code")). In furtherance of such purposes, the corporation may:

(a) Promote and support the interests and purposes of organizations which provide health care, education or research and which fall within the categories of Section 501(c)(3) and Section 509(a)(1) or Section 509(a)(2) of the Internal Revenue Code.

(b) Raise funds for any or all of the organizations described in subparagraph (a) of this Article from the public and from all other sources available; receive and maintain such funds and expend principal and income therefrom in furtherance of these purposes.

(c) Establish, develop, sponsor, promote and/or conduct educational programs, scientific research, treatment facilities, hospitals, rehabilitation centers, housing centers, management services, human services programs and other charitable activities, all in promotion and support of the interests and purposes of the organizations described in subparagraph (a) of this Article.

(d) Own, lease or otherwise deal with all property, real and personal, to be used in furtherance of these purposes.

(e) Contract with other organizations, for profit and not-for-profit, with individuals, and with governmental agencies in furtherance of these purposes.

(f) Otherwise operate exclusively for charitable, scientific or educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code, in the course of which operation:

(i) No part of the net earnings of the corporation shall inure to the benefit of, or be distributable to, any private shareholder or individual, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth herein.

(ii) No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements), any political campaign on behalf of any candidate for public office, except as authorized under the Internal Revenue Code.

(iii) Notwithstanding any other provisions of these articles, the corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from Federal income tax under Section 501(c)(3) of the Internal Revenue Code or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code.

Article 5: The corporation shall have no members.

0737 1 0219

Article 6: In the event of the dissolution of the corporation, the board of directors, after paying or making provision for the payment of all of the liabilities of the corporation, shall distribute, in any proportions considered prudent, all of the assets of the corporation to Northwestern Memorial Foundation, an Illinois not-for-profit corporation, if then in existence and if qualified under Section 501(c)(3) of the Internal Revenue Code, otherwise in such manner, or to such organization or organizations organized and operated exclusively for charitable, educational or scientific purposes as shall at the time qualify as an exempt organization or organizations under Section 501(c)(3) of the Internal Revenue Code, as the board of directors shall determine. Any such assets not so disposed of shall be disposed of by a court of competent jurisdiction of the county in which the principal office of the corporation is then located, exclusively for such purposes or to such organization or organizations, as said court shall determine, which are organized and operated exclusively for such purposes.

Article 7: The corporation was incorporated on November 30, 1981 under the name, "The Northwestern Memorial Group."

Article 8: The corporation is not a condominium association as established under the Condominium Property Act, a cooperative housing corporation as defined in Section 216 of the Internal Revenue Code of 1986, as amended, or a homeowner's association which administers a common interest community as defined in Subsection (c) of Section 9-102 of the Illinois Code of Civil Procedure.

File Number 5257 740 3

SEAL OF THE STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE



Whereas, ARTICLES OF AMENDMENT RESTATING THE ARTICLES OF INCORPORATION OF NORTHWESTERN MEMORIAL CORPORATION, INCORPORATED UNDER THE LAWS OF THE STATE OF ILLINOIS HAVE BEEN FILED IN THE OFFICE OF THE SECRETARY OF STATE AS PROVIDED BY THE GENERAL NOT FOR PROFIT CORPORATION ACT OF ILLINOIS, IN FORCE JANUARY 1, A.D. 1987.

Now Therefore, I, Jim Edgar, Secretary of State of the State of Illinois, by virtue of the powers vested in me by law, do hereby issue this certificate and attach hereto a copy of the Application of the aforesaid corporation.

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, at the City of Springfield, this 5th day of FEBRUARY AD 1987 and of the Independence of the United States the two hundred and 11th.

Jim Edgar
 SECRETARY OF STATE

ATTACHMENT 5

NFP - 110.30
(Rev. Jan., 1987)

Submit in Duplicate

Remit payment in Check or Money
Order, payable to "Secretary of
State".

DO NOT SEND CASH

JIM EDGAR
Secretary of State
State of Illinois

ARTICLES OF AMENDMENT

under the

GENERAL NOT FOR PROFIT CORPORATION ACT

File # 5257-240-3

Title Space For Use By
Secretary of State

Date 2-5-87

Filing Fee 100

Clerk AR

Pursuant to the provisions of "The General Not For Profit Corporation Act of 1986", the undersigned corporation hereby adopts these Articles of Amendment to its Articles of Incorporation.

ARTICLE ONE The name of the corporation is Northwestern Memorial Corporation

(Note 1)

ARTICLE TWO The following amendment to the Articles of Incorporation was adopted on January
19 87 in the manner indicated below ("X" one box only.)

- ☐ By the affirmative vote of a majority of the directors in office, at a meeting of the board of directors, in accordance with Section 110.15. (Note 2)
- ☐ By written consent, signed by all the directors in office, in compliance with Sections 110.15 and 108.45 of this Act. (Note 3)
- ☒ By the members at a meeting of members entitled to vote by the affirmative vote of the members having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the articles of incorporation or the bylaws, in accordance with Section 110.20. (Note 4)
- ☐ By written consent signed by members entitled to vote having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the articles of incorporation, or the bylaws, in compliance with Sections 107.10 and 110.20 of this Act. (Note 4)

(INSERT RESOLUTION)

See attachment

(If space is insufficient, attach additional pages size 8 1/2 x 11)

The undersigned corporation has caused these articles to be signed by its duly authorized officers, each of whom affirm, under penalty of perjury, that the facts stated herein are true.

Dated February 5, 19 87

Northwestern Memorial Corporation

attested by Anne B. Blancon
(Signature of Secretary or Assistant Secretary)

by Gary A. Mecklenburg
(Signature of President or Vice President)

Anne B. Blancon, Asst. Secretary
(Type or Print Name and Title)

Gary A. Mecklenburg, President
(Type or Print Name and Title)

NOTES AND INSTRUCTIONS

- NOTE 1: State the true exact corporate name as it appears on the records of the Office of the Secretary of State, BEFORE any amendments herein reported.
- NOTE 2: Directors may adopt amendments without member approval only when the corporation has no members, or no members entitled to vote.
- NOTE 3: Director approval may be (1) by vote at a director's meeting (either annual or special) or (2) by consent, in writing, without a meeting.
- NOTE 4: All amendments not adopted under Sec. 110.15 require (1) that the board of directors adopt a resolution setting forth the proposed amendment and (2) that the members approve the amendment.
- Member approval may be (1) by vote at a members meeting (either annual or special) or (2) by consent, in writing, without a meeting.
- To be adopted, the amendment must receive the affirmative vote or consent of the holders of at least 2/3 of the outstanding members entitled to vote on the amendment, (but if class voting applies, then also at least a 2/3 vote within each class is required).
- The articles of incorporation may supersede the 2/3 vote requirement by specifying any smaller or larger vote requirement not less than a majority of the outstanding votes of such members entitled to vote and not less than a majority within each when class voting applies. (Sec. 110.20)
- NOTE 5: When a member approval is by written consent, all members must be given notice of the proposed amendment at least 5 days before the consent is signed. If the amendment is adopted, members who have not signed the consent must be promptly notified of the passage of the amendment. (Sec. 107.10 & 110.20)

FORM NFP-110.30

File No. _____

ARTICLES OF AMENDMENT

under the

GENERAL NOT FOR PROFIT

CORPORATION ACT

Filing Fee \$25

Filing Fee for Re-Statuted Articles \$100

F I L E

FEB 5 - 1987

JIM EDGAR

Secretary of State

RETURN TO:

Corporation Department
Secretary of State
Springfield, Illinois 62756
Telephone (217) 782-5961

ATTACHMENT 5

ATTACHMENT
TO
ARTICLES OF AMENDMENT
TO
ARTICLES OF INCORPORATION
OF
NORTHWESTERN MEMORIAL CORPORATION

Pursuant to Section 110.30 of the General Not For Profit Corporation Act of 1986 of the State of Illinois, the Articles of Incorporation of NORTHWESTERN MEMORIAL CORPORATION, an Illinois not-for-profit corporation, are hereby restated to read in their entirety as follows:

RESTATED ARTICLES OF INCORPORATION
OF
NORTHWESTERN MEMORIAL CORPORATION

Article 1: The name of the corporation is NORTHWESTERN MEMORIAL CORPORATION. ✓

Article 2: The duration of the corporation is perpetual.

Article 3: The name and address of the registered agent and the registered office are:

Registered Agent: Mitchell J. Wiet, Esq.
Registered Office: 750 North Lake Shore Drive ✓
Chicago, Cook County,
Illinois 60611

Article 4: The corporation is organized and shall be operated exclusively for charitable, scientific or educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue Law (the "Internal Revenue Code")). In furtherance of such purposes, the corporation may:

(a) Promote and support the interests and purposes of organizations which provide health care, education or research and which fall within the categories of Section 501(c)(3) and Section 509(a)(1) or Section 509(a)(2) of the Internal Revenue Code.

(b) Raise funds for any or all of the organizations described in subparagraph (a) of this Article from the public and from all other sources available; receive and maintain such funds and expend principal and income therefrom in furtherance of these purposes.

(c) Establish, develop, sponsor, promote and/or conduct educational programs, scientific research, treatment facilities, hospitals, rehabilitation centers, housing centers, management services, human services programs and other charitable activities, all in promotion and support of the interests and purposes of the organizations described in subparagraph (a) of this Article.

(d) Own, lease or otherwise deal with all property, real and personal, to be used in furtherance of these purposes.

(e) Contract with other organizations, for profit and not-for-profit, with individuals, and with governmental agencies in furtherance of these purposes.

(f) Otherwise operate exclusively for charitable, scientific or educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code, in the course of which operation:

(i) No part of the net earnings of the corporation shall inure to the benefit of, or be distributable to, any private shareholder or individual, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth herein.

(ii) No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements), any political campaign on behalf of any candidate for public office, except as authorized under the Internal Revenue Code.

(iii) Notwithstanding any other provisions of these articles, the corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from Federal income tax under Section 501(c)(3) of the Internal Revenue Code or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code.

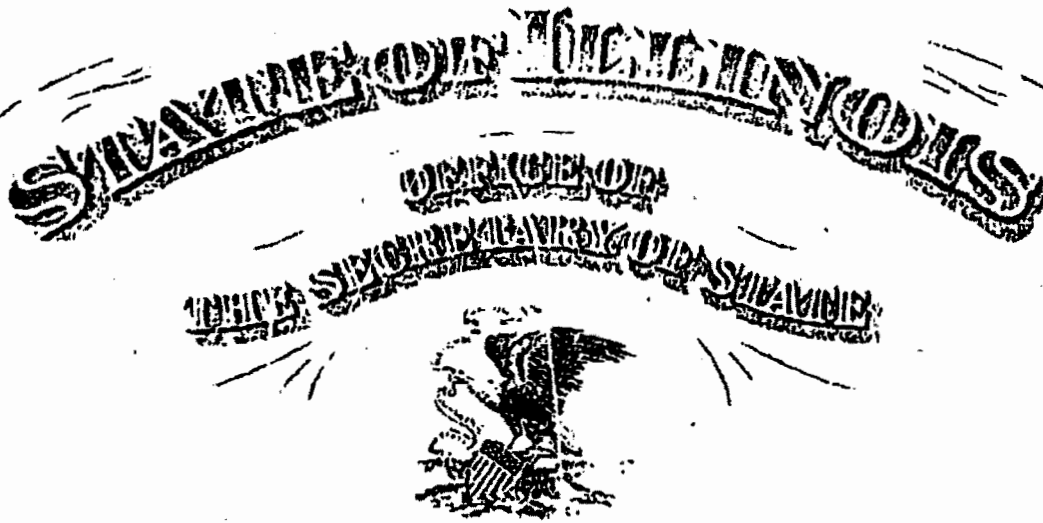
Article 5: The corporation shall have no members.

Article 6: In the event of the dissolution of the corporation, the board of directors, after paying or making provision for the payment of all of the liabilities of the corporation, shall distribute, in any proportions considered prudent, all of the assets of the corporation to Northwestern Memorial Foundation, an Illinois not-for-profit corporation, if then in existence and if qualified under Section 501(c)(3) of the Internal Revenue Code, otherwise in such manner, or to such organization or organizations organized and operated exclusively for charitable, educational or scientific purposes as shall at the time qualify as an exempt organization or organizations under Section 501(c)(3) of the Internal Revenue Code, as the board of directors shall determine. Any such assets not so disposed of shall be disposed of by a court of competent jurisdiction of the county in which the principal office of the corporation is then located, exclusively for such purposes or to such organization or organizations, as said court shall determine, which are organized and operated exclusively for such purposes.

Article 7: The corporation was incorporated on November 30, 1981 under the name, "The Northwestern Memorial Group." The corporation adopted the name, "Northwestern Memorial Corporation," pursuant to an amendment of its articles of incorporation, effective February 3, 1987.

Article 8: The corporation is not a condominium association as established under the Condominium Property Act, a cooperative housing corporation as defined in Section 216 of the Internal Revenue Code of 1986, as amended, or a homeowner's association which administers a common-interest community as defined in subsection (c) of Section 9-102 of the Illinois Code of Civil Procedure.

File Number 5257 740 3



Whereas, ARTICLES OF AMENDMENT TO THE ARTICLES OF
INCORPORATION OF

NORTHWESTERN MEMORIAL CORPORATION

INCORPORATED UNDER THE LAWS OF THE STATE OF ILLINOIS HAVE BEEN
FILED IN THE OFFICE OF THE SECRETARY OF STATE AS PROVIDED BY THE
GENERAL, NOT FOR PROFIT CORPORATION ACT OF ILLINOIS, IN FORCE
JANUARY 1, A.D. 1987.

*Now Therefore, I, Jim Edgar, Secretary of State of the State
of Illinois, by virtue of the powers vested in me by law, do hereby
issue this certificate and attach hereto a copy of the Application
of the aforesaid corporation.*

In Testimony Whereof, I have set my hand and cause to
be affixed the Great Seal of the State of Illinois.

at the City of Springfield, this 1st
day of NOVEMBER AD 1990 and
of the Independence of the United States
the two hundred and 15th

Jim Edgar

SECRETARY OF STATE

ATTACHMENT 5

NFP-110.30
(Rev. Jan., 1987)

Submit in Duplicate

Remit payment in Check or Money
Order, payable to "Secretary of
State".

DO NOT SEND CASH!

JIM EDGAR
Secretary of State
State of Illinois

ARTICLES OF AMENDMENT
under the

GENERAL NOT FOR PROFIT CORPORATION ACT

File # 5257-740-

This Space For Use By Secretary of State	
Date	11-1-90
Filing Fee	25
Clerk	(signature)

Pursuant to the provisions of "The General Not For Profit Corporation Act of 1986", the undersigned corporation hereby adopts these Articles of Amendment to its Articles of Incorporation.

ARTICLE ONE The name of the corporation is Northwestern Memorial
Corporation (Note 1)

ARTICLE TWO The following amendment to the Articles of Incorporation was adopted on April 23
19 90 in the manner indicated below ("X" one box only.)

- ☒ By the affirmative vote of a majority of the directors in office, at a meeting of the board of directors, in accordance with Section 110.15. (Note 2)
- ☐ By written consent, signed by all the directors in office, in compliance with Sections 110.15 and 108.45 of this Act. (Note 3)
- ☐ By the members at a meeting of members entitled to vote by the affirmative vote of the members having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the articles of incorporation or the bylaws, in accordance with Section 110.20. (Note 4)
- ☐ By written consent signed by members entitled to vote having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the articles of incorporation, or the bylaws, in compliance with Sections 107.10 and 110.20 of this Act. (Note 4)

(INSERT RESOLUTION)

See Attached.

PAID

NOV 7 1990

(If space is insufficient, attach additional pages size 8 1/2 x 11)

The undersigned corporation has caused these articles to be signed by its duly authorized officers, each of whom affirm, under penalties of perjury, that the facts stated herein are true.

Dated October 23, 19 90 Northwestern Memorial Corporation

attested by Anne B. Blanton by Gary A. Mecklenburg
(Signature of Secretary or Assistant Secretary) (Signature of President or Vice President)
Anne B. Blanton-Assistant Secretary Gary A. Mecklenburg-President
(Type or Print Name and Title) (Type or Print Name and Title)

NOTES AND INSTRUCTIONS

- NOTE 1: State the true exact corporate name as it appears on the records of the Office of the Secretary of State, BEFORE any amendments herein reported.
- NOTE 2: Directors may adopt amendments without member approval only when the corporation has no members, or no members entitled to vote.
- NOTE 3: Director approval may be (1) by vote at a directors meeting (either annual or special) or (2) by consent, in writing, without a meeting.
- NOTE 4: All amendments not adopted under Sec. 110.15 require (1) that the board of directors adopt a resolution setting forth the proposed amendment and (2) that the members approve the amendment.
- Member approval may be (1) by vote at a members meeting (either annual or special) or (2) by consent, in writing, without a meeting.
- To be adopted, the amendment must receive the affirmative vote or consent of the holders of at least 2/3 of the outstanding members entitled to vote on the amendment (but if class voting applies, then also at least a 2/3 vote within each class is required).
- The articles of incorporation may supercede the 2/3 vote requirement by specifying any smaller or larger vote requirement not less than a majority of the outstanding votes of such members entitled to vote and not less than a majority within each class when class voting applies. (Sec. 110.20)
- NOTE 5: When a member approval is by written consent, all members must be given notice of the proposed amendment at least 5 days before the consent is signed. If the amendment is adopted, members who have not signed the consent must be promptly notified of the passage of the amendment. (Sec. 107.10 & 110.20)

FORM NFP-110.30

File No. _____

ARTICLES OF AMENDMENT
 under the
 GENERAL NOT FOR PROFIT
 CORPORATION ACT

Filing Fee \$25

Filing Fee for Re-Filed Articles \$100

FILED

NOTARY PUBLIC
 Secretary of State

RETURN TO:

Corporation Department
 Secretary of State
 Springfield, Illinois 62756
 Telephone (217) 782-6951

ATTACHMENT 5

ATTACHMENT TO
ARTICLES OF AMENDMENT TO
ARTICLES OF INCORPORATION OF
NORTHWESTERN MEMORIAL CORPORATION

Pursuant to Section 110.30 of the General Not For Profit Corporation Act of 1986 of the State of Illinois, the Articles of Incorporation of NORTHWESTERN MEMORIAL CORPORATION, an Illinois not-for-profit corporation, are hereby amended as follows:

Article 4 is revised to read as follows:

Article 4. The corporation is organized and shall be operated exclusively for charitable, scientific or educational purposes within the meaning of § 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue Law (the "Internal Revenue Code")), to promote and support, directly or indirectly, by donation, loan or otherwise, the interests and purposes of Northwestern Memorial Hospital, an organization which qualifies as a tax-exempt organization under § 501(c)(3) of the Internal Revenue Code and as a public charity under § 509(a)(1) of the Internal Revenue Code, and, in furtherance of these purposes, the corporation may:

(a) raise funds from the public and from all other sources available, receive and maintain such funds and expend principal and income therefrom;

(b) establish, develop, sponsor, promote and/or conduct, directly or indirectly, educational programs, scientific research, treatment facilities, hospitals, rehabilitation centers, housing centers, management services, human services programs and other charitable activities;

(c) own, lease or otherwise deal with all property, real and personal, to be used in furtherance of these purposes;

(d) contract with other organizations, for-profit and not-for-profit, with individuals, and with governmental agencies in furtherance of these purposes; and

(e) otherwise operate exclusively for charitable, scientific or educational purposes within the meaning of § 501(c)(3) of the Internal Revenue Code, in the course of which operation:

(i) No part of the net earnings of the corporation shall inure to the benefit of, or be distributable to, any private shareholder or individual, except that the

44

corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth herein.

(ii) No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office except as authorized under the Internal Revenue Code.

(iii) Notwithstanding any other provisions of these articles, the corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from Federal income tax under Section 501(c)(3) of the Internal Revenue Code or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code.

Article 5 is revised to read as follows:

Article 5: The sole member of the corporation shall be Northwestern Healthcare Network, an Illinois not-for-profit corporation. The member shall have the powers set forth in the corporation's bylaws.

The following provision is added:

Article 9: The power to alter, amend or repeal these Articles of Incorporation shall be vested in the board of directors of the corporation, provided, however, that except as set forth in the corporation's bylaws, the sole member of the corporation shall approve all amendments to the corporation's articles of incorporation concerning the corporation's relationship to Northwestern Healthcare Network. Except as set forth in the corporation's bylaws, the corporation shall not, without the approval of the member, approve amendments to the articles of incorporation of organizations of which the corporation is either a member or shareholder, which amendments concern their or the corporation's relationship to Northwestern Healthcare Network.

4101c

File Number 5257-740-3

State of Illinois
Office of
The Secretary of State

Whereas, ARTICLES OF AMENDMENT TO THE ARTICLES OF
INCORPORATION OF
NORTHWESTERN MEMORIAL CORPORATION
INCORPORATED UNDER THE LAWS OF THE STATE OF ILLINOIS HAVE BEEN
FILED IN THE OFFICE OF THE SECRETARY OF STATE AS PROVIDED BY THE
GENERAL NOT FOR PROFIT CORPORATION ACT OF ILLINOIS, IN FORCE
JANUARY 1, A.D. 1987.

Now Therefore, I, Jesse White, Secretary of State of the State of Illinois, by virtue of the powers vested in me by law, do hereby issue this certificate and attach hereto a copy of the Application of the aforesaid corporation.

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, at the City of Springfield, this 31ST day of JANUARY A.D. 2001 and of the Independence of the United States the two hundred and 25TH



C-212.3

Jesse White

Secretary of State

ATTACHMENT 5

NFP-110.30
(Rev. Jan. 1999)

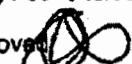
Submit In Duplicate
Remit payment in check or money
order, payable to "Secretary of
State."

DO NOT SEND CASH!

JESSE WHITE
Secretary of State
State of Illinois

ARTICLES OF AMENDMENT
under the
GENERAL NOT FOR PROFIT
CORPORATION ACT

File # 5257-740-3

This Space For Use By Secretary of State	
Date	1/31/01
Filing Fee	\$25.00
Approved	

PAID
FEB 01 2001

Pursuant to the provisions of "The General Not For Profit Corporation Act of 1986," the undersigned corporation hereby adopts these Articles of Amendment to its Articles of Incorporation.

ARTICLE ONE The name of the corporation is Northwestern Memorial Corporation
(Note 1)

ARTICLE TWO The following amendment to the Articles of Incorporation was adopted on January 17
2001 in the manner indicated below ("X" one box only.)
(Year) (Month & Day)

- ☒ By the affirmative vote of a majority of the directors in office, at a meeting of the board of directors, in accordance with Section 110.15. (Note 2)
- ☐ By written consent, signed by all the directors in office, in compliance with Sections 110.15 and 108.45 of this Act. (Note 3)
- ☐ By the members at a meeting of members entitled to vote by the affirmative vote of the members having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the articles of incorporation or the bylaws, in accordance with Section 110.20. (Note 4)
- ☐ By written consent signed by members entitled to vote having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the articles of incorporation, or the bylaws, in compliance with Sections 107.10 and 110.20 of this Act. (Note 5)

(INSERT RESOLUTION)

RESOLVED THAT:

The Board of Directors approves the amendment of Article One of the Corporation's Articles of Incorporation to read as follows:

The name of the corporation is Northwestern Memorial HealthCare.


PER MIKE IGO

(If space is insufficient, attach additional pages size 8 1/2 x 11)

The undersigned corporation has caused these articles to be signed by its duly authorized officers, each of whom affirm, under penalties of perjury, that the facts stated herein are true. (All signatures must be in **BLACK INK**.)

Dated January 18, 2001 Northwestern Memorial Corporation
 (Month & Day) (Year) (Exact Name of Corporation)
 attested by Joy V. Cunningham by Gary A. Mecklenburg
 (Signature of Secretary or Assistant Secretary) (Signature of President or Vice President)
Joy V. Cunningham, Secretary Gary A. Mecklenburg, President
 (Type or Print Name and Title) (Type or Print Name and Title)

NOTES AND INSTRUCTIONS

- NOTE 1:** State the true exact corporate name as it appears on the records of the Office of the Secretary of State, **BEFORE** any amendments herein reported.
- NOTE 2:** Directors may adopt amendments without member approval only when the corporation has no members, or no members entitled to vote.
- NOTE 3:** Director approval may be (1) by vote at a director's meeting (either annual or special) or (2) consent, in writing, without a meeting.
- NOTE 4:** All amendments not adopted under Sec. 110.15 require (1) that the board of directors adopt a resolution setting forth the proposed amendment and (2) that the members approve the amendment.
- Member approval may be (1) by vote at a members meeting (either annual or special) or (2) by consent, in writing, without a meeting.
- To be adopted, the amendment must receive the affirmative vote or consent of the holders of at least 2/3 of the outstanding members entitled to vote on the amendment, (but if class voting applies, then also at least a 2/3 vote within each class is required).
- The articles of incorporation may supersede the 2/3 vote requirement by specifying any smaller or larger vote requirement not less than a majority of the outstanding votes of such members entitled to vote and not less than a majority within each when class voting applies. (Sec. 110.20)
- NOTE 5:** When a member approval is by written consent, all members must be given notice of the proposed amendment at least 5 days before the consent is signed. If the amendment is adopted, members who have not signed the consent must be promptly notified of the passage of the amendment. (Sec. 107.10 & 110.20)

FORM NFP-110.30

File No.

ARTICLES OF AMENDMENT
 under the
 GENERAL NOT FOR PROFIT
 CORPORATION ACT

Filing Fee \$25

FILED

JAN 31 2001

JESSE WHITE
 SECRETARY OF STATE

RETURN TO:

Department of Business Services
 Secretary of State
 Springfield, Illinois 62756
 Telephone (217) 782-1832
 http://www.sos.state.il.us

C-130.10

ATTACHMENT 5

4/8

FORM NFP 110.30 (rev. Dec. 2003)
ARTICLES OF AMENDMENT
General Not For Profit Corporation Act

Jesse White, Secretary of State
Department of Business Services
501 S. Second St., Rm. 350
Springfield, IL 62756
217-782-1832
www.cyberdriveillinois.com

Filed: 2/1/2010 Jesse White Secretary of State



CP0982782

File #

52577403

Filing Fee: \$25

Approved: MJE

----- Submit in duplicate ----- Type or Print clearly in black ink ----- Do not write above this line -----

1. Corporate Name (See Note 1 on back.): Northwestern Memorial HealthCare

2. Manner of Adoption of Amendment:

The following amendment to the Articles of Incorporation was adopted on September 21, 2009 in the man-
ner indicated below (check one only):
Month, Day & Year

- ☒ By affirmative vote of a majority of the directors in office, at a meeting of the board of directors, in accordance with Section 110.15. (See Note 2 on back.)
- ☐ By written consent, signed by all the directors in office, in compliance with Sections 110.15 and 108.45. (See Note 3 on back.)
- ☐ By members at a meeting of members entitled to vote by the affirmative vote of the members having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the Articles of Incorporation or the bylaws, in accordance with Section 110.20. (See Note 4 on back.)
- ☐ By written consent signed by members entitled to vote having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the Articles of Incorporation, or the bylaws, in compliance with Sections 107.10 and 110.20. (See Note 5 on back.)

3. Text of Amendment:

(a.) When an amendment effects a name change, insert the new corporate name below. Use 3(b.) below for all other amendments. *Article 1: The Name of the Corporation is:

New Name

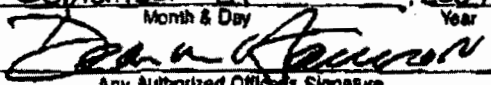
(b.) All amendments other than name change.

If the amendment affects the corporate purpose, the amended purpose is required to be set forth in its entirety. If there is not sufficient space to add the full text of the amendment, attach additional sheets of this size.

(See Attached)

4. The undersigned Corporation has caused these Articles to be signed by a duly authorized officer who affirms, under penalties of perjury, that the facts stated herein are true and correct.

All signatures must be in BLACK INK.

Dated September 21, 2009 Northwestern Memorial HealthCare
Month & Day Year Exact Name of Corporation

Any Authorized Officer's Signature
Dean M. Harrison, President and CEO
Name and Title (type or print)

5. If there are no duly authorized officers, the persons designated under Section 101.10(b)(2) must sign below and print name and title.

The undersigned affirms, under penalties of perjury, that the facts stated herein are true.

Dated _____	_____
Month & Day Year	
_____ Signature	_____ Name and Title (print)
_____ Signature	_____ Name and Title (print)
_____ Signature	_____ Name and Title (print)
_____ Signature	_____ Name and Title (print)

NOTES

- State the true and exact corporate name as it appears on the records of the Secretary of State BEFORE any amendment herein is reported.
- Directors may adopt amendments without member approval only when the corporation has no members, or no members entitled to vote pursuant to §110.15.
- Director approval may be:
 - by vote at a director's meeting (either annual or special), or
 - by consent, in writing, without a meeting.
- All amendments not adopted under Sec. 110.15 require that:
 - the board of directors adopt a resolution setting forth the proposed amendment, and
 - the members approve the amendment.

Member approval may be:

- by vote at a members meeting (either annual or special), or
- by consent, in writing, without a meeting.

To be adopted, the amendment must receive the affirmative vote or consent of the holders of at least two-thirds of the outstanding members entitled to vote on the amendment (but if class voting applies, also at least a two-thirds vote within each class is required).

The Articles of Incorporation may supersede the two-thirds vote requirement by specifying any smaller or larger vote requirement not less than a majority of the outstanding votes of such members entitled to vote, and not less than a majority within each class when class voting applies. (Sec. 110.20)

- When member approval is by written consent, all members must be given notice of the proposed amendment at least five days before the consent is signed. If the amendment is adopted, members who have not signed the consent must be promptly notified of the passage of the amendment. (Sec. 107.10 & 110.20)

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**ATTACHMENT TO
ARTICLES OF AMENDMENT TO ARTICLES OF INCORPORATION OF
NORTHWESTERN MEMORIAL HEALTHCARE**

Article 4 is revised to read as follows:

Article 4. Corporate Purposes. The corporation is organized and shall be operated exclusively for charitable, scientific or educational purposes within the meaning of § 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue Law (the "Internal Revenue Code")), to promote and support, directly or indirectly, by donation, loan or otherwise, the interests and purposes of Northwestern Memorial Hospital and Lake Forest Hospital, organizations which qualify as tax-exempt organizations under § 501(c)(3) of the Internal Revenue Code and as a public charity under § 509(a)(1) of the Internal Revenue Code, and, in furtherance of these purposes, the corporation may:

- (a) raise funds from the public and from all other sources available, receive and maintain such funds and expend principal and income therefrom;
- (b) establish, develop, sponsor, promote and or conduct, directly or indirectly, educational programs, scientific research, treatment facilities, hospitals, rehabilitation center, housing centers, management services, human services programs and other charitable activities;
- (c) own, lease or otherwise deal with all property, real and personal, to be used in furtherance of these purposes;
- (d) contract with other organizations, for-profit and not-for-profit, with individuals, and with governmental agencies in furtherance of these purposes; and
- (e) otherwise operate exclusively for charitable, scientific or educational purposes within the meaning of § 501(c)(3) of the Internal Revenue Code, in the course of which operation:
 - (i) No part of the net earnings of the corporation shall inure to the benefit of, or be distributable to, any private shareholder or individual, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth herein.
 - (ii) No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office except as authorized under the Internal Revenue Code.

(iii) Notwithstanding any other provisions of these bylaws, the corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from Federal income tax under Section 501(c)(3) of the Internal Revenue Code or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code.

Article 5 is revised to read as follows:

Article 5. The corporation shall have no members.

Article 9 is revised to read as follows:

Article 9. The power to alter, amend or repeal these Articles of Incorporation shall be vested in the board of directors of the corporation.

File Number 5257-740-3



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

THE FOREGOING AND HERETO ATTACHED IS A TRUE AND CORRECT COPY, CONSISTING OF 36 PAGES, AS TAKEN FROM THE ORIGINAL ON FILE IN THIS OFFICE FOR NORTHWESTERN MEMORIAL HEALTHCARE. *****



In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 23RD
day of AUGUST A.D. 2013

Jesse White

SECRETARY OF STATE

Authentication #: 1323501563

Authenticate at: <http://www.cyberdriveillinois.com>

ATTACHMENT 5

Articles of Amendment
to
Articles of Incorporation



OFFICE OF THE SECRETARY OF STATE

JESSE WHITE • Secretary of State

SEPTEMBER 3, 2013

5257-740-3

CT CORPORATION SYSTEM
600 S 2ND ST
SPRINGFIELD IL 62704

RE NORTHWESTERN MEMORIAL HEALTHCARE

DEAR SIR OR MADAM:

ENCLOSED YOU WILL FIND THE ARTICLES OF AMENDMENT FOR THE ABOVE NAMED CORPORATION.

FEES IN THIS CONNECTION HAVE BEEN RECEIVED AND CREDITED.

SINCERELY,

A handwritten signature in cursive script that reads "Jesse White".

JESSE WHITE
SECRETARY OF STATE
DEPARTMENT OF BUSINESS SERVICES
CORPORATION DIVISION
TELEPHONE (217) 782-6961

ATTACHMENT 5

FILED

SEP 3 - 2013

JESSE WHITE
SECRETARY OF STATE

Jesse White, Secretary of State
Department of Business Services
501 S. Second St., Rm. 350
Springfield, IL 62756
217-782-1832
www.cyberdriveillinois.com

Remit payment in the form of a
check or money order payable
to Secretary of State.

File #

5257-740-3

Filing Fee: \$25

Approved: _____

----- Submit in duplicate ----- Type or Print clearly in black ink ----- Do not write above this line -----

1. Corporate Name (See Note 1 on back.): Northwestern Memorial HealthCare

2. Manner of Adoption of Amendment:

The following amendment to the Articles of Incorporation was adopted on August 28, 2013 in the man-
ner indicated below (check one only):
Month, Day & Year

- ☒ By affirmative vote of a majority of the directors in office, at a meeting of the board of directors, in accordance with Section 110.15. (See Note 2 on back.)
- ☐ By written consent, signed by all the directors in office, in compliance with Sections 110.15 and 108.45. (See Note 3 on back.)
- ☐ By members at a meeting of members entitled to vote by the affirmative vote of the members having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the Articles of Incorporation or the bylaws, in accordance with Section 110.20. (See Note 4 on back.)
- ☐ By written consent signed by members entitled to vote having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the Articles of Incorporation, or the bylaws, in compliance with Sections 107.10 and 110.20. (See Note 5 on back.)

3. Text of Amendment:

(a.) When an amendment effects a name change, insert the new corporate name below. Use 3(b.) below for all other amendments. *Article 1: The Name of the Corporation is:

New Name

(b.) All amendments other than name change.

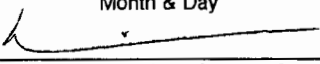
If the amendment affects the corporate purpose, the amended purpose is required to be set forth in its entirety. If there is not sufficient space to add the full text of the amendment, attach additional sheets of this size.

See Attachment.

SL

4. The undersigned Corporation has caused these Articles to be signed by a duly authorized officer who affirms, under penalties of perjury, that the facts stated herein are true and correct.

All signatures must be in BLACK INK.

Dated August 28, 2013 Northwestern Memorial HealthCare
Month & Day Year Exact Name of Corporation

Any Authorized Officer's Signature
Carol Lind, Secretary
Name and Title (type or print)

5. If there are no duly authorized officers, the persons designated under Section 101.10(b)(2) must sign below and print name and title.

The undersigned affirms, under penalties of perjury, that the facts stated herein are true.

Dated _____, _____
Month & Day Year

_____ Signature	_____ Name and Title (print)
_____ Signature	_____ Name and Title (print)
_____ Signature	_____ Name and Title (print)
_____ Signature	_____ Name and Title (print)

NOTES

1. State the true and exact corporate name as it appears on the records of the Secretary of State BEFORE any amendment herein is reported.
2. Directors may adopt amendments without member approval only when the corporation has no members, or no members entitled to vote pursuant to §110.15.
3. Director approval may be:
 - a. by vote at a director's meeting (either annual or special), or
 - b. by consent, in writing, without a meeting.
4. All amendments not adopted under Sec. 110.15 require that:
 - a. the board of directors adopt a resolution setting forth the proposed amendment, and
 - b. the members approve the amendment.

Member approval may be:

- a. by vote at a members meeting (either annual or special), or
- b. by consent, in writing, without a meeting.

To be adopted, the amendment must receive the affirmative vote or consent of the holders of at least two-thirds of the outstanding members entitled to vote on the amendment (but if class voting applies, also at least a two-thirds vote within each class is required).

The Articles of Incorporation may supersede the two-thirds vote requirement by specifying any smaller or larger vote requirement not less than a majority of the outstanding votes of such members entitled to vote, and not less than a majority within each class when class voting applies. (Sec. 110.20)

5. When member approval is by written consent, all members must be given notice of the proposed amendment at least five days before the consent is signed. If the amendment is adopted, members who have not signed the consent must be promptly notified of the passage of the amendment. (Sec. 107.10 & 110.20)

The State of Illinois

Jesse White

Secretary of State

Department of Business Services

501 S. Second Street, Room 350, Springfield, IL 62756

Attachment to Articles of Amendment of Northwestern Memorial HealthCare

Article 4 is amended in its entirety and replaced with the following:

Article 4. The corporation is organized and shall be operated exclusively for charitable, scientific or educational purposes within the meaning of § 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue Law) (the "Internal Revenue Code"), to promote and support, directly or indirectly, by donation, loan or otherwise, the interests and purposes of Northwestern Memorial Hospital, Northwestern Lake Forest Hospital, and Northwestern Medical Faculty Foundation, doing business as Northwestern Medical Group, each of which qualify as tax-exempt organizations under § 501(c)(3) of the Internal Revenue Code and as public charities under § 509(a)(1) of the Internal Revenue Code, and, in furtherance of these purposes, the corporation may:

(a) raise funds from the public and from all other sources available, receive and maintain such funds and expend principal and income therefrom;

(b) establish, develop, sponsor, promote and or conduct, directly or indirectly, educational programs, scientific research, treatment facilities, hospitals, rehabilitation center, housing centers, management services, human services programs and other charitable activities;

(c) own, lease or otherwise deal with all property, real and personal, to be used in furtherance of these purposes;

(d) contract with other organizations, for-profit and not-for-profit, with individuals, and with governmental agencies in furtherance of these purposes; and

(e) otherwise operate exclusively for charitable, scientific or educational purposes within the meaning of § 501(c)(3) of the Internal Revenue Code, in the course of which operation:

(i) No part of the net earnings of the corporation shall inure to the benefit of, or be distributable to, any private shareholder or individual, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth herein.

(ii) No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office except as authorized under the Internal Revenue Code.

(iii) Notwithstanding any other provisions of these bylaws, the corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from Federal income tax under Section 501(c)(3) of the Internal Revenue Code or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code.

Medicare Enrollment Applications



MEDICARE ENROLLMENT APPLICATION

**Clinics/Group Practices
and Certain Other Suppliers**

CMS-855B

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 35 TO FIND A LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.



ATTACHMENT 5

WHO SHOULD SUBMIT THIS APPLICATION

Clinics and group practices can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper enrollment application process (e.g., CMS 855B).

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to <http://www.cms.gov/MedicareProviderSupEnroll>.

Clinics and group practices who are enrolled in the Medicare program, but have not submitted the CMS 855B since 2003, are required to submit a Medicare enrollment application (i.e., Internet-based PECOS or the CMS 855B) as an initial application when reporting a change for the first time.

The following suppliers must complete this application to initiate the enrollment process:

- | | |
|--|--|
| • Ambulance Service Supplier | • Mammography Center |
| • Ambulatory Surgical Center | • Mass Immunization (Roster Biller Only) |
| • Clinic/Group Practice | • Part B Drug Vendor |
| • Independent Clinical Laboratory | • Portable X-ray Supplier |
| • Independent Diagnostic Testing Facility (IDTF) | • Radiation Therapy Center |
| • Intensive Cardiac Rehabilitation Supplier | |

If your supplier type is not listed above, contact your designated fee-for-service contractor before you submit this application.

Complete and submit this application if you are an organization/group that plans to bill Medicare and you are:

- A **medical practice or clinic that will bill for Medicare Part B services** (e.g., group practices, clinics, independent laboratories, portable x-ray suppliers).
- A **hospital or other medical practice or clinic** that may bill for Medicare Part A services but will also bill for Medicare Part B practitioner services or provide purchased laboratory tests to other entities that bill Medicare Part B.
- **Currently enrolled with a Medicare fee-for-service contractor but need to enroll in another fee-for-service contractor's jurisdiction** (e.g., you have opened a practice location in a geographic territory serviced by another Medicare fee-for-service contractor).
- **Currently enrolled in Medicare and need to make changes to your enrollment data** (e.g., you have added or changed a practice location). Changes must be reported in accordance with the timeframes established in 42 C.F.R. § 424.516(d). (IDTF changes of information must be reported in accordance with 42 C.F.R. § 410.33.)

BILLING NUMBER INFORMATION

The National Provider Identifier (NPI) is the standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES). **As a Medicare health supplier, you must obtain an NPI prior to enrolling in Medicare or before submitting a change for your existing Medicare enrollment information.** Applying for an NPI is a process separate from Medicare enrollment. As a supplier, it is your responsibility to determine if you have "subparts." A subpart is a component of an organization (supplier) that furnishes healthcare and is not itself a legal entity. If you do have subparts, you must determine if they should obtain their own unique NPIs. Before you complete this enrollment application, you need to make those determinations and obtain NPI(s) accordingly.

ATTACHMENT 5

Important: For NPI purposes, sole proprietors and sole proprietorships are considered to be "Type 1" providers. Organizations (e.g., corporations, partnerships) are treated as "Type 2" entities. When reporting the NPI of a sole proprietor on this application, therefore, the individual's Type 1 NPI should be reported; for organizations, the Type 2 NPI should be furnished.

To obtain an NPI, you may apply online at <https://NPES.cms.hhs.gov>. For more information about subparts, visit www.cms.gov/NationalProvIdentStand to view the "Medicare Expectations Subparts Paper."

The Medicare Identification Number, often referred to as a Provider Transaction Access Number (PTAN) or Medicare "legacy" number, is a generic term for any number other than the NPI that is used to identify a Medicare supplier.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

- Type or print all information so that it is legible. Do not use pencil.
- Report additional information within a section by copying and completing that section for each additional entry.
- Attach all required supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your records.
- Send the completed application with original signatures and all required documentation to your designated Medicare fee-for-service contractor.

AVOID DELAYS IN YOUR ENROLLMENT

To avoid delays in the enrollment process, you should:

- Complete all required sections.
- Ensure that the legal business name shown in Section 2 matches the name on the tax documents.
- Ensure that the correspondence address shown in Section 2 is the supplier's address.
- Enter your NPI in the applicable sections.
- Enter all applicable dates.
- Ensure that the correct person signs the application.
- Send your application and all supporting documentation to the designated fee-for-service contractor.

ADDITIONAL INFORMATION

For additional information regarding the Medicare enrollment process, visit www.cms.gov/MedicareProviderSupEnroll.

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support and validate information reported on the application. You are responsible for providing this documentation in a timely manner.

Certain information you provide on this application is considered to be protected under 5 U.S.C. Section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application for the Privacy Act Statement.

MAIL YOUR APPLICATION

The Medicare fee-for-service contractor (also referred to as a carrier or a Medicare administrative contractor) that services your State is responsible for processing your enrollment application. To locate the mailing address for your fee-for-service contractor, go to www.cms.gov/MedicareProviderSupEnroll.

ATTACHMENT 5

SECTION 1: BASIC INFORMATION

NEW ENROLLEES AND THOSE WITH A NEW TAX ID NUMBER

If you are:

- Enrolling in the Medicare program for the first time with this Medicare fee-for-service contractor under this tax identification number.
- Already enrolled with a Medicare fee-for-service contractor but are establishing a practice location in another fee-for-service contractor's jurisdiction.
- Enrolled with a Medicare fee-for-service contractor but have a new tax identification number. If you are reporting a change to your tax identification number, you must complete a new application.
- A hospital or an individual hospital department that is enrolling with a fee-for-service contractor to bill for Part B services.

The following actions apply to Medicare suppliers already enrolled in the program:

ENROLLED MEDICARE SUPPLIERS

Reactivation

To reactivate your Medicare billing privileges, submit this enrollment application. In addition, prior to being reactivated, you must be able to submit a valid claim and meet all current requirements for your supplier type before reactivation may occur.

Voluntary Termination

A supplier should voluntarily terminate its Medicare enrollment when it:

- Will no longer be rendering services to Medicare patients, or
- Is planning to cease (or has ceased) operations.

Change of Ownership

If a hospital, ambulatory surgical center, or portable X-ray supplier is undergoing a change of ownership (CHOW) in accordance with the principles outlined in 42 C.F.R. 489.18, the entity must submit a new application for the new ownership.

Change of Information

A change of information should be submitted if you are changing, adding or deleting information under your current tax identification number.

Changes in your existing enrollment data must be reported to the fee-for-service contractor in accordance with 42 C.F.R. § 424.516 (Physician and Non Physician Practitioner Organizations). (IDTF changes of information must comply with the provisions found at 42 C.F.R. § 410.33.)

If you are already enrolled in Medicare and are not receiving Medicare payments via EFT, any change to your enrollment information will require you to submit a CMS-588 form. All future payments will then be made via EFT.

Revalidation

CMS may require you to submit or update your enrollment information. The fee-for-service contractor will notify you when it is time for you to revalidate your enrollment information. Do not submit a revalidation application until you have been contacted by the fee-for-service contractor.

ATTACHMENT 5

SECTION 1: BASIC INFORMATION**ALL APPLICANTS MUST COMPLETE THIS SECTION** (See instructions for details.)**A. Check one box and complete the required sections.**

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
☐ You are a new enrollee in Medicare	Enter your Medicare Identification Number (<i>if issued</i>) and the NPI you would like to link to this number in Section 4.	Complete all applicable sections Ambulance suppliers must complete Attachment 1 IDTF suppliers must complete Attachment 2
☐ You are enrolling in another fee-for-service contractor's jurisdiction	Enter your Medicare Identification Number (<i>if issued</i>) and the NPI you would like to link to this number in Section 4.	Complete all applicable sections Ambulance suppliers must complete Attachment 1 IDTF suppliers must complete Attachment 2
☐ You are reactivating your Medicare enrollment	Enter your Medicare Identification Number (<i>if issued</i>) and the NPI you would like to link to this number in Section 4. Medicare Identification Number(s) (<i>if issued</i>): National Provider Identifier (<i>if issued</i>):	Complete all applicable sections Ambulance suppliers must complete Attachment 1 IDTF suppliers must complete Attachment 2
☐ You are voluntarily terminating your Medicare enrollment. (This is not the same as "opting out" of the program)	Effective Date of Termination: Medicare Identification Number(s) to Terminate (<i>if issued</i>): National Provider Identifier (<i>if issued</i>):	Sections 1, 2B1, 13, and either 15 or 16 If you are terminating an employment arrangement with a physician assistant, complete Sections 1A, 2G, 13, and either 15 or 16

SECTION 1: BASIC INFORMATION (Continued)**ALL APPLICANTS MUST COMPLETE THIS SECTION (See instructions for details.)****A. Check one box and complete the required sections.**

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
☒ You are changing your Medicare information	Medicare Identification Number: 522620 National Provider Identifier (if issued): 1346235314	Go to Section 1B
☐ You are revalidating your Medicare enrollment	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	Complete all applicable sections Ambulance suppliers must complete Attachment 1 IDTF suppliers must complete Attachment 2

ATTACHMENT 5

SECTION 1: BASIC INFORMATION (Continued)**B. Check all that apply and complete the required sections:**

	REQUIRED SECTIONS
☐ Identifying Information	1, 2 (complete only those sections that are changing), 3, 13 , and either 15 (if you are an authorized official) or 16 (if you are a delegated official), and 6 for the signer if that authorized or delegated official has not been established for this supplier
☐ Final Adverse Actions/Convictions	1, 2B1, 3, 13 , and either 15 (if you are an authorized official) or 16 (if you are a delegated official), and 6 for the signer if that authorized or delegated official has not been established for this supplier
☐ Practice Location Information, Payment Address & Medical Record Storage Information	1, 2B1, 3, 4 (complete only those sections that are changing), 13 , and either 15 (if you are an authorized official) or 16 (if you are a delegated official), and 6 for the signer if that authorized or delegated official has not been established for this supplier
☐ Change of Ownership (Hospitals, Portable X-Ray Suppliers & Ambulatory Surgical Centers Only)	Complete all sections and provide a copy of the sales agreement
☒ Ownership Interest and/or Managing Control Information (Organizations)	1, 2B1, 3, 5, 13 , and either 15 (if you are an authorized official) or 16 (if you are a delegated official), and 6 for the signer if that authorized or delegated official has not been established for this supplier
☒ Ownership Interest and/or Managing Control Information (Individuals)	1, 2B1, 3, 6, 13 , and either 15 (if you are an authorized official) or 16 (if you are a delegated official), and 6 for the signer if that authorized or delegated official has not been established for this supplier
☐ Billing Agency Information	1, 2B1, 3, 8 (complete only those sections that are changing), 13 , and either 15 (if you are an authorized official) or 16 (if you are a delegated official), and 6 for the signer if that authorized or delegated official has not been established for this supplier
☐ Authorized Official(s)	1, 2B1, 3, 13, 15 or 16 (if you are a delegated official), and 6 for the signer if that authorized or delegated official has not been established for this supplier
☐ Delegated Official(s) (Optional)	1, 2B1, 3, 13, 15, 16 , and 6 for the signer if that delegated official has not been established for this supplier.

ATTACHMENT 5

SECTION 1: BASIC INFORMATION (Continued)

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS (ONLY)	REQUIRED SECTIONS
☐ Geographic Area	1, 2B1, 3, 13, and 15 if you are the authorized official or 16 if you are the delegated official Attachment 1(A)
☐ State License Information	1, 2B1, 3, 13, and 15 if you are the authorized official or 16 if you are the delegated official Attachment 1(B)
☐ Paramedic Intercept Services Information	1, 2B1, 3, 13, and 15 if you are the authorized official or 16 if you are the delegated official Attachment 1(C)
☐ Vehicle Information	1, 2B1, 3, 13, and 15 if you are the authorized official or 16 if you are the delegated official Attachment 1(D)
ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (ONLY)	REQUIRED SECTIONS
☐ CPT-4 and HCPCS Codes	1, 2B1, 3, 13, and 15 if you are the authorized official or 16 if you are the delegated official Attachment 2(B)
☐ Interpreting Physician Information	1, 2B1, 3, 13, and 15 if you are the authorized official or 16 if you are the delegated official Attachment 2(C)
☐ Personnel (Technicians) Who Perform Tests	1, 2B1, 3, 13, and 15 if you are the authorized official or 16 if you are the delegated official Attachment 2(D)
☐ Supervising Physician(s)	1, 2B1, 3, 13, and 15 if you are the authorized official or 16 if you are the delegated official Attachment 2(E)
☐ Liability Insurance Information	1, 2B1, 3, 13, and 15 if you are the authorized official or 16 if you are the delegated official Attachment 2(F)

ATTACHMENT 5

LP

SECTION 2: IDENTIFYING INFORMATION

A. Type of Supplier

Check the appropriate box to identify the type of supplier you are enrolling as with Medicare. If you are more than one type of supplier, submit a separate application for each type. If you change the type of service that you provide (i.e., become a different supplier type), submit a new application.

Your organization must meet all Federal and State requirements for the type of supplier checked below.

TYPE OF SUPPLIER: (Check one only)

- | | |
|--|--|
| ☐ Ambulance Service Supplier | ☐ Mass Immunization (Roster Biller Only) |
| ☐ Ambulatory Surgical Center | ☐ Pharmacy |
| ☒ Clinic/Group Practice | ☐ Physical/Occupational Therapy Group in Private Practice |
| ☐ Hospital Department(s) | ☐ Portable X-ray Supplier |
| ☐ Independent Clinical Laboratory | ☐ Radiation Therapy Center |
| ☐ Independent Diagnostic Testing Facility | ☐ Other (Specify): _____ |
| ☐ Intensive Cardiac Rehabilitation | |
| ☐ Mammography Center | |

B. Supplier Identification Information

1. BUSINESS INFORMATION

Legal Business Name (not the "Doing Business As" name) as reported to the Internal Revenue Service

Northwestern Medical Faculty Foundation

Tax Identification Number

36-3097297

Other Name

Northwestern Medical Group

Type of Other Name

- ☐ Former Legal Business Name
☒ Doing Business As Name
☐ Other (Specify): _____

Identify how your business is registered with the IRS. (NOTE: If your business is a Federal and/or State government provider or supplier, indicate "Non-Profit" below.)

☐ Proprietary ☒ Non-Profit

NOTE: If a checkbox indicating Proprietary or non-profit status is not completed, the provider/supplier will be defaulted to "Proprietary."

Identify the type of organizational structure of this provider/supplier (Check one)

- ☒ Corporation ☐ Limited Liability Company ☐ Partnership
☐ Sole Proprietor ☐ Other (Specify): _____

Incorporation Date (mm/dd/yyyy) (if applicable)

10/03/1980

State Where Incorporated (if applicable)

Illinois

Is this supplier an Indian Health Facility enrolling with the designated Indian Health Service (IHS) Medicare Administrative Contractor (MAC)?

☐ Yes ☒ No

ATTACHMENT 5

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

2. STATE LICENSE INFORMATION/CERTIFICATION INFORMATION

Provide the following information if the supplier has a State license/certification to operate as the supplier type for which you are enrolling.

☐ State License Not Applicable

License Number	State Where Issued
Effective Date (mm/dd/yyyy)	Expiration/Renewal Date (mm/dd/yyyy)

Certification Information

☐ Certification Not Applicable

Certification Number	State Where Issued
Effective Date (mm/dd/yyyy)	Expiration/Renewal Date (mm/dd/yyyy)

3. CORRESPONDENCE ADDRESS

Provide contact information for the entity or person listed in Question 1 of this section. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

Mailing Address Line 1 (Street Name and Number)

Mailing Address Line 2 (Suite, Room, etc.)

City/Town	State	ZIP Code + 4
Telephone Number	Fax Number (if applicable)	E-mail Address (if applicable)

C. Hospitals Only

This section should only be completed by hospitals that are currently enrolled or enrolling with a fee-for-service contractor (the Part A Medicare contractor), and will be billing a fee-for-service contractor for Medicare Part B services, as follows:

- Hospitals that need departmental billing numbers to bill for Part B practitioner services.
- Hospitals requiring a Part B billing number to provide pathology services.
- Hospitals requiring a Medicare Part B billing number to provide purchased tests to other Medicare Part B billers.
- If the hospital requires more than one departmental Part B billing number, list each department needing a number.

If your organization is not a hospital, and believes it will need a Part B billing number, contact the designated fee-for-service contractor to determine if this form should be submitted.

ATTACHMENT 5

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

C. Hospitals Only *(Continued)*

NOTE: If your hospital is enrolling a clinic that is not provider-based, do not complete this section.

Check ☐ "Clinic/Group Practice" in Section 2A and complete this entire application for the clinic.

- Are you going to:
☐ bill for the entire hospital with one billing number? (If yes, continue to Section 2D.)
☐ separately bill for each hospital department? (If yes, answer Question 2.)
- List the hospital departments for which you plan to bill separately:

DEPARTMENT	MEDICARE IDENTIFICATION NUMBER	NPI

D. Comments/Special Circumstances

Explain any unique circumstances concerning your practice location, the method by which you render health care services, etc.

E. Physical Therapy (PT) and Occupational Therapy (OT) Groups Only

- Are all of the group's PT/OT services rendered in patients' homes or in the group's private office space? ☐ YES ☐ NO
- Does this group maintain private office space? ☐ YES ☐ NO
- Does this group own, lease, or rent its private office space? ☐ YES ☐ NO
- Is this private office space used exclusively for the group's private practice? ☐ YES ☐ NO
- Does this group provide PT/OT services outside of its office and/or patients' homes? ☐ YES ☐ NO

If you responded YES to any of the questions 2–5 above, submit a copy of the lease agreement that gives the group exclusive use of the facilities for PT/OT services.

F. Accreditation for Ambulatory Surgical Centers (ASCs) Only

NOTE: Copy and complete this section if more than one accreditation needs to be reported.

Check one of the following and furnish any additional information as requested:

- ☐ The enrolling ASC supplier is accredited.
☐ The enrolling ASC supplier is not accredited (includes exempt providers).

Name of Accrediting Organization

Effective Date of Current Accreditation (mm/dd/yyyy)

Expiration of Current Accreditation (mm/dd/yyyy)

ATTACHMENT 5

SECTION 2: IDENTIFYING INFORMATION (Continued)**G. Termination of Physician Assistants (Only)**

Complete this section to delete employed physician assistants from your group or clinic.

EFFECTIVE DATE OF DEPARTURE	PHYSICIAN ASSISTANT'S NAME	PHYSICIAN ASSISTANT'S MEDICARE IDENTIFICATION NUMBER	PHYSICIAN ASSISTANT'S NPI

H. Advanced Diagnostic Imaging (ADI) Suppliers Only

This section must be completed by all suppliers that also furnish and will bill Medicare for ADI services. All suppliers furnishing ADI services MUST be accredited in each ADI Modality checked below to qualify to bill Medicare for those services.

Check each ADI modality this supplier will furnish and the name of the Accrediting Organization that accredited that ADI Modality for this supplier.

☐ **Magnetic Resonance Imaging (MRI)**

Name of Accrediting Organization for MRI

Effective Date of Current Accreditation (mm/dd/yyyy)

Expiration Date of Current Accreditation (mm/dd/yyyy)

☐ **Computed Tomography (CT)**

Name of Accrediting Organization for CT

Effective Date of Current Accreditation (mm/dd/yyyy)

Expiration Date of Current Accreditation (mm/dd/yyyy)

☐ **Nuclear Medicine (NM)**

Name of Accrediting Organization for NM

Effective Date of Current Accreditation (mm/dd/yyyy)

Expiration Date of Current Accreditation (mm/dd/yyyy)

☐ **Positron Emission Tomography (PET)**

Name of Accrediting Organization for PET

Effective Date of Current Accreditation (mm/dd/yyyy)

Expiration Date of Current Accreditation (mm/dd/yyyy)

ATTACHMENT 5

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include:
 - Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Act.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

SECTION 3: FINAL ADVERSE ACTIONS/CONVICTIONS *(Continued)*

FINAL ADVERSE HISTORY

1. Has your organization, under any current or former name or business identity, ever had any of the final adverse actions listed on page 13 of this application imposed against it?

☐ YES—Continue Below ☒ NO—Skip to Section 4

2. If yes, report each final adverse action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse action documentation and resolution.

FINAL ADVERSE ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

SECTION 4: PRACTICE LOCATION INFORMATION

INSTRUCTIONS

This section captures information about the physical location(s) where you currently provide health care services. If you operate a mobile facility or portable unit, provide the address for the "Base of Operations," as well as vehicle information and the geographic area serviced by these facilities or units.

Only report those practice locations within the jurisdiction of the Medicare fee-for-service contractor to which you will submit this application. If you have practice locations in another Medicare fee-for-service contractor's jurisdiction, complete a separate enrollment application (CMS-855B) for those practice locations and submit it to the Medicare fee-for-service contractor that has jurisdiction over those locations.

Provide the specific street address as recorded by the United States Postal Service. Do not provide a P.O. Box. If you provide services in a hospital and/or other health care facility for which you bill Medicare directly for the services rendered at that facility, provide the name and address of the hospital or facility.

MOBILE FACILITY AND/OR PORTABLE UNIT

A "mobile facility" is generally a mobile home, trailer, or other large vehicle that has been converted, equipped, and licensed to render health care services. These vehicles usually travel to local shopping centers or community centers to see and treat patients inside the vehicle.

A "portable unit" is when the supplier transports medical equipment to a fixed location (e.g., physician's office, nursing home) to render services to the patient.

The most common types of mobile facilities/portable units are mobile IDTFs, portable X-ray suppliers, portable mammography, and mobile clinics. Physicians and non-physician practitioners (e.g., nurse practitioners, physician assistants) who perform services at multiple locations (e.g., house calls, assisted living facilities) are not considered to be mobile facilities/portable units.

SECTION 4: PRACTICE LOCATION INFORMATION (Continued)

A. Practice Location Information

If you see patients in more than one practice location, copy and complete Section 4A for each location.

To ensure that CMS establishes the correct association between your Medicare legacy number and your NPI, providers and suppliers must list a Medicare legacy number—NPI combination for each practice location. If you have multiple NPIs associated with both a single legacy number and a single practice location, please list below all NPIs and associated legacy numbers for that practice location.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

If you are enrolling for the first time, or if you are adding a new practice location, the date you provide should be the date you saw your first Medicare patient at this location.

Practice Location Name ("Doing Business As" name if different from Legal Business Name)

Practice Location Street Address Line 1 (Street Name and Number – NOT a P.O. Box)

Practice Location Street Address Line 2 (Suite, Room, etc.)

City/Town	State	ZIP Code + 4
Telephone Number	Fax Number (if applicable)	E-mail Address (if applicable)

Date you saw your first Medicare patient at this practice location (mm/dd/yyyy)

Medicare Identification Number (if issued)	National Provider Identifier
Medicare Identification Number (if issued)	National Provider Identifier
Medicare Identification Number (if issued)	National Provider Identifier
Medicare Identification Number (if issued)	National Provider Identifier
Medicare Identification Number (if issued)	National Provider Identifier

Is this practice location a:

☐ Group practice office/clinic

☐ Hospital

☐ Retirement/assisted living community

☐ Skilled Nursing Facility and/or Nursing Facility

☐ Other health care facility

(Specify): _____

CLIA Number for this location (if applicable)

Attach a copy of the most current CLIA certifications for each of the practice locations reported on this application

FDA/Radiology (Mammography) Certification Number for this location (if issued)

ATTACHMENT 5

Attach a copy of the most current FDA certifications for each of the practice locations reported on this application.

SECTION 4: PRACTICE LOCATION INFORMATION (Continued)**B. Where do you want remittance notices or special payments sent?**

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Medicare will issue payments via electronic funds transfer (EFT). Since payments will be made by EFT, the "Special Payments" address should indicate where all other payment information (e.g., remittance notices, special payments) should be sent.

- ☐ "Special Payments" address is the same as the practice location (only one address is listed in Section 4A). Skip to Section 4C.
- ☐ "Special Payments" address is different than that listed in Section 4A, or multiple locations are listed. Provide address below.

"Special Payments" Address Line 1 (PO Box or Street Name and Number)

"Special Payments" Address Line 2 (Suite, Room, etc.)

City/Town	State	ZIP Code + 4
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C. Where do you keep patients' medical records?

If you store patients' medical records (current and/or former patients) at a location other than the location in Section 4A or 4E, complete this section with the address of the storage location.

Post Office boxes and drop boxes are not acceptable as physical addresses where patients' records are maintained. For IDTFs and mobile facilities/portable units, the patients' medical records must be under the supplier's control. The records must be the supplier's records, not the records of another supplier. If this section is not completed, you are indicating that all records are stored at the practice locations reported in Section 4A or 4E.

SECTION 4: PRACTICE LOCATION INFORMATION (Continued)

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

First Medical Record Storage Facility (for current and former patients)

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Storage Facility Address Line 1 (Street Name and Number)

Storage Facility Address Line 2 (Suite, Room, etc.)

City/Town	State	ZIP Code + 4
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Second Medical Record Storage Facility (for current and former patients)

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Storage Facility Address Line 1 (Street Name and Number)

Storage Facility Address Line 2 (Suite, Room, etc.)

City/Town	State	ZIP Code + 4
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ATTACHMENT 5

SECTION 4: PRACTICE LOCATION INFORMATION (Continued)

D. Rendering Services in Patients' Homes

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Furnish the city/town, State and ZIP code for all locations where health care services are rendered in patients' homes. If you provide health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate CMS-855B enrollment application for each Medicare fee-for-service contractor's jurisdiction.

If you are adding or deleting an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If you are providing services in selected cities/towns, furnish the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

ATTACHMENT 5

SECTION 4: PRACTICE LOCATION INFORMATION (Continued)**E. Base of Operations Address for Mobile or Portable Suppliers (Location of Business Office or Dispatcher/Scheduler)**

The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored, and when applicable, where vehicles are parked when not in use.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Check here ☐ and skip to Section 4F if the "Base of Operations" address is the same as the "Practice Location" listed in Section 4A.

Street Address Line 1 (Street Name and Number)

Street Address Line 2 (Suite, Room, etc.)

City/Town	State	ZIP Code + 4
Telephone Number	Fax Number (if applicable)	E-mail Address (if applicable)

F. Vehicle Information

If the mobile health care services are rendered inside a vehicle, such as a mobile home or trailer, furnish the following vehicle information. Do not provide information about vehicles that are used only to transport medical equipment (e.g., when the equipment is transported in a van but is used in a fixed setting, such as a doctor's office) or ambulance vehicles. If more than two vehicles are used, copy and complete this section as needed.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE FOR EACH VEHICLE	TYPE OF VEHICLE (van, mobile home, trailer, etc.)	VEHICLE IDENTIFICATION NUMBER
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		

For each vehicle, submit a copy of all health care related permits/licenses/registrations.

ATTACHMENT 5

SECTION 4: PRACTICE LOCATION INFORMATION (Continued)

G. Geographic Location for Mobile Or Portable Suppliers Where the Base of Operations and/or Vehicle Renders Services

Provide the city/town, State, and ZIP Code for all locations where mobile and/or portable services are rendered.

NOTE: If you provide mobile or portable health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate enrollment application (CMS-855B) for each Medicare fee-for-service contractor's jurisdiction.

INITIAL REPORTING AND/OR ADDITIONS

If you are reporting or adding an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

DELETIONS

If you are deleting an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services you are deleting are furnished in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE
		ATTACHMENT 5

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)

NOTE: Only report organizations in this section. Individuals must be reported in Section 6.

Complete this section with information about all organizations that have 5 percent or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Section 2, as well as information on any adverse legal actions that have been imposed against that organization. For examples of organizations that should be reported here, visit our Web site: www.cms.hhs.gov/MedicareProviderSupEnroll. If there is more than one organization that should be reported, copy and complete this section for each.

MANAGING CONTROL (ORGANIZATIONS)

Any organization that exercises operational or managerial control over the supplier, or conducts the day-to-day operations of the supplier, is a managing organization and must be reported. The organization need not have an ownership interest in the supplier in order to qualify as a managing organization. For instance, it could be a management services organization under contract with the supplier to furnish management services for the business.

SPECIAL TYPES OF ORGANIZATIONS

Governmental/Tribal Organizations

If a Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe should be reported as an owner. The supplier must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization that attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an appointed or elected official of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of the Medicare program.

Non-Profit, Charitable and Religious Organizations

Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a board of trustees or other governing body. The actual name of the board of trustees or other governing body should be reported in this section. While the organization should be listed in Section 5, individual board members should be listed in Section 6. Each non-profit organization should submit a copy of a 501(c)(3) document verifying its non-profit status.

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) (Continued)

All organizations that have any of the following must be reported in Section 5:

- 5 percent or more ownership of the supplier,
- Managing control of the supplier, or
- A partnership interest in the supplier, regardless of the percentage of ownership the partner has.

Owning/Managing organizations are generally one of the following types:

- Corporations (including non-profit corporations)
- Partnerships and Limited Partnerships (as indicated above)
- Limited Liability Companies
- Charitable and/or Religious organizations
- Governmental and/or Tribal organizations

A. Organization with Ownership Interest and/or Managing Control—Identification Information

☐ Not Applicable

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE (mm/dd/yyyy)		09/01/2013	

Check all that apply:

☒ 5 Percent or More Ownership Interest ☐ Partner ☐ Managing Control

Legal Business Name as Reported to the Internal Revenue Service

Northwestern Memorial HealthCare

"Doing Business As" Name (if applicable)

Address Line 1 (Street Name and Number)

211 E. Ontario Street

Address Line 2 (Suite, Room, etc.)

Suite 1800

City/Town Chicago	State IL	ZIP Code + 4 60611-3242
Telephone Number (312) 926-4505	Fax Number (if applicable) N/A	E-mail Address (if applicable) N/A
NPI (if issued) N/A	Tax Identification Number (Required) 	Medicare Identification Number(s) (if issued) N/A

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) 09/01/2013

What is the effective date this organization acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) N/A

NOTE: Furnish both dates if applicable.

ATTACHMENT 5

**SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(ORGANIZATIONS) (Continued)**

B. Final Adverse Legal Action History

If reporting a change to existing information, check "Change," provide the effective date of the change, and complete the appropriate fields in this section.

☐ Change

Effective Date: _____

1. Has this individual in Section 5A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 6

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

NOTE: Only Individuals should be reported in Section 6. Organizations must be reported in Section 5. For more information on “direct” and “indirect” owners, go to www.cms.hhs.gov/MedicareProviderSupEnroll.

The supplier MUST have at least ONE owner and/or managing employee.

The following individuals must be reported in Section 6A:

- All persons who have a 5 percent or greater direct or indirect ownership interest in the supplier;
- If (and only if) the supplier is a corporation (whether for-profit or non-profit), all officers and directors of the supplier;
- All managing employees of the supplier;
- All individuals with a partnership interest in the supplier, regardless of the percentage of ownership the partner has; and
- Authorized and delegated officials.

Example: A supplier is 100 percent owned by Company C, which itself is 100 percent owned by Individual D. Assume that Company C is reported in Section 5A as an owner of the supplier. Assume further that Individual D, as an indirect owner of the supplier, is reported in Section 6A. Based on this example, the supplier would check the “5 percent or Greater Direct/Indirect Owner” box in Section 6A.

NOTE: All partners within a partnership must be reported on this application. This applies to both “General” and “Limited” partnerships. For instance, if a limited partnership has several limited partners and each of them only has a 1 percent interest in the supplier, each limited partner must be reported on this application, even though each owns less than 5 percent. The 5 percent threshold primarily applies to corporations and other organizations that are not partnerships.

Non-Profit, Charitable or Religious Organizations: If you are a non-profit charitable or religious organization that has no organizational or individual owners (only board members, directors or managers), you should submit with your application a 501(c)(3) document verifying non-profit status.

For purposes of this application, the terms “officer,” “director,” and “managing employee” are defined as follows:

Officer is any person whose position is listed as being that of an officer in the supplier’s “articles of incorporation” or “corporate bylaws,” or anyone who is appointed by the board of directors as an officer in accordance with the supplier’s corporate bylaws.

Director is a member of the supplier’s “board of directors.” It does not necessarily include a person who may have the word “director” in his/her job title (e.g., departmental director, director of operations). Moreover, where a supplier has a governing body that does not use the term “board of directors,” the members of that governing body will still be considered “directors.” Thus, if the supplier has a governing body titled “board of trustees” (as opposed to “board of directors”), the individual trustees are considered “directors” for Medicare enrollment purposes.

Managing Employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the supplier, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the supplier.

NOTE: If a governmental or tribal organization will be legally and financially responsible for Medicare payments received (per the instructions for Governmental/Tribal Organizations in Section 5), the supplier is only required to report its managing employees in Section 6. Owners, partners, officers, and directors do not need to be reported, except those who are listed as authorized or delegated officials on this application.

Any information on final adverse actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual. Owners, Authorized Officials and/or Delegated Officials must complete this section.

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

A. Individuals with Ownership Interest and/or Managing Control—Identification Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE (mm/dd/yyyy)		09/01/2013	

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

First Name Eric	Middle Initial G.	Last Name Neilson	Jr., Sr., etc. M.D.	Title Board Member
Date of Birth (mm/dd/yyyy) [REDACTED]		Place of Birth (State) New York	Country of Birth USA	
Social Security Number (Required) [REDACTED]	Medicare Identification Number (if issued) [REDACTED]	NPI (if issued) [REDACTED]		

What is the above individual's relationship with the supplier in Section 2B1? (Check all that apply.)

- | | |
|---|---|
| ☐ 5 Percent or Greater Direct/Indirect Owner | ☒ Director/Officer |
| ☐ Authorized Official | ☐ Contracted Managing Employee |
| ☐ Delegated Official | ☐ Managing Employee (W-2) |
| ☐ Partner | |

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) 09/01/2011

NOTE: Furnish both dates if applicable.

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change

Effective Date: _____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

⌞ Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION
			

ATTACHMENT 5

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)****A. Individuals with Ownership Interest and/or Managing Control—Identification Information**

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE (mm/dd/yyyy)		09/01/2013	

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

First Name Glenn	Middle Initial F.	Last Name Tilton	Jr., Sr., etc.	Title Board Member
Date of Birth (mm/dd/yyyy) [REDACTED]	Place of Birth (State) Washington, D.C.		Country of Birth USA	
Social Security Number (Required) [REDACTED]	Medicare Identification Number (if issued) N/A	NPI (if issued) N/A		

What is the above individual's relationship with the supplier in Section 2B1? (Check all that apply.)

- | | |
|---|---|
| ☐ 5 Percent or Greater Direct/Indirect Owner | ☒ Director/Officer |
| ☐ Authorized Official | ☐ Contracted Managing Employee |
| ☐ Delegated Official | ☐ Managing Employee (W-2) |
| ☐ Partner | |

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) 09/01/2013

NOTE: Furnish both dates if applicable.

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change

Effective Date: _____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

A. Individuals with Ownership Interest and/or Managing Control—Identification Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE (mm/dd/yyyy)		09/01/2013	

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

First Name Thomas	Middle Initial A.	Last Name Cole	Jr., Sr., etc.	Title Board Member
Date of Birth (mm/dd/yyyy) [REDACTED]	Place of Birth (State) Pennsylvania		Country of Birth USA	
Social Security Number (Required) [REDACTED]	Medicare Identification Number (if issued) N/A	NPI (if issued) N/A		

What is the above individual's relationship with the supplier in Section 2B1? (Check all that apply.)

- | | |
|---|---|
| ☐ 5 Percent or Greater Direct/Indirect Owner | ☒ Director/Officer |
| ☐ Authorized Official | ☐ Contracted Managing Employee |
| ☐ Delegated Official | ☐ Managing Employee (W-2) |
| ☐ Partner | |

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) 09/01/2013

NOTE: Furnish both dates if applicable.

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change

Effective Date: _____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)****A. Individuals with Ownership Interest and/or Managing Control—Identification Information**

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE (mm/dd/yyyy)		09/01/2013	

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

First Name Stephen	Middle Initial	Last Name Crawford	Jr., Sr., etc.	Title Board Member
Date of Birth (mm/dd/yyyy) 	Place of Birth (State) Illinois	Country of Birth USA		
Social Security Number (Required) 	Medicare Identification Number (if issued) N/A	NPI (if issued) N/A		

What is the above individual's relationship with the supplier in Section 2B1? (Check all that apply.)

- | | |
|---|---|
| ☐ 5 Percent or Greater Direct/Indirect Owner | ☒ Director/Officer |
| ☐ Authorized Official | ☐ Contracted Managing Employee |
| ☐ Delegated Official | ☐ Managing Employee (W-2) |
| ☐ Partner | |

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) 10/19/2005

NOTE: Furnish both dates if applicable.

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change

Effective Date: _____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

A. Individuals with Ownership Interest and/or Managing Control—Identification Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE (mm/dd/yyyy)		09/01/2013	

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

First Name Daniel	Middle Initial M.	Last Name Derman	Jr., Sr., etc. M.D.	Title Board Member
Date of Birth (mm/dd/yyyy) [REDACTED]	Place of Birth (State) Illinois	Country of Birth USA		
Social Security Number (Required) [REDACTED]	Medicare Identification Number (if issued) [REDACTED]	NPI (if issued) [REDACTED]		

What is the above individual's relationship with the supplier in Section 2B1? (Check all that apply.)

- | | |
|---|---|
| ☐ 5 Percent or Greater Direct/Indirect Owner | ☒ Director/Officer |
| ☐ Authorized Official | ☐ Contracted Managing Employee |
| ☐ Delegated Official | ☐ Managing Employee (W-2) |
| ☐ Partner | |

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) 09/01/2013

NOTE: Furnish both dates if applicable.

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change

Effective Date: _____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

A. Individuals with Ownership Interest and/or Managing Control—Identification Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE (mm/dd/yyyy)		09/01/2013	

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

First Name John	Middle Initial A.	Last Name Edwardson	Jr., Sr., etc.	Title Board Member
Date of Birth (mm/dd/yyyy) [REDACTED]		Place of Birth (State) Indiana	Country of Birth USA	
Social Security Number (Required) [REDACTED]	Medicare Identification Number (if issued) N/A	NPI (if issued) N/A		

What is the above individual's relationship with the supplier in Section 2B1? (Check all that apply.)

- | | |
|---|---|
| ☐ 5 Percent or Greater Direct/Indirect Owner | ☒ Director/Officer |
| ☐ Authorized Official | ☐ Contracted Managing Employee |
| ☐ Delegated Official | ☐ Managing Employee (W-2) |
| ☐ Partner | |

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) 09/01/2013

NOTE: Furnish both dates if applicable.

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change

Effective Date: _____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

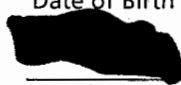
SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

A. Individuals with Ownership Interest and/or Managing Control—Identification Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE (mm/dd/yyyy)		09/01/2013	

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

First Name Dean	Middle Initial M.	Last Name Harrison	Jr., Sr., etc.	Title Board Member
Date of Birth (mm/dd/yyyy) 	Place of Birth (State) Michigan	Country of Birth USA		
Social Security Number (Required) 	Medicare Identification Number (if issued) N/A	NPI (if issued) N/A		

What is the above individual's relationship with the supplier in Section 2B1? (Check all that apply.)

- | | |
|---|---|
| ☐ 5 Percent or Greater Direct/Indirect Owner | ☒ Director/Officer |
| ☐ Authorized Official | ☐ Contracted Managing Employee |
| ☐ Delegated Official | ☐ Managing Employee (W-2) |
| ☐ Partner | |

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) 12/06/2004

NOTE: Furnish both dates if applicable.

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change

Effective Date: _____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

A. Individuals with Ownership Interest and/or Managing Control—Identification Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE (mm/dd/yyyy)		09/01/2013	

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

First Name David	Middle Initial M.	Last Name Mahvi	Jr., Sr., etc. M.D.	Title Board Member
Date of Birth (mm/dd/yyyy) [REDACTED]	Place of Birth (State) Oklahoma	Country of Birth USA		
Social Security Number (Required) [REDACTED]	Medicare Identification Number (if issued) [REDACTED]	NPI (if issued) [REDACTED]		

What is the above individual's relationship with the supplier in Section 2B1? (Check all that apply.)

- | | |
|---|---|
| ☐ 5 Percent or Greater Direct/Indirect Owner | ☒ Director/Officer |
| ☐ Authorized Official | ☐ Contracted Managing Employee |
| ☐ Delegated Official | ☐ Managing Employee (W-2) |
| ☐ Partner | |

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) 12/02/2009

NOTE: Furnish both dates if applicable.

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change

Effective Date: _____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)****A. Individuals with Ownership Interest and/or Managing Control—Identification Information**

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE (mm/dd/yyyy)		09/01/2013	

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

First Name Amy	Middle Initial S.	Last Name Paller	Jr., Sr., etc. M.D.	Title Board Member
Date of Birth (mm/dd/yyyy) [REDACTED]	Place of Birth (State) Ohio	Country of Birth USA		
Social Security Number (Required) [REDACTED]	Medicare Identification Number (if issued) [REDACTED]	NPI (if issued) [REDACTED]		

What is the above individual's relationship with the supplier in Section 2B1? (Check all that apply.)

- | | |
|---|---|
| ☐ 5 Percent or Greater Direct/Indirect Owner | ☒ Director/Officer |
| ☐ Authorized Official | ☐ Contracted Managing Employee |
| ☐ Delegated Official | ☐ Managing Employee (W-2) |
| ☐ Partner | |

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) 02/01/2004

NOTE: Furnish both dates if applicable.

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change

Effective Date: _____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

A. Individuals with Ownership Interest and/or Managing Control—Identification Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE (mm/dd/yyyy)		09/01/2013	

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

First Name Robert	Middle Initial L.	Last Name Parkinson	Jr., Sr., etc. Jr.	Title Board Member
Date of Birth (mm/dd/yyyy) 	Place of Birth (State) Iowa	Country of Birth USA		
Social Security Number (Required) 	Medicare Identification Number (if issued) N/A	NPI (if issued) N/A		

What is the above individual's relationship with the supplier in Section 2B1? (Check all that apply.)

- | | |
|---|---|
| ☐ 5 Percent or Greater Direct/Indirect Owner | ☒ Director/Officer |
| ☐ Authorized Official | ☐ Contracted Managing Employee |
| ☐ Delegated Official | ☐ Managing Employee (W-2) |
| ☐ Partner | |

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) 09/01/2013

NOTE: Furnish both dates if applicable.

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change

Effective Date: _____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

A. Individuals with Ownership Interest and/or Managing Control—Identification Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE (mm/dd/yyyy)		09/01/2013	

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

First Name Andrew	Middle Initial T.	Last Name Parsa	Jr., Sr., etc. M.D.	Title Board Member
Date of Birth (mm/dd/yyyy) [REDACTED]	Place of Birth (State) New York	Country of Birth USA		
Social Security Number (Required) [REDACTED]	Medicare Identification Number (if issued) [REDACTED]	NPI (if issued) [REDACTED]		

What is the above individual's relationship with the supplier in Section 2B1? (Check all that apply.)

- | | |
|---|---|
| ☐ 5 Percent or Greater Direct/Indirect Owner | ☒ Director/Officer |
| ☐ Authorized Official | ☐ Contracted Managing Employee |
| ☐ Delegated Official | ☐ Managing Employee (W-2) |
| ☐ Partner | |

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) 07/01/2013

NOTE: Furnish both dates if applicable.

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change

Effective Date: _____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

A. Individuals with Ownership Interest and/or Managing Control—Identification Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE (mm/dd/yyyy)		09/01/2013	

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

First Name Jane	Middle Initial D.	Last Name Pigott	Jr., Sr., etc.	Title Board Member
Date of Birth (mm/dd/yyyy) [REDACTED]	Place of Birth (State) Virginia	Country of Birth USA		
Social Security Number (Required) [REDACTED]	Medicare Identification Number (if issued) N/A	NPI (if issued) N/A		

What is the above individual's relationship with the supplier in Section 2B1? (Check all that apply.)

- | | |
|---|---|
| ☐ 5 Percent or Greater Direct/Indirect Owner | ☒ Director/Officer |
| ☐ Authorized Official | ☐ Contracted Managing Employee |
| ☐ Delegated Official | ☐ Managing Employee (W-2) |
| ☐ Partner | |

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) 01/11/2012

NOTE: Furnish both dates if applicable.

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change

Effective Date: _____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

A. Individuals with Ownership Interest and/or Managing Control—Identification Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE (mm/dd/yyyy)		09/01/2013	

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

First Name Edward	Middle Initial T.	Last Name Tilly	Jr., Sr., etc.	Title Board Member
Date of Birth (mm/dd/yyyy) 	Place of Birth (State) Illinois	Country of Birth USA		
Social Security Number (Required) 	Medicare Identification Number (if issued) N/A	NPI (if issued) N/A		

What is the above individual's relationship with the supplier in Section 2B1? (Check all that apply.)

- | | |
|---|---|
| ☐ 5 Percent or Greater Direct/Indirect Owner | ☒ Director/Officer |
| ☐ Authorized Official | ☐ Contracted Managing Employee |
| ☐ Delegated Official | ☐ Managing Employee (W-2) |
| ☐ Partner | |

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) 09/01/2013

NOTE: Furnish both dates if applicable.

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change

Effective Date: _____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

A. Individuals with Ownership Interest and/or Managing Control—Identification Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE (mm/dd/yyyy)		09/01/2013	

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

First Name Nicholas	Middle Initial J.	Last Name Volpe	Jr., Sr., etc. M.D.	Title Board Member
Date of Birth (mm/dd/yyyy) [REDACTED]	Place of Birth (State) New York	Country of Birth USA		
Social Security Number (Required) [REDACTED]	Medicare Identification Number (if issued) [REDACTED]	NPI (if issued) [REDACTED]		

What is the above individual's relationship with the supplier in Section 2B1? (Check all that apply.)

- | | |
|---|---|
| ☐ 5 Percent or Greater Direct/Indirect Owner | ☒ Director/Officer |
| ☐ Authorized Official | ☐ Contracted Managing Employee |
| ☐ Delegated Official | ☐ Managing Employee (W-2) |
| ☐ Partner | |

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) 09/01/2010

NOTE: Furnish both dates if applicable.

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change

Effective Date: _____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

A. Individuals with Ownership Interest and/or Managing Control—Identification Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☒ ADD	☐ DELETE
DATE (mm/dd/yyyy)		09/01/2013	

The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

First Name Forrest	Middle Initial	Last Name Whittaker	Jr., Sr., etc.	Title Board Member
Date of Birth (mm/dd/yyyy) [REDACTED]	Place of Birth (State) Massachusetts	Country of Birth USA		
Social Security Number (Required) [REDACTED]	Medicare Identification Number (if issued) N/A	NPI (if issued) N/A		

What is the above individual's relationship with the supplier in Section 2B1? (Check all that apply.)

- | | |
|---|---|
| ☐ 5 Percent or Greater Direct/Indirect Owner | ☒ Director/Officer |
| ☐ Authorized Official | ☐ Contracted Managing Employee |
| ☐ Delegated Official | ☐ Managing Employee (W-2) |
| ☐ Partner | |

What is the effective date this owner acquired ownership of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) _____

What is the effective date this individual acquired managing control of the provider identified in Section 2B1 of this application? (mm/dd/yyyy) 09/01/2013

NOTE: Furnish both dates if applicable.

**SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change

Effective Date: _____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

SECTION 7: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 8: BILLING AGENCY INFORMATION

A billing agency is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency, you are responsible for the claims submitted on your behalf.

☐ Check here if this section does not apply and skip to Section 13.

BILLING AGENCY NAME AND ADDRESS

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Legal Business/Individual Name as Reported to the Social Security Administration or the Internal Revenue Service

If Individual, Billing Agent Date of Birth (mm/dd/yyyy)

"Doing Business As" Name (if applicable)

Tax Identification/Social Security Number (required)

Billing Agency Street Address Line 1 (Street Name and Number)

Billing Agency Street Address Line 2 (Suite, Room, etc.)

City/Town	State	ZIP Code + 4
Telephone Number	Fax Number (if applicable)	E-mail Address (if applicable)

SECTION 9: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 10: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 11: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 12: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

ATTACHMENT 5

SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the fee-for-service contractor will contact the individual shown below. If the contact person is either an authorized or delegated official, check the appropriate box below.

☐ Contact an Authorized Official listed in Section 15.

☐ Contact a Delegated Official listed in Section 16.

First Name Sarah	Middle Initial J.	Last Name Kitchell	Jr., Sr., etc.
Telephone Number (617) 535-3929	Fax Number (if applicable) (617) 535-3800	E-mail Address (if applicable) skitchell@mwe.com	
Address Line 1 (Street Name and Number) 28 State Street			
Address Line 2 (Suite, Room, etc.) McDermott Will & Emery			
City/Town Boston	State MA	ZIP Code + 4 02109	

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

This section explains the penalties for deliberately falsifying information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program.

The offender is subject to fines of up to \$25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:
 - a) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;
 - b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
 - c) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

The Act imposes a civil penalty of \$5,000 to \$10,000 per violation, plus three times the amount of damages sustained by the Government.

ATTACHMENT 5

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION (Continued)

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency...a claim...that the Secretary determines is for a medical or other item or service that the person knows or should know:

- a) was not provided as claimed; and/or
- b) the claim is false or fraudulent.

This provision authorizes a civil monetary penalty of up to \$10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.
6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to execute a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.
7. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

SECTION 15: CERTIFICATION STATEMENT

An **AUTHORIZED OFFICIAL** means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

A **DELEGATED OFFICIAL** means an individual who is delegated by an authorized official the authority to report changes and updates to the supplier's enrollment record. A delegated official must be an individual with an "ownership or control interest" in (as that term is defined in Section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of, the supplier.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the supplier's Medicare status. Even when delegated officials are reported in this application, an authorized official retains the authority to make any such changes and/or updates by providing his or her printed name, signature, and date of signature as required in Section 15B.

NOTE: Authorized officials and delegated officials must be reported in Section 6, either on this application or on a previous application to this same Medicare fee-for-service contractor. **If this is the first time an authorized and/or delegated official has been reported on the CMS-855B, you must complete Section 6 for that individual.**

By his/her signature(s), an authorized official binds the supplier to all of the requirements listed in the Certification Statement and acknowledges that the supplier may be denied entry to or revoked from the Medicare program if any requirements are not met. All signatures must be original and in ink. Faxed, photocopied, or stamped signatures will not be accepted.

Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the supplier or (2) the enrollment application that must be submitted as part of the periodic revalidation process. A delegated official does not have this authority.

By signing this application, an authorized official agrees to immediately notify the Medicare fee-for-service contractor if any information furnished on the application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the Medicare fee-for-service contractor of any future changes to the information contained in this form, after the supplier is enrolled in Medicare, in accordance with the timeframes established in 42 C.F.R. 424.520(b). (IDTF changes of information must be reported in accordance with 42 C.F.R. 410.33.)

The supplier can have as many authorized officials as it wants. If the supplier has more than two authorized officials, it should copy and complete this section as needed.

**EACH AUTHORIZED AND DELEGATED OFFICIAL MUST HAVE
AND DISCLOSE HIS/HER SOCIAL SECURITY NUMBER.**

SECTION 15: CERTIFICATION STATEMENT (Continued)

A. Additional Requirements for Medicare Enrollment

These are additional requirements that the supplier must meet and maintain in order to bill the Medicare program. Read these requirements carefully. By signing, the supplier is attesting to having read the requirements and understanding them.

By his/her signature(s), the authorized official(s) named below and the delegated official(s) named in Section 16 agree to adhere to the following requirements stated in this Certification Statement:

1. I authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of any future changes to the information contained in this application in accordance with the timeframes established in 42 C.F.R. § 424.516. I understand that any change in the business structure of this supplier may require the submission of a new application.
2. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
3. I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.
4. Neither this supplier, nor any five percent or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.
5. I agree that any existing or future overpayment made to the supplier by the Medicare program may be recouped by Medicare through the withholding of future payments.
6. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
7. I authorize any national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS) a copy of my most recent accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).

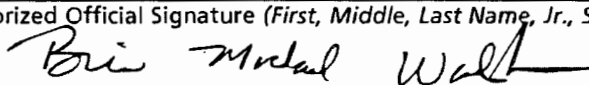
SECTION 15: CERTIFICATION STATEMENT (Continued)**B. 1ST Authorized Official Signature**

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 CFR § 424.516.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Authorized Official's Information and Signature

First Name Brian	Middle Initial M.	Last Name Walsh	Suffix (e.g., Jr., Sr.)
Telephone Number (312) 695-0141	Title/Position Vice President and Chief Financial Officer		
Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.) 			Date Signed (mm/dd/yyyy) 09/26/2013

(blue ink preferred)

C. 2ND Authorized Official Signature

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 CFR § 424.516.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Telephone Number	Title/Position		
Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)			Date Signed (mm/dd/yyyy)

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

- You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the supplier's status in the Medicare program.
- The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, the delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. A delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier's enrollment information maintained by the Medicare program, a delegated official certifies that the information provided is true, correct, and complete.
- Delegated officials being deleted do not have to sign or date this application.
- Independent contractors are not considered "employed" by the supplier, and therefore cannot be delegated officials.
- The signature(s) of an authorized official in Section 16 constitutes a legal delegation of authority to all delegated official(s) assigned in Section 16.
- If there are more than two individuals, copy and complete this section for each individual.

A. 1ST Delegated Official Signature

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Delegated Official First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
-------------------------------	----------------	-----------	-------------------------

Delegated Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)	Date Signed (mm/dd/yyyy)
---	--------------------------

☐ Check here if Delegated Official is a W-2 Employee	Telephone Number
---	------------------

Authorized Official's Signature Assigning this Delegation (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)	Date Signed (mm/dd/yyyy)
--	--------------------------

(blue ink preferred)

ATTACHMENT 5

SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

B. 2ND Delegated Official Signature

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Delegated Official First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
-------------------------------	----------------	-----------	-------------------------

Delegated Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)	Date Signed (mm/dd/yyyy)
---	--------------------------

☐ Check here if Delegated Official is a W-2 Employee	Telephone Number
---	------------------

Authorized Official's Signature Assigning this Delegation (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)	Date Signed (mm/dd/yyyy)
--	--------------------------

(blue ink preferred)

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

ATTACHMENT 5

SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. If you are newly enrolling, or are reactivating or revalidating your enrollment, you must provide all applicable documents. For changes, only submit documents that are applicable to that change.

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. The Medicare fee-for-service contractor may also request documents from you, other than those identified in this Section 17, as are necessary to bill Medicare.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

- ☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2.
(NOTE: This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.)
- ☐ Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement.
(NOTE: If a supplier already receives payments electronically and is not making a change to its banking information, the CMS-588 is not required.)

MANDATORY FOR SELECTED PROVIDER/SUPPLIER TYPES

- ☐ Copy(s) of all documentation verifying IDTF Supervisory Physician(s) proficiency and/or State licenses or certification for IDTF non-physician personnel.
- ☐ Copy(s) of all documentation verifying the State licenses or certifications of the laboratory Director or non-physician practitioner personnel of an independent clinical laboratory.

MANDATORY, IF APPLICABLE

- ☐ Copy of IRS Determination Letter, if supplier is registered with the IRS as non-profit.
- ☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity. (e.g., Form 8832).
(NOTE: A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.)
- ☐ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) with whom the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- ☐ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).
- ☐ Completed Form(s) CMS 855R, Reassignment of Medicare Benefits.
- ☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.
- ☐ Copy of an attestation for government entities and tribal organizations.
- ☐ Copy of FAA 135 certificate (air ambulance suppliers).
- ☐ Copy(s) of comprehensive liability insurance policy (IDTFs only).

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 0938-0685. The time required to complete this information collection is estimated to 6 hours per response, including the time to review instructions, search existing data 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 Reports Clearance Officer, Baltimore, Maryland 21244-1850.

DO NOT MAIL APPLICATIONS TO THIS ADDRESS. Mailing your application to this address will significantly delay application processing.

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS

All ambulance service suppliers enrolling in the Medicare program must complete this attachment.

A. Geographic Area

This section is to be completed with information about the geographic area in which this company provides ambulance services. If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Provide the city/town, State, and ZIP code for all locations where this ambulance company renders services.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

NOTE: If the ambulance company has vehicles garaged within a different Medicare contractor's jurisdiction, a separate CMS-855B enrollment application must be submitted to that fee-for-service contractor.

1. INITIAL REPORTING AND/OR ADDITIONS

If services are provided in selected cities/towns, provide the locations below. List ZIP codes only if they are not within the entire city/town.

CITY/TOWN	STATE	ZIP CODE

2. DELETIONS

If services are no longer provided in selected cities/towns, provide the locations below. List ZIP codes only if they are not within the entire city/town.

CITY/TOWN	STATE	ZIP CODE

ATTACHMENT 5

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS (Continued)

B. State License Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Crew members must complete continuing education requirements in accordance with State and local licensing laws. Evidence of re-certification must be retained with the employer in case it is required by the Medicare fee-for-service contractor.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Is this ambulance company licensed in the State where services are rendered and billed for? ☐ YES ☐ NO

If NO, explain why:

If YES, provide the license information for the State where this ambulance service supplier will be rendering services and billing Medicare. Attach a copy of the current State license.

License Number	Issuing State (if applicable)	Issuing City/Town (if applicable)
Effective Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	

C. Paramedic Intercept Services Information

Paramedic Intercept Services involve an arrangement between a Basic Life Support (BLS) ambulance company and an Advanced Life Support (ALS) ambulance company whereby the latter provides the ALS services and the BLS ambulance company provides the transportation component. If such an arrangement exists between the enrolling ambulance company and another ambulance company, the enrolling ambulance company must attach a copy of the signed contract. For more information, see 42 C.F.R. 410.40.

If reporting a change to information about a previously reported agreement/contract, check "Change" and provide the effective date of the change.

☐ Change

Effective Date: _____

Does this ambulance company currently participate in a paramedic intercept services arrangement?

☐ YES ☐ NO

ATTACHMENT 5

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS (Continued)

D. Vehicle Information

Complete this section with information about the vehicles used by this ambulance company and the services they provide. If there is more than one vehicle, copy and complete this section as needed. Attach a copy of each vehicle registration.

To qualify as an air ambulance supplier, the following is required:

- A written statement, signed by the President, Chief Executive Officer or Chief Operating Officer of the airport from where the aircraft is hangared that gives the name and address of the facility, and
- Proof that the enrolling ambulance company, or the company leasing the air ambulance vehicle to the enrolling ambulance company, possesses a valid charter flight license (FAA 135 Certificate) for the aircraft being used as an air ambulance. If the enrolling ambulance company owns the aircraft, the owner's name on the FAA 135 Certificate must be the same as the enrolling ambulance company's name (or the ambulance company owner as reported in Sections 5 or 6) in this application. If the enrolling ambulance company leases the aircraft from another company, a copy of the lease agreement must accompany this enrollment application.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Type (automobile, aircraft, boat, etc.)		Vehicle Identification Number	
Make (e.g., Ford)	Model (e.g., 350T)	Year (yyyy)	

Does this vehicle provide:

Advanced life support (Level 1)	☐ YES ☐ NO	Specialty care transport	☐ YES ☐ NO
Advanced life support (Level 2)	☐ YES ☐ NO	Land ambulance	☐ YES ☐ NO
Basic life support	☐ YES ☐ NO	Air ambulance—fixed wing	☐ YES ☐ NO
Emergency runs	☐ YES ☐ NO	Air ambulance—rotary wing	☐ YES ☐ NO
Non-emergency runs	☐ YES ☐ NO	Marine ambulance	☐ YES ☐ NO

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES

INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF) PERFORMANCE STANDARDS

Below is a list of the performance standards that an IDTF must meet in order to obtain or maintain their Medicare billing privileges. These standards, in their entirety, can be found in 42 C.F.R section 410.33(g).

1. Operate its business in compliance with all applicable Federal and State licensure and regulatory requirements for the health and safety of patients.
2. Provides complete and accurate information on its enrollment application. Changes in ownership, changes of location, changes in general supervision, and adverse legal actions must be reported to the Medicare fee-for-service contractor on the Medicare enrollment application within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 calendar days.
3. Maintain a physical facility on an appropriate site. For the purposes of this standard, a post office box, commercial mail box, hotel or motel is not considered an appropriate site.
 - (i) The physical facility, including mobile units, must contain space for equipment appropriate to the services designated on the enrollment application, facilities for hand washing, adequate patient privacy accommodations, and the storage of both business records and current medical records within the office setting of the IDTF, or IDTF home office, not within the actual mobile unit.
 - (ii) IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing hand washing and adequate patient privacy accommodations.
4. Have all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. A catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers, must be maintained at the physical site. In addition, portable diagnostic testing equipment must be available for inspection within two business days of a CMS inspection request. The IDTF must maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, provide this information to the designated fee-for-service contractor upon request, and notify the contractor of any changes in equipment within 90 days.
5. Maintain a primary business phone under the name of the designated business. The primary business phone must be located at the designated site of the business, or within the home office of the mobile IDTF units. The telephone number or toll free numbers must be available in a local directory and through directory assistance.
6. Have a comprehensive liability insurance policy of at least \$300,000 per location that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a non-relative owned company. Failure to maintain required insurance at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed. IDTF suppliers are responsible for providing the contact information for the issuing insurance agent and the underwriter. In addition, the IDTF must:
 - (i) Ensure that the insurance policy must remain in force at all times and provide coverage of at least \$300,000 per incident; and
 - (ii) Notify the CMS designated contractor in writing of any policy changes or cancellations.
7. Agree not to directly solicit patients, which include, but is not limited to, a prohibition on telephone, computer, or in-person contacts. The IDTF must accept only those patients referred for diagnostic testing by an attending physician, who is furnishing a consultation or treating a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Nonphysician practitioners may order tests as set forth in §410.32(a)(3).

ATTACHMENT 5

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (Continued)

8. Answer, document, and maintain documentation of a beneficiary's written clinical complaint at the physical site of the IDTF (For mobile IDTFs, this documentation would be stored at their home office.) This includes, but is not limited to, the following:
 - (i) The name, address, telephone number, and health insurance claim number of the beneficiary.
 - (ii) The date the complaint was received; the name of the person receiving the complaint; and a summary of actions taken to resolve the complaint.
 - (iii) If an investigation was not conducted, the name of the person making the decision and the reason for the decision.
9. Openly post these standards for review by patients and the public.
10. Disclose to the government any person having ownership, financial, or control interest or any other legal interest in the supplier at the time of enrollment or within 30 days of a change.
11. Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers suggested maintenance and calibration standards.
12. Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable Federal or State licenses or certifications of the individuals performing these services.
13. Have proper medical record storage and be able to retrieve medical records upon request from CMS or its fee-for-service contractor within 2 business days.
14. Permit CMS, including its agents, or its designated fee-for-service contractors, to conduct unannounced, on-site inspections to confirm the IDTF's compliance with these standards. The IDTF must be accessible during regular business hours to CMS and beneficiaries and must maintain a visible sign posting the normal business hours of the IDTF.
15. With the exception of hospital-based and mobile IDTFs, a fixed base IDTF does not include the following:
 - (i) Sharing a practice location with another Medicare-enrolled individual or organization.
 - (ii) Leasing or subleasing its operations or its practice location to another Medicare enrolled individual or organization.
 - (iii) Sharing diagnostic testing equipment using in the initial diagnostic test with another Medicare-enrolled individual or organization.
16. Enrolls in Medicare for any diagnostic testing services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed base location.
17. Bills for all mobile diagnostic services that are furnished to a Medicare beneficiary, unless the mobile diagnostic service is part of a service provided under arrangement as described in section 1861(w)(1) of the Act.

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES *(Continued)*

Instructions

If you perform diagnostic tests, other than clinical laboratory or pathology tests, and are required to enroll as an IDTF, you must complete this attachment. CMS requires the information in this attachment to determine whether the enrolling supplier meets all IDTF standards including, but not limited to, those listed on page 40 of this application. Not all suppliers that perform diagnostic tests are required to enroll as an IDTF.

Diagnostic Radiology

Many diagnostic tests are radiological procedures that require the professional services of a radiologist. A radiologist's practice is generally different from those of other physicians because radiologists usually do not bill E&M codes or treat a patient's medical condition on an ongoing basis. A radiologist or group practice of radiologists is not necessarily required to enroll as an IDTF. If enrolling as a diagnostic radiology group practice or clinic and billing for the technical component of diagnostic radiological tests without enrolling as an IDTF (if the entity is a free standing diagnostic facility), it should contact the carrier to determine that it does not need to enroll as an IDTF.

A mobile IDTF that provides X-ray services is not classified as a portable X-ray supplier.

Regulations governing IDTFs can be found at 42 C.F.R. 410.33.

CPT-4 and HCPCS Codes—Report all CPT-4 and HCPCS codes for which this IDTF will bill Medicare. Include the following:

- Provide the CPT-4 or HCPCS codes for which this IDTF intends to bill Medicare,
- The name and type of equipment used to perform the reported procedure, and
- The model number of the reported equipment.

The IDTF should report all Current Procedural Terminology, Version 4 (CPT-4) codes, Healthcare Common Procedural Coding System codes (HCPCS), and types of equipment (including the model number), for which it will perform tests, supervise, interpret, and/or bill. All codes reported must be for diagnostic tests that an IDTF is allowed to perform. Diagnostic tests that are clearly surgical in nature, which must be performed in a hospital or ambulatory surgical center, should not be reported.

Consistent with IDTF supplier standard 6 on page 40 of this application, all IDTFs enrolling in Medicare must have a comprehensive liability insurance policy of at least \$300,000 per location, that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a non-relative owned company. Failure to maintain the required insurance at all times will result in revocation of the Medicare supplier billing number, retroactive to the date the insurance lapsed. Malpractice insurance policies do not demonstrate compliance with this requirement.

All IDTFs must submit a complete copy of the aforementioned liability insurance policy with this application.

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (Continued)**A. Standards Qualifications**

Provide the date this Independent Diagnostic Testing Facility met all current CMS standards (mm/dd/yyyy)

B. CPT-4 and HCPCS Codes

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

All codes reported here must be for diagnostic tests that an IDTF is allowed to perform. Diagnostic tests that are clearly surgical in nature, which must be performed in a hospital or ambulatory surgical center, should not be reported. Clinical laboratory and pathology codes should not be reported. This page may be copied for additional codes or equipment.

	CPT-4 OR HCPCS CODE	EQUIPMENT	MODEL NUMBER (Required)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (Continued)

C. Interpreting Physician Information

Check here ☐ if this section does not apply because the interpreting physician will bill separate from the IDTF.

All physicians whose interpretations will be billed by this IDTF with the technical component (TC) of the test (i.e., global billing) must be listed in this section. If there are more than three physicians, copy and complete this section as needed. All interpreting physicians must be currently enrolled in the Medicare program.

If you are billing for interpretations as an individual reassigning benefits, the interpreting physician must complete the Reassignment of Benefits Form (CMS 855R). Note: Both the IDTF and individual physician must be enrolled with the fee-for-service contractor where the IDTF is located.

If you are billing for purchased interpretations, all requirements for purchased interpretations must be met.

When a mobile unit of the IDTF performs a technical component of a diagnostic test and the interpretive physician is the same physician who ordered the test, the IDTF cannot bill for the interpretation. Therefore, these interpreting physicians should not be reported since the interpretive physician must submit his/her own claims for these tests.

1ST Interpreting Physician Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Social Security Number (Required)		Date of Birth (mm/dd/yyyy) (Required)	
Medicare Identification Number (if issued)		NPI	

2ND Interpreting Physician Information

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Social Security Number (Required)		Date of Birth (mm/dd/yyyy) (Required)	
Medicare Identification Number (if issued)		NPI	

ATTACHMENT 5

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (Continued)**3RD Interpreting Physician Information**

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Social Security Number (Required)		Date of Birth (mm/dd/yyyy) (Required)	
Medicare Identification Number (if issued)		NPI	

D. Personnel (Technicians) Who Perform Tests

Complete this section with information about all non-physician personnel who perform tests for this IDTF. Notarized or certified true copies of the State license or certificate should be attached.

1ST PERSONNEL (TECHNICIAN) INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Social Security Number (Required)		Date of Birth (mm/dd/yyyy) (Required)	

Is this technician State licensed or State certified? (see instructions for clarification) ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (mm/dd/yyyy) (if applicable)
--	---

Is this technician certified by a national credentialing organization? ☐ YES ☐ NO

Name of credentialing organization (if applicable)	Type of Credentials (if applicable)
--	-------------------------------------

Is this technician employed by a hospital? ☐ YES ☐ NO

If YES, provide the name of the hospital here: _____

ATTACHMENT 5

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (Continued)**2ND Personnel (Technician) Information**

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
------------	----------------	-----------	-------------------------

Social Security Number (Required)	Date of Birth (mm/dd/yyyy) (Required)
-----------------------------------	---------------------------------------

Is this technician State licensed or State certified? (see instructions for clarification) ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (mm/dd/yyyy) (if applicable)
--	---

Is this technician certified by a national credentialing organization? ☐ YES ☐ NO

Name of credentialing organization (if applicable)	Type of Credentials (if applicable)
--	-------------------------------------

Is this technician employed by a hospital? ☐ YES ☐ NO

If YES, provide the name of the hospital here: _____

E. Supervising Physicians

Complete this section with identifying information about the physician(s) who supervise the operation of the IDTF and who provides the personal, direct, or general supervision per 42 C.F.R. 410.32(b)(3). The supervising physician must also attest to his/her supervising responsibilities for the enrolling IDTF.

Information concerning the type of supervision (personal, direct, or general) required for performance of specific IDTF tests can be obtained from your Medicare fee-for-service contractor. All IDTFs must report at least one supervisory physician, and at least one supervising physician must perform the supervision requirements stated in 42 C.F.R. 410.32(b)(3). All supervisory physician(s) must be currently enrolled in Medicare.

The type of supervision being performed by each physician who signs the attestation on page 47 of this application should be listed in this section.

Definitions of the types of supervision are as follows:

- **Personal Supervision** means a physician must be in attendance in the room during the performance of the procedure.
- **Direct Supervision** means the physician must be present in the office suite and immediately available to provide assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.
- **General Supervision** means the procedure is provided under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. General supervision also includes the responsibility that the non-physician personnel who perform the tests are qualified and properly trained and that the equipment is operated properly, maintained, calibrated and that necessary supplies are available.

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (Continued)**E. Supervising Physicians (Continued)**

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			
First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Social Security Number (Required)		Date of Birth (mm/dd/yyyy) (Required)	
Medicare Identification Number (if issued)		NPI	
Telephone Number	Fax Number (if applicable)	E-mail Address (if applicable)	

TYPE OF SUPERVISION PROVIDED

Check the appropriate box below indicating the type of supervision provided by the physician reported above for the tests performed by the IDTF in accordance with 42 C.F.R. 410.32 (b)(3) (See instructions for definitions).

☐ Personal Supervision ☐ Direct Supervision ☐ General Supervision

For each physician performing General Supervision, at least one of the three functions listed here must be checked. However, to meet the General Supervision requirement, in accordance with 42 C.F.R. 410.33(b), the enrolling IDTF must have at least one supervisory physician for each of the three functions. For example, two physicians may be responsible for function 1, a third physician may be responsible for function 2, and a fourth physician may be responsible for function 3. All four supervisory physicians must complete and sign the supervisory physician section of this application. Each physician should only check the function(s) he/she actually performs.

- ☐ Assumes responsibility for the overall direction and control of the quality of testing performed.
- ☐ Assumes responsibility for assuring that the non-physician personnel who actually perform the diagnostic procedures are properly trained and meet required qualifications.
- ☐ Assumes responsibility for the proper maintenance and calibration of the equipment and supplies necessary to perform the diagnostic procedures.

OTHER SUPERVISION SITES

Does this supervising physician provide supervision at any other IDTF? ☐ YES ☐ NO

If yes, list all other IDTFs for which this physician provides supervision. For more than five, copy this sheet.

	NAME OF FACILITY	ADDRESS	TAX IDENTIFICATION NUMBER	LEVEL OF SUPERVISION
1.				
2.				
3.				
4.				
5.				

ATTACHMENT 5

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (Continued)

E. Supervising Physicians (Continued)**ATTESTATION STATEMENT FOR SUPERVISING PHYSICIANS**

All Supervising Physician(s) rendering supervisory services for this IDTF must sign and date this section. All signatures must be original.

1. I hereby acknowledge that I have agreed to provide (IDTF Name) _____ with the Supervisory Physician services checked above for all CPT-4 and HCPCS codes reported in this Attachment. (See number 2 below if all reported CPT-4 and HCPCS codes do not apply). I also hereby certify that I have the required proficiency in the performance and interpretation of each type of diagnostic procedure, as reported by CPT-4 or HCPCS code in this Attachment (except for those CPT-4 or HCPCS codes identified in number 2 below). I have read and understand the Penalties for Falsifying Information on this Enrollment Application, as stated in Section 14 of this application. I am aware that falsifying information may result in fines and/or imprisonment. If I undertake supervisory responsibility at any additional IDTFs, I understand that it is my responsibility to notify this IDTF at that time.
2. I am not acting as a Supervising Physician for the following CPT-4 and/or HCPCS codes reported in this Attachment.

CPT-4 OR HCPCS CODE	CPT-4 OR HCPCS CODE	CPT-4 OR HCPCS CODE

3. Signature of Supervising Physician (<i>First, Middle, Last, Jr., Sr., M.D., D.O., etc.</i>)	Date (<i>mm/dd/yyyy</i>)
--	----------------------------

All signatures must be original and signed and dated in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395(l)(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as "optional" on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1. CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2. A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3. The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4. Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5. To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6. To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7. To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the National Plan and Provider Enumeration System is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8. An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9. Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers of medical services or to detect fraud or abuse;
10. State Licensing Boards for review of unethical practices or non-professional conduct;
11. States for the purpose of administration of health care programs; and/or
12. Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process supplier's health care claims.

The supplier should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

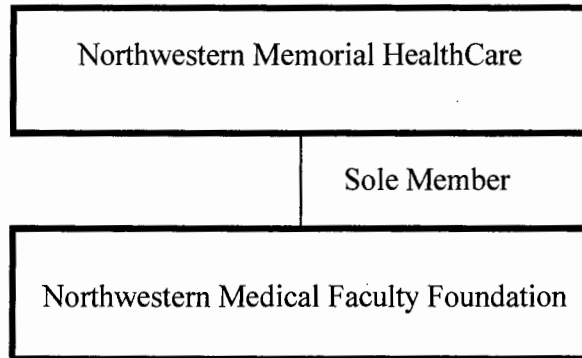
Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

ATTACHMENT 3

Post-Closing Structure



Internal Revenue Service
Washington, D.C. 20224

Department of the Treasury

Date: 04 DEC 1981

Employer Identification Number:

Key District:

Chicago

Accounting Period Ending:

August
Foundation Status Classification:

509(a)(1) & 170(b)(1)(A)(vi)
Advance Ruling Period Ends:

December 31, 1982

Person to Contact: William C. Gorms
(202) 388-6873

Contact Telephone Number:

Northwestern Foundation
For Research and Education
79 W. Monroe Street
Suite 700
Chicago, IL 60603

Dear Applicant:

Based on information supplied, and assuming your operations will be as stated in your application for recognition of exemption, we have determined you are exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code.

Because you are a newly created organization, we are not now making a final determination of your foundation status under section 509(a) of the Code. However, we have determined that you can reasonably be expected to be a publicly supported organization described in section 509(a)(1) and 170(b)(1)(A)(vi).

Accordingly, you will be treated as a publicly supported organization, and not as a private foundation, during an advance ruling period. This advance ruling period begins on the date of your inception and ends on the date shown above.

Within 90 days after the end of your advance ruling period, you must submit to your key District Director information needed to determine whether you have met the requirements of the applicable support test during the advance ruling period. If you establish that you have been a publicly supported organization, you will be classified as a section 509(a)(1) or 509(a)(2) organization as long as you continue to meet the requirements of the applicable support test. If you do not meet the public support requirements during the advance ruling period, you will be classified as a private foundation for future periods. Also, if you are classified as a private foundation, you will be treated as a private foundation from the date of your inception for purposes of sections 507(d) and 4940.

Grantors and donors may rely on the determination that you are not a private foundation until 90 days after the end of your advance ruling period. If you submit the required information within the 90 days, grantors and donors may continue to rely on the advance determination until the Service makes a final determination of your foundation status. However, if notice that you will no longer be treated as a section 509(a)(1) organization is published in the Internal Revenue Bulletin, grantors and donors may not rely on this determination after the date of such publication. Also, a grantor or donor may not rely on this 509(a)(1) determination if he or she was in part responsible for, or was aware of, the act or failure to act that resulted in your loss of section 509(a)(1) status, or acquired knowledge that the Internal Revenue Service had given notice that you would be removed from classification as a section 509(a)(1) organization.

(over)

M-6483 (6-77)

ATTACHMENT 5

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If your sources of support, or your purposes, character, or method of operation change, please let your key district know so that office can consider the effect of the change on your exempt status and foundation status. Also, you should inform your key District Director of all changes in your name or address.

Generally, you are not liable for social security (FICA) taxes unless you file a waiver of exemption certificate as provided in the Federal Insurance Contributions Act. If you have paid FICA taxes without filing the waiver, you should contact your key District Director. You are not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

Organizations that are not private foundations are not subject to the excise taxes under Chapter 42 of the Code. However, you are not automatically exempt from other Federal excise taxes. If you have questions about excise, employment, or other Federal taxes, contact any Internal Revenue Service office.

Donors may deduct contributions to you as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for Federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

You are required to file Form 990, Return of Organization Exempt from Income Tax, only if your gross receipts each year are normally more than \$10,000. If a return is required, it must be filed by the 15th day of the fifth month after the end of your annual accounting period. The law imposes a penalty of \$10 a day, up to a maximum of \$5,000, when a return is filed late, unless there is reasonable cause for the delay.

You are not required to file Federal income tax returns unless you are subject to the tax on unrelated business income under section 511 of the Code. If you are subject to this tax, you must file an income tax return on Form 990-T. In this letter, we are not determining whether any of your present or proposed activities are unrelated trade or business as defined in section 513 of the Code.

You need an employer identification number even if you have no employees. If an employer identification number was not entered on your application, a number will be assigned to you and you will be advised of it. Please use that number on all returns you file and in all correspondence with the Internal Revenue Service.

We are informing your key District Director of this action. Because this letter could help resolve any questions about your exempt status and foundation status, you should keep it in your permanent records.

If you have any questions, please contact the person whose name and telephone number are shown in the heading of this letter.

Sincerely yours,

Peter K. Bros

Peter K. Bros
Chief, Rulings Section 2
Exempt Organizations
Technical Branch

M-6483 (6-77)

ATTACHMENT 5

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Internal Revenue Service
District Director

Department of the Treasury

Date: 28 FEB 1985

Our Letter Dated: December 4, 1984

Person to Contact: Mr. E. H. H. H.

Contact Telephone Number:

(312) 856 1278

NORTHWESTERN MEDICAL FACULTY
FOUNDATION, INC
79 WEST MONROE STREET SUITE 700
CHICAGO, IL 60603

Gentlemen:

This modifies our letter of the above date in which we stated that you would be treated as an organization which is not a private foundation until the expiration of your advance ruling period.

Based on the information you submitted, we have determined that you are not a private foundation within the meaning of section 509(a) of the Internal Revenue Code, because you are an organization of the type described in section 509(a)(2). Your exempt status under section 501(c)(3) of the code is still in effect.

Grantors and contributors may rely on this determination until the Internal Revenue Service publishes notice to the contrary. However, a grantor or a contributor may not rely on this determination if he or she was in part responsible for, or was aware of, the act or failure to act that resulted in your loss of section 509(a)(2) status, or acquired knowledge that the Internal Revenue Service had given notice that you would be removed from classification as a section 509(a)(2) organization.

Because this letter could help resolve any questions about your private foundation status, please keep it in your permanent records.

If you have any questions, please contact the person whose name and telephone number are shown above.

Sincerely yours,

J. R. Starnes

District Director



OFFICE OF THE SECRETARY OF STATE

JESSE WHITE • Secretary of State

SEPTEMBER 13, 2013

5217-965-3

CT CORPORATION SYSTEM
600 S 2ND ST
SPRINGFIELD IL 62704

RE NORTHWESTERN MEDICAL FACULTY FOUNDATION

DEAR SIR OR MADAM:

APPLICATION TO ADOPT AN ASSUMED NAME HAS BEEN PLACED ON FILE AND THE CORPORATION CREDITED WITH THE REQUIRED FEE.

THE DUPLICATE COPY IS ENCLOSED.

SINCERELY,

Jesse White

JESSE WHITE
SECRETARY OF STATE
DEPARTMENT OF BUSINESS SERVICES
CORPORATION DIVISION
TELEPHONE (217) 782-6961

JW:CD

ATTACHMENT 5

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Form NFP 104.15/20
(Rev. Jan. 2003)

Secretary of State Jesse White
Department of Business Services
501 S. Second St., Rm. 350
Springfield, IL 62756
217-782-9520
www.cyberdriveillinois.com

Payment may be made by check payable
or money order to Secretary of State. If
check is returned for any reason this fil-
ing will be void. Please do not send cash.

**Application to Adopt,
Change or Cancel an
Assumed Corporate Name**
Under the General Not for Profit, Corporation Act

SUBMIT IN DUPLICATE

Please type or print clearly.

Filing Fee: \$ 60.-
(See Note Below)

Approved: LC

FILE # 52179653

This space for use by Secretary of State.

FILED

SEP 13 2013

**JESSE WHITE
SECRETARY OF STATE**

1. Corporate Name: Northwestern Medical Faculty Foundation
2. State or Country of Incorporation: Illinois
3. Date Incorporated (if an Illinois corporation) or Date Authorized to Transact Business in Illinois (if a foreign corporation):
October 3 1980
Month & Day Year

Complete No. 4 and No. 5 if adopting or changing an assumed corporate name.

4. Corporation intends to adopt and to transact business under the Assumed Corporate Name of:
Northwestern Medical Group
5. The right to use the Assumed Corporate Name shall be effective from the date this application is filed by the Secretary of State until October 1, 2015, the first day of the corporation's anniversary
Month & Day Year
month in the next year evenly divisible by five.

Complete No. 6 if changing or cancelling an assumed corporate name.

6. Corporation intends to cease transacting business under the Assumed Corporate Name of:

7. The undersigned corporation has caused this statement to be signed by a duly authorized officer who affirms, under penalties of perjury, that the facts stated herein are true and correct.

Dated August 26, 2013 Northwestern Medical Faculty Foundation
Month & Day Year Exact Name of Corporation
B Walsh
Any Authorized Officer's Signature
Brian Walsh, Vice President, Finance, Chief Financial Officer, and Treasurer
Name and Title (type or print)

- NOTE:** • The filing fee to adopt an assumed corporate name is \$150 if the current year ends with a 0 or 5; \$120 if the current year ends with a 1 or 6; \$90 if the current year ends with a 2 or 7; \$60 if the current year ends with a 3 or 8; or \$30 if the current year ends with a 4 or 9.
- The fee for cancelling an assumed corporate name is \$5.
 - The fee to change an assumed corporate name is \$5.

SW 67 200808
200938 086296

3643
60611

K
IRS USE ONLY

93490-132-00616-9 A0151772 2
363097297 TE 3



Department of the Treasury
Internal Revenue Service
OGDEN UT 84201-0074

For assistance, call:
1-800-829-0115

Notice Number: CP210
Date: October 5, 2009

Taxpayer Identification Number:
36-3097297
Tax Form: 990
Tax Period: August 31, 2008

066742.649751.0237.006 1 AT 0.357 695



066742

NORTHWESTERN MEDICAL FACULTY
FOUNDATION INC
680 N LAKE SHORE DR STE 1118
CHICAGO IL 60611-4402934

Amount of Refund

\$673.16

Statement of Adjustment to Your Account

Balance Due on Account Before Adjustment \$11,034.38

Adjustment Computation

Penalty Decrease - Filing Late \$11,700.00

Interest Allowed \$7.54

Net Adjustment Credit \$11,707.54

Overpayment \$673.16

This is a result of your inquiry of July 31, 2009.

Interest allowed must be reported as income on your next income tax return.

Status of Your Account - Refund

We'll refund your overpayment (plus interest when applicable), if you owe no other taxes or have no other debts the law requires us to collect.

Status of Your Account (Exam)

This notice isn't the result of an examination of your return. We notify a taxpayer when we select his/her return for examination.

For tax forms, instructions and information visit www.irs.gov. (Access to this site will not provide you with your specific taxpayer account information.)

ATTACHMENT 5

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Seq. No.: A0151772

CP: 210

TIN: 36-3097297 Form: 990

Tax Period: August 31, 2008



066742

 **CUT HERE**

Return this voucher with your payment or correspondence.

Your Telephone Number:

() -

Best Time to Call:

AM PM

☐ **Correspondence enclosed:**

- Write your Taxpayer Identification Number, tax period and tax form number on your inquiry or correspondence

TE 200938 102425 93490-132-00616-9

210 Internal Revenue Service
OGDEN UT 84201-0074

NORTHWESTERN MEDICAL FACULTY
FOUNDATION INC
680 N LAKE SHORE DR STE 1118
CHICAGO IL 60611-4402934



ATTACHMENT 5

363097297 SW 67 2 200808

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Enrollment Disclosure Statement
Illinois Medical Assistance Program



MEDICARE ENROLLMENT APPLICATION

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

CMS-855S

SEE PAGE 1 FOR A SUMMARY OF THE DMEPOS SUPPLIER STANDARDS. TO ENROLL IN THE MEDICARE PROGRAM AND BE ELIGIBLE TO SUBMIT CLAIMS AND RECEIVE PAYMENTS, EVERY DMEPOS SUPPLIER APPLICANT MUST MEET AND MAINTAIN THESE ENROLLMENT STANDARDS.

SEE PAGE 2 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.

SEE SECTION 12 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THIS APPLICATION.

TO VIEW YOUR CURRENT MEDICARE ENROLLMENT RECORD GO TO:
[HTTPS://PECOS.CMS.HHS.GOV](https://pecos.cms.hhs.gov)

DMEPOS SUPPLIER STANDARDS FOR MEDICARE ENROLLMENT

Below is an abbreviated summary of the standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, including the surety bond provisions, are listed in 42 CFR § 424.57(c) and (d) and can be found at http://www.cms.gov/MedicareProviderSupEnroll/10_DMEPOSSupplierStandards.asp#TopOfPage.

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. A supplier must have an authorized individual whose signature is binding sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory or contract with other companies for the purchase of items necessary to fill orders. A supplier cannot contract with any entity that is currently excluded from the Medicare program, any State health care programs, or any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least \$300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57(c)(11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair cost either directly or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
22. A supplier must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services for which the supplier is accredited in order for the supplier to receive payment for those specific products and services (except for certain exempt pharmaceuticals).
23. A supplier must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. A supplier must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57(d).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act), physical and occupational therapists or DMEPOS suppliers working with custom made orthotics and prosthetics.

ATTACHMENT 5

WHO SHOULD COMPLETE AND SUBMIT THIS APPLICATION

The following types of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers must complete this application to enroll in the Medicare program and receive a Medicare Billing number:

- Ambulatory Surgical Center
- Department Store
- Grocery Store
- Home Health Agency
- Hospital
- Indian Health Service or Tribal Facility
- Intermediate Care Nursing Facility
- Medical Supply Company
- Nursing Facility (other)
- Ocularist
- Occupational Therapist
- Optician
- Orthotics Personnel
- Oxygen and/or Oxygen Related Equipment Supplier
- Pedorthic Personnel
- Pharmacy
- Physical Therapist
- Physician, including Dentist and Optometrist
- Prosthetics Personnel
- Prosthetic/Orthotic Personnel
- Rehabilitation Agency
- Skilled Nursing Facility
- Sleep Laboratory/Medicine
- Sports Medicine

If your DMEPOS supplier type is not listed, contact the National Supplier Clearinghouse Medicare Administrative Contractor (NSC MAC) before you submit this application.

Complete this application if you plan to bill or already bill Medicare for DMEPOS and you are:

- Enrolling in Medicare for the first time as a DMEPOS supplier.
- Currently enrolled in Medicare as a DMEPOS supplier and need to report changes to your current business, (e.g., you are adding, removing, or changing existing information under this Medicare supplier billing number). Changes must be reported within 30 days of the change.
- Currently enrolled in Medicare as a DMEPOS supplier and need to enroll a new business location using the same tax identification number already enrolled with the NSC MAC.
- Currently enrolled in Medicare as a DMEPOS supplier and need to enroll a new business location using a tax identification number not currently enrolled with the NSC MAC.
- Currently enrolled in Medicare as a DMEPOS supplier and received notice to revalidate your enrollment.
- Reactivating your Medicare DMEPOS supplier billing number.
- Voluntarily terminating your Medicare DMEPOS supplier billing number.

DMEPOS suppliers can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper CMS-855S enrollment application. Be sure you are using the most current version.

For additional information regarding the Medicare enrollment process, including Internet-based PECOS and to get the current version of the CMS-855S, go to <http://www.cms.gov/MedicareProviderSupEnroll>.

BILLING NUMBER AND NATIONAL PROVIDER IDENTIFIER INFORMATION

The Medicare Identification Number, often referred to as a Medicare supplier number or Medicare billing number is a generic term for any number other than the National Provider Identifier (NPI) that is used by a DMEPOS supplier to bill the Medicare program.

The National Provider Identifier (NPI) is the standard unique health identifier for health care providers and suppliers and is assigned by the National Plan and Provider Enumeration System (NPPES). **To become a Medicare DMEPOS supplier, you must obtain an NPI and furnish it on this application prior to enrolling in Medicare or when submitting a change to your existing Medicare enrollment information.** Applying for the NPI is a process separate from Medicare enrollment. To obtain an NPI, you may apply online at <https://nppes.cms.hhs.gov>. For more information about NPI enumeration, visit www.cms.gov/NationalProviderIdentStand.

NOTE: The Legal Business Name (LBN) and Tax Identification Number (TIN) that you furnish in Section 1B of this application must be the same LBN and TIN you used to obtain your NPI. Once this information is entered into PECOS from this application, your LBN, TIN and NPI **must** match exactly in both the Medicare Provider Enrollment Chain and Ownership System and the National Plan and Provider Enumeration System.

INSTRUCTIONS FOR COMPLETING THIS APPLICATION

All information on this form is required with the exception of those fields specifically marked as "optional." Any field marked as optional is not required to be completed nor does it need to be updated or reported as a "change of information" as required in 42 CFR § 424.516. However, it is highly recommended that if reported, these fields be kept up-to-date.

ATTACHMENT 5

INSTRUCTIONS FOR COMPLETING THIS APPLICATION (Continued)

- Type or print all information so that it is legible. Do not use pencil. Blue ink is preferred.
 - When necessary to report additional information, copy and complete the applicable section as needed.
 - Attach all supporting documentation.
 - Keep a copy of your completed Medicare enrollment package for your own records.
-

TIPS TO AVOID DELAYS IN YOUR ENROLLMENT

- Complete all required sections as shown in Section 1;
- Complete Section 9 for all delegated and authorized officials reported in Sections 14 and 15;
- Report at least one owner and one managing employee for each location;
- Enter your NPI in the applicable sections;
- Include the Electronic Funds Transfer (EFT) Agreement (CMS-588), when applicable, with your enrollment application;
- Respond timely to development/information requests; and
- Be sure the Legal Business Name shown in Section 1B matches the name on your tax documents.

Additional information and reasons for processing delays can be found at www.palmettogba.com/nsc.

PROCESS FOR OBTAINING MEDICARE APPROVAL

The standard process for becoming a Medicare DMEPOS supplier is as follows:

1. The supplier obtains the required National Provider Identification Number (NPI), surety bond and/or accreditation **PRIOR** to completing and submitting this application to the NSC MAC.
 2. The supplier completes and submits this enrollment application (CMS-855S) and all supporting documentation to the NSC MAC.
 3. The NSC MAC reviews the application and conducts a site visit to verify compliance with the supplier standards found at 42 CFR § 424.57, 424.58, and 42 CFR § 424.500–565.
 4. After completing its review, the NSC MAC notifies the supplier in writing about its enrollment decision.
-

ADDITIONAL INFORMATION

The NSC MAC may request additional documentation to support or validate information reported on this application. You are responsible for providing this documentation within 30 days of the request.

The information you provide on this form is protected under 5 U.S.C. Section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application to read the Privacy Act Statement.

ACRONYMS COMMONLY USED IN THIS APPLICATION

CFR: Code of Federal Regulations

DME MAC: Durable Medical Equipment Medicare Administrative Contractor

DMEPOS: Durable Medical Equipment, Prosthetics, Orthotics and Supplies

EFT: Electronic Funds Transfer

IRS: Internal Revenue Service

LBN: Legal Business Name

LLC: Limited Liability Corporation

NPI: National Provider Identifier

NPES: National Plan and Provider Enumeration System

NSC MAC: National Supplier Clearinghouse Medicare Administrative Contractor

PECOS: Provider Enrollment Chain and Ownership System

SSN: Social Security Number

TIN: Tax Identification Number

WHERE TO MAIL YOUR APPLICATION

The NSC MAC is responsible for processing your enrollment application. Mail this application to:

National Supplier Clearinghouse
Post Office Box 100142
Columbia, SC 29202-3142

Customer Service: 1-866-238-9652

Web: <http://www.palmettogba.com/nsc>

Overnight Mailing Address:
National Supplier Clearinghouse
Palmetto GBA* AG-495
2300 Springdale Drive, Bldg. 1
Camden, SC 29020

ATTACHMENT 5

SECTION 1: BASIC INFORMATION

This section captures basic information and information about the reason you are submitting this application.

A. BUSINESS LOCATION

Provide the two-letter State Code (e.g., TX for Texas) where this business is physically located.

I	L
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B. BUSINESS IDENTIFICATION

DMEPOS suppliers must furnish their National Provider Identifier (NPI), Tax Identification Number (TIN), and Supplier Billing Number (if issued) below.

NOTE: Each business location **MUST** have it's own NPI, unless enrolling as a sole proprietor/proprietorship with multiple locations. See Section 2C.

Legal Business Name (LBN)

Northwestern Medical Faculty Foundation

National Provider Identifier (NPI)

Tax Identification Number (TIN)

Supplier Billing Number (if issued)

0597400001

Read this in full prior to indicating the reason for submission in Section 1C.

NEW ENROLLEES AND THOSE REPORTING A NEW TAX ID NUMBER

You are considered a new enrollee if you are:

- Enrolling in the Medicare program as a DMEPOS supplier for the first time under the tax identification number reported in Section 1B.
- Currently enrolled in the Medicare program as a DMEPOS supplier but have a new tax identification number. If you are reporting a change to your tax identification number, you must complete a new CMS-855S enrollment application in its entirety.
- A currently enrolled DMEPOS supplier under new ownership with a different tax identification number.

NOTE: New owners of existing DMEPOS suppliers must submit a dated bill of sale with the effective date of the new ownership.

CURRENTLY ENROLLED MEDICARE DMEPOS SUPPLIERS

Adding a New Location

If you are currently enrolled as a Medicare DMEPOS supplier and are applying to enroll a new business location using a tax identification number that is already enrolled with the NSC MAC, you will need to complete only the required sections listed in Section 1C of this application for the new location.

Change of Information Other than Adding a New Location

If you are adding, removing, or changing information under your current Medicare supplier billing number, including a change of ownership that does not change the current tax identification number, you will need to complete the appropriate sections as instructed and submit any new documentation. Any change to your existing enrollment data must be reported within 30 days of the effective date of the change.

Reactivation

If your Medicare DMEPOS supplier billing number was deactivated, you will be required to submit an updated CMS-855S. You must also meet all current requirements for your supplier type to reactivate your supplier billing number.

Revalidation

If you have been contacted by the NSC MAC to revalidate your Medicare enrollment you will be required to submit an updated enrollment application. Do not submit an application for revalidation until you have been contacted by the NSC MAC.

Voluntary Termination

If you will no longer provide DMEPOS items or services to Medicare beneficiaries you should voluntarily terminate your enrollment in the Medicare program as a DMEPOS supplier.

NOTE: Enrollment applications submitted for "NEW ENROLLEES" **MUST** be signed by an Authorized Official, otherwise they will be returned unprocessed.

SECTION 1: BASIC INFORMATION *(Continued)*

C. REASON FOR SUBMITTING THIS APPLICATION

Check one box and complete the Sections as indicated.

☐ You are a new enrollee in Medicare or are enrolling a new location with a tax identification number not previously enrolled with the NSC MAC.	Complete all sections
☐ You are adding a new business location using a tax identification number currently enrolled with the NSC MAC.	Complete sections 1–7, 9 <i>(for managing employee only)</i> , 11 (optional), 12, and either 14 or 15
☐ You are adding a new business location using a tax identification number NOT currently enrolled with the NSC MAC.	Complete all sections
☐ You are reactivating your Medicare Supplier Billing Number.	Complete all sections
☐ You are revalidating your Medicare enrollment.	Complete all sections
☐ You are voluntarily terminating your Medicare enrollment . Effective date of termination: _____	Complete sections 1, 2A, 4B, 4D, 11 (optional), and either 14 or 15
☒ You are changing your Medicare enrollment information other than your tax identification number.	Go to Section 1D
☐ You are changing your Tax Identification Number .	Complete all sections

D. WHAT INFORMATION IS CHANGING?

Check all that apply and complete the required sections.

PLEASE NOTE: When reporting ANY information, Sections 1B, 7 and either 14 or 15 **MUST** always be completed in addition to completing the information that is changing within the required Section.

CHECK ALL THAT APPLY	REQUIRED SECTIONS
☐ Current Business Location Information	1, 2, 7, 11 (optional), 12 (if applicable), and either 14 or 15
☐ Supplier Type <i>(submit licensure if applicable)</i>	1, 3, 7, 11 (optional), 12 (if applicable), and either 14 or 15
☐ Products and Services <i>(submit accreditation if applicable)</i>	
☐ Accreditation Information	1, 3, 7, 11 (optional), 12 (if applicable), and either 14 or 15
☐ Address Information ☐ 1099 Mailing Address ☐ Correspondence Mailing Address ☐ Revalidation Mailing Address ☐ Remittance/Special Payment Mailing Address ☐ Record Storage Address	1, 4 as applicable for the address that is being changed, 7, 11 (optional), 12 (if applicable), and either 14 or 15.
☐ Comprehensive Liability Insurance Information	1, 5, 7, 11 (optional), 12, and either 14 or 15
☐ Surety Bond Information	1, 6, 7, 11 (optional), 12, and either 14 or 15
☐ Final Adverse Legal Actions	1, 7, 11 (optional), 12, and either 14 or 15
☒ Ownership and/or Managing Control Information (Organizations and/or Individuals)	1, 7, 8 and/or 9, 11 (optional), 12 (if applicable), and either 14 or 15
☐ Billing Agency Information	1, 7, 10, 11 (optional), and either 14 or 15
☐ Delegated Official	1, 7, 9, 11 (optional), 12, 14 and 15
☐ Authorized Official	1, 7, 9, 11 (optional), 12 (if applicable), 15
☐ Any other information not specified above	1, 7, 11 (optional), 12 (if applicable), and either 14 or 15 and the applicable section or sub-section that is changing.

SECTION 2: IDENTIFYING INFORMATION

A. BUSINESS LOCATION INFORMATION

- DMEPOS suppliers must complete and submit a separate CMS-855S enrollment application to enroll each physical location (i.e., store or other retail establishment) used to furnish Medicare covered DMEPOS to Medicare beneficiaries except for locations only used as warehouses or repair facilities.
- The address must be a specific street address as recorded by the United States Postal Service. Do not furnish a P.O. Box. If you are located in a hospital and/or other health care facility and you provide services to patients at that facility, furnish the name and address of the hospital or facility.
- A change to the business location address requires submission of professional and business licenses for the new address, and proof of insurance covering the new address.

If you are reporting a change of information to your current business location, check the box below and furnish the effective date.

☐ **Change** **Effective Date (mm/dd/yyyy):** _____

Business Location Name/Doing Business As Name

Business Location Address Line 1 (Street Name and Number)

Business Location Address Line 2 (Suite, Room, Apt. #, etc.)

City/Town

State

ZIP Code + 4

Telephone Number

Fax Number (if applicable)

E-mail Address (if applicable)

Date this Business Started at this Location (mm/dd/yyyy)

Date this Business Terminated at this Location (if applicable) (mm/dd/yyyy)

B. HOURS OF OPERATION

List your **posted** hours of operation as displayed at the business location in Section 2A above.

If you are reporting a change to your hours of operation, check the box below and furnish the effective date.

☐ **Change** **Effective Date (mm/dd/yyyy):** _____

You must list all hours of each day you are open to the public.

Check and/or complete all boxes and/or sections for each day as appropriate.

☐ Open 24/7 (Open 24 hours a day, 7 days a week)

☐ By Appointment Only

NOTE: "By Appointment Only" can only be checked if you meet the exemption requirements stated in 42 CFR § 424.57(c)(30).

Day of Week	Hours (Indicate A.M. or P.M)		Hours (Indicate A.M. or P.M)		Total Hours Open to the Public Each Day
	Open	Close	Open	Close	
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					

Total Hours Open to the Public Weekly ATTACHMENT 5

SECTION 2: IDENTIFYING INFORMATION (Continued)

C. BUSINESS STRUCTURE INFORMATION

Identify the type of business structure for this supplier (Check one):

- ☐ Publicly Traded Corporation (regardless of whether supplier is "for-profit" or "non-profit")
- ☐ Not Publicly Traded Corporation (regardless of whether supplier is "for-profit" or "non-profit")
- ☐ Limited Liability Company (LLC)
- ☐ Partnership ("general" or "limited")
- ☐ Sole Proprietor/Sole Proprietorship
- ☐ Government-Owned
- ☐ Other (Specify) _____

D. INTERNAL REVENUE SERVICE REGISTRATION INFORMATION

Identify how your business is registered with the IRS.

If you check Non-Profit submit a copy of your IRS Form 501(c)(3).

If you check Disregarded Entity submit a copy of your IRS Form 8832.

NOTE: If your business is a Federal and/or State government supplier indicate "Non-Profit" below.

- ☐ Proprietary ☐ Non-Profit ☐ Disregarded Entity

E. STATES WHERE ITEMS PROVIDED

Select all State(s)/Territory(ies) where you provide items or services to Medicare beneficiaries from the business location in Section 2A. For each State/Territory selected, submit all required licenses for the products and services being provided.

Jurisdiction A:

☐ All States in Jurisdiction A

- | | | | |
|---|--|--|---------------------------------------|
| ☐ Connecticut | ☐ Maine | ☐ New Hampshire | ☐ Pennsylvania |
| ☐ Delaware | ☐ Maryland | ☐ New Jersey | ☐ Rhode Island |
| ☐ District of Columbia | ☐ Massachusetts | ☐ New York | ☐ Vermont |

Jurisdiction B:

☐ All States in Jurisdiction B

- | | | |
|-----------------------------------|------------------------------------|------------------------------------|
| ☐ Illinois | ☐ Michigan | ☐ Wisconsin |
| ☐ Indiana | ☐ Minnesota | |
| ☐ Kentucky | ☐ Ohio | |

Jurisdiction C:

☐ All States and Territories in Jurisdiction C

- | | | | |
|-----------------------------------|---|---|--|
| ☐ Alabama | ☐ Louisiana | ☐ Puerto Rico | ☐ Virginia |
| ☐ Arkansas | ☐ Mississippi | ☐ South Carolina | ☐ West Virginia |
| ☐ Colorado | ☐ New Mexico | ☐ Tennessee | |
| ☐ Florida | ☐ North Carolina | ☐ Texas | |
| ☐ Georgia | ☐ Oklahoma | ☐ Virgin Islands | |

Jurisdiction D:

☐ All States and Territories in Jurisdiction D

- | | | | |
|-------------------------------------|-----------------------------------|---------------------------------------|---|
| ☐ Alaska | ☐ Idaho | ☐ Nebraska | ☐ Utah |
| ☐ Arizona | ☐ Iowa | ☐ Nevada | ☐ Washington |
| ☐ California | ☐ Kansas | ☐ North Dakota | ☐ Wyoming |
| ☐ Guam | ☐ Missouri | ☐ Oregon | ☐ Northern Mariana Islands |
| ☐ Hawaii | ☐ Montana | ☐ South Dakota | ☐ American Samoa |

ATTACHMENT 5

SECTION 3: PRODUCTS/ACCREDITATION INFORMATION

A. TYPE OF SUPPLIER

The supplier must meet all Medicare requirements for the DMEPOS supplier type checked. Any specialty personnel including, but not limited to, Respiratory Therapists and Orthotics/Prosthetics personnel must have current licensure as applicable to the supplier type checked as well as for all products and services checked in Sections 3C and 3D.

Check all that apply:

- | | |
|--|--|
| ☐ Ambulatory Surgical Center | ☐ Nursing Facility (other) |
| ☐ Department Store | ☐ Ocularist |
| ☐ Grocery Store | ☐ Occupational Therapist |
| ☐ Home Health Agency | ☐ Optician |
| ☐ Hospital | ☐ Orthotics Personnel |
| ☐ Indian Health Service or Tribal Facility | ☐ Oxygen and/or Oxygen Related Equipment Supplier |
| ☐ Intermediate Care Nursing Facility | ☐ Pedorthic Personnel |
| ☐ Medical Supply Company | ☐ Pharmacy |
| ☐ Medical Supply Company with Orthotics Personnel | ☐ Physical Therapist |
| ☐ Medical Supply Company with Pedorthic Personnel | ☐ Physician |
| ☐ Medical Supply Company with Prosthetics Personnel | ☐ Physician/Dentist |
| ☐ Medical Supply Company with Prosthetic and Orthotic Personnel | ☐ Physician/Optomtrist |
| ☐ Medical Supply Company with Registered Pharmacist | ☐ Prosthetics Personnel |
| ☐ Medical Supply Company with Respiratory Therapist | ☐ Prosthetic and Orthotic Personnel |
| | ☐ Rehabilitation Agency |
| | ☐ Skilled Nursing Facility |
| | ☐ Sleep Laboratory/Medicine |
| | ☐ Sports Medicine |
| | ☐ Other _____ |

B. ACCREDITATION INFORMATION

NOTE: If more than one accreditation needs to be reported, copy and complete this section for each.

Check one of the following and furnish any additional information as requested:

- ☐ The enrolling supplier business location in Section 2A is accredited.
- ☐ The enrolling supplier business location in Section 2A is exempt from accreditation requirements.

To determine if you qualify for exemption, go to <https://www.palmettogba.com/NSC>.

Name of Accrediting Organization _____

Effective Date of Current Accreditation (mm/dd/yyyy) _____

Expiration Date of Current Accreditation (mm/dd/yyyy) _____

C. NON-ACCREDITED PRODUCTS

Check all that apply. These products do not require accreditation.

- ☐ Epoetin
- ☐ Immunosuppressive Drugs
- ☐ Infusion Drugs
- ☐ Nebulizer Drugs
- ☐ Oral Anticancer Drugs
- ☐ Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

NOTE: ☐ Check here if the supplier provides one or more of the products shown above but does not furnish any of the products and/or services listed in Section 3D. If checked, skip Section 3D and continue to Section 4.

SECTION 3: PRODUCTS/ACCREDITATION INFORMATION (Continued)

D. PRODUCTS AND SERVICES FURNISHED BY THIS SUPPLIER

Check all that apply and submit all applicable licenses and/or certifications.

If you are unsure of the licensure and/or certification and/or accreditation requirements for your product(s) or services(s), check with your State. The NSC MAC website at <https://www.palmettogba.com/nsc> may offer guidance. Failure to attach applicable licensure and/or certification could result in denial or revocation of your Medicare billing privileges and/or overpayment collection.

- | | |
|--|---|
| ☐ Automatic External Defibrillators (AEDs) and/or Supplies | ☐ Orthoses: Off-the-Shelf |
| ☐ Blood Glucose Monitors and/or Supplies (mail order) | ☐ Osteogenesis Stimulators |
| ☐ Blood Glucose Monitors and/or Supplies (non-mail order) | ☐ Ostomy Supplies |
| ☐ Breast Prostheses and/or Accessories | ☐ Oxygen Equipment and/or Supplies |
| ☐ Canes and/or Crutches | ☐ Parenteral Nutrients |
| ☐ Cochlear Implants | ☐ Parenteral Equipment and/or Supplies |
| ☐ Commodes/Urinals/Bedpans | ☐ Patient Lifts |
| ☐ Continuous Passive Motion (CPM) Devices | ☐ Penile Pumps |
| ☐ Continuous Positive Airway Pressure (CPAP) Devices and/or Supplies | ☐ Pneumatic Compression Devices and/or Supplies |
| ☐ Contracture Treatment Devices: Dynamic Splint | ☐ Power Operated Vehicles (Scooters) |
| ☐ Diabetic Shoes/Inserts | ☐ Prosthetic Lenses: Conventional Contact Lenses |
| ☐ Diabetic Shoes/Inserts—Custom | ☐ Prosthetic Lenses: Conventional Eyeglasses |
| ☐ Enteral Nutrients | ☐ Prosthetic Lenses: Prosthetic Cataract Lenses |
| ☐ Enteral Equipment and/or Supplies | ☐ Respiratory Assist Devices |
| ☐ External Infusion Pumps and/or Supplies | ☐ Respiratory Suction Pumps |
| ☐ Facial Prostheses | ☐ Seat Lift Mechanisms |
| ☐ Gastric Suction Pumps | ☐ Somatic Prostheses |
| ☐ Heat & Cold Applications | ☐ Speech Generating Devices |
| ☐ Hemodialysis Equipment and/or Supplies | ☐ Support Surfaces: Pressure Reducing Beds/Mattresses/Overlays/Pads |
| ☐ High Frequency Chest Wall Oscillation (HFCWO) Devices and/or Supplies | ☐ Surgical Dressings |
| ☐ Home Dialysis Equipment and/or Supplies | ☐ Tracheostomy Supplies |
| ☐ Hospital Beds—Electric | ☐ Traction Equipment |
| ☐ Hospital Beds—Manual | ☐ Transcutaneous Electrical Nerve Stimulators (TENS) and/or Supplies |
| ☐ Implanted Infusion Pumps and/or Supplies | ☐ Ultraviolet Light Devices and/or Supplies |
| ☐ Infrared Heating Pad Systems and/or Supplies | ☐ Urological Supplies |
| ☐ Insulin Infusion Pumps and/or Supplies | ☐ Ventilators Accessories and/or Supplies |
| ☐ Intermittent Positive Pressure Breathing (IPPB) Devices | ☐ Voice Prosthetics |
| ☐ Intrapulmonary Percussive Ventilation Devices | ☐ Walkers |
| ☐ Invasive Mechanical Ventilation Devices | ☐ Wheelchair Seating/Cushions |
| ☐ Limb Prostheses | ☐ Wheelchairs—Complex Rehabilitative Manual Wheelchairs |
| ☐ Mechanical In-Exsufflation Devices | ☐ Wheelchairs—Complex Rehabilitative Manual Wheelchair Related Accessories |
| ☐ Nebulizer Equipment and/or Supplies | ☐ Wheelchairs—Complex Rehabilitative Power Wheelchairs |
| ☐ Negative Pressure Wound Therapy Pumps and/or Supplies | ☐ Wheelchairs—Complex Rehabilitative Power Wheelchair Related Accessories |
| ☐ Neuromuscular Electrical Stimulators (NMES) and/or Supplies | ☐ Wheelchairs—Standard Manual |
| ☐ Neurostimulators and/or Supplies | ☐ Wheelchairs—Standard Manual Related Accessories |
| ☐ Ocular Prostheses | ☐ Wheelchairs—Standard Power |
| ☐ Orthoses: Custom Fabricated | ☐ Wheelchairs—Standard Power Related Accessories |
| ☐ Orthoses: Prefabricated (non-custom fabricated) | |

SECTION 4: IMPORTANT ADDRESS INFORMATION

A. 1099 MAILING ADDRESS

1. Organizational Suppliers (e.g., Corporations, Partnerships, LLCs, Sub-Chapter S)

If you are an organizational supplier, furnish the supplier's legal business name (as reported to the IRS) and TIN. Furnish 1099 mailing address information where indicated. A copy of the IRS Form CP-575 or other document issued by the IRS showing the TIN and LBN for this business **MUST** be submitted.

If you are reporting a change to your 1099 mailing address, check the box below and furnish the effective date.

☐ **Change** **Effective Date (mm/dd/yyyy):** _____

Organizational Suppliers: 1099 Mailing Address

Legal Business Name as Reported to the IRS

Tax Identification Number

Prior Tax Identification Number (if applicable)

1099 Mailing Address Line 1 (P.O. Box or Street Name and Number)

1099 Mailing Address Line 2 (Suite, Room, Apt. #, etc.)

1099 Mailing Address City/Town

1099 Mailing Address State

1099 Mailing Address ZIP Code + 4

2. Sole Proprietors

If you are a sole proprietor (the only owner of a business that is not incorporated), list your Social Security Number (SSN) and the full legal name associated with your SSN as reported to the IRS in the appropriate fields. If you want your Medicare payments reported under your Employer Identification Number (EIN) furnish it in the appropriate space below. Furnish 1099 mailing address information where indicated.

NOTE: Sole Proprietors: If you furnish an EIN, payment will be made to your EIN. If you do not furnish an EIN, payment will be made to your SSN. You can not use both an SSN and EIN. You can only use one number to bill Medicare. If furnishing an EIN, a copy of the IRS Form CP-575 or other document issued by the IRS showing the EIN and legal name for this business **MUST** be submitted.

If you are reporting a change to your 1099 mailing address, check the box below and furnish the effective date.

☐ **Change** **Effective Date (mm/dd/yyyy):** _____

Sole Proprietors: 1099 Mailing Address

Social Security Number (required)

Employer Identification Number (optional)

Prior Employer Identification Number (if applicable)

Full Legal Name Associated with this Social Security Number

1099 Mailing Address Line 1 (P.O. Box or Street Name and Number)

1099 Mailing Address Line 2 (Suite, Room, Apt. #, etc.)

1099 Mailing Address City/Town

1099 Mailing Address State

1099 Mailing Address ZIP Code + 4

ATTACHMENT 5

SECTION 4: IMPORTANT ADDRESS INFORMATION *(Continued)*

B. CORRESPONDENCE MAILING ADDRESS

This is the address where correspondence will be sent to you by the NSC MAC and/or the DME MAC, OR

- ☐ Check here if you want all Correspondence mailed to your Business Location Address in Section 2A and skip this section.

If you are reporting a change to your Correspondence Mailing Address, check the box below and furnish the effective date.

- ☐ **Change** **Effective Date (mm/dd/yyyy):** _____

Business Location Name

Attention *(optional)*

Correspondence Mailing Address Line 1 *(P.O. Box or Street Name and Number)*

Correspondence Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town

State

ZIP Code + 4

Telephone Number *(if applicable)*

Fax Number *(if applicable)*

E-mail Address *(if applicable)*

C. REVALIDATION REQUEST PACKAGE MAILING ADDRESS

This is the address where the NSC MAC will send your enrollment revalidation request package, OR

- ☐ Check here if your Revalidation Request Package should be mailed to your Business Location Address in Section 2A and skip this section, OR

- ☐ Check here if your Revalidation Request Package should be mailed to your Correspondence Mailing Address in Section 4B and skip this section.

If you are reporting a change to your Revalidation Request Package Mailing Address, check the box below and furnish the effective date.

- ☐ **Change** **Effective Date (mm/dd/yyyy):** _____

Business Location Name

Attention *(optional)*

Revalidation Request Package Mailing Address Line 1 *(P.O. Box or Street Name and Number)*

Revalidation Request Package Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town

State

ZIP Code + 4

Telephone Number *(if applicable)*

Fax Number *(if applicable)*

E-mail Address *(if applicable)*

ATTACHMENT 5

SECTION 4: IMPORTANT ADDRESS INFORMATION (Continued)

D. REMITTANCE NOTICES/SPECIAL PAYMENTS MAILING ADDRESS

Medicare will issue all routine payments via electronic funds transfer (EFT). Since payment will be made by EFT, the special payments address below should indicate where all other payment information (e.g., remittance notices, non-routine special payments) should be sent, **OR**

- ☐ Check here if your Remittance Notices/Special Payments should be mailed to your Business Location Address in Section 2A and skip this section, **OR**
- ☐ Check here if your Remittance Notices/Special Payments should be mailed to your Correspondence Address in Section 4B and skip this section.

NOTE: If you are a new enrollee, you must submit an EFT Authorization Agreement (CMS-588) with this application.

If you need to make changes to your current EFT Authorization Agreement (CMS-588), contact your DME MAC.

If you are reporting a change to your Remittance Notice/Special Payment Mailing Address, check the box below and furnish the effective date.

☐ **Change** **Effective Date (mm/dd/yyyy):** _____

NOTE: Payments will be made in the supplier's legal business name as shown in Section 1B.

Special Payments Address Line 1 (P.O. Box or Street Name and Number)

Special Payments Address Line 2 (Suite, Room, Apt. #, etc.)

City/Town	State	ZIP Code + 4

E. MEDICARE BENEFICIARY MEDICAL RECORDS STORAGE ADDRESS

If the Medicare beneficiaries' medical records are stored at a location other than the Business Location Address in Section 2A in accordance with 42 CFR § 424.57 (c)(7)(E), complete this section with the name and address of the storage location. This includes the records for both current and former Medicare beneficiaries.

Post office boxes and drop boxes are not acceptable as a physical address where Medicare beneficiaries' records are maintained. The records must be the supplier's records, not the records of another supplier. If all records are stored at the Business Location Address reported in Section 2A, check the box below and skip this section.

☐ Records are stored at the Business Location Address reported in Section 2A.

If you are adding or removing a Storage Location, check the box below and furnish the effective date.

☐ **Add** ☐ **Remove** **Effective Date (mm/dd/yyyy):** _____

1. Paper Storage

Name of Storage Facility

Storage Facility Address Line 1 (Street Name and Number)

Storage Facility Address Line 2 (Suite, Room, Apt. #, etc.)

City/Town	State	ZIP Code + 4

2. Electronic Storage

Do you store your patient medical records electronically? ☐ **Yes** ☐ **No**

If yes, identify where/how these records are stored below. This can be a website, URL, in-house software program, online service, vendor, etc. This must be a site that can be accessed by the NSC MAC if necessary.

Site where electronic records stored

ATTACHMENT 5

SECTION 5: COMPREHENSIVE LIABILITY INSURANCE INFORMATION

As required in 42 CFR § 424.57(c)(10), all DMEPOS suppliers must have comprehensive liability insurance in the amount of at least \$300,000 per occurrence and the insurance must remain in force at all times. The NSC MAC, with full mailing address as shown on page 3, must be listed on the policy as a Certificate Holder. You must submit a copy of the liability insurance policy or evidence of self-insurance with this application. Failure to maintain the required insurance at all times will result in revocation of your Medicare supplier billing number retroactive to the date the insurance lapsed, and/or overpayment collection.

Malpractice Insurance is not the same as Comprehensive Liability Insurance and does not meet compliance for this requirement.

If you are changing your comprehensive liability insurance information, check the box below and furnish the effective date.

☐ **Change** **Effective Date (mm/dd/yyyy):** _____

Name of Insurance Company

Insurance Policy Number	Date Policy Issued (mm/dd/yyyy)		Expiration Date of Policy (mm/dd/yyyy)	
Insurance Agent's First Name	Middle Initial	Last Name		Jr., Sr., M.D., etc.
Agent's Telephone Number	Agent's Fax Number (if applicable)		Agent's E-mail Address (if applicable)	
Underwriter's Company Name				
Underwriter's Telephone Number	Underwriter's Fax Number (if applicable)		Underwriter's E-mail Address (if applicable)	

SECTION 6: SURETY BOND INFORMATION

As required in 42 CFR § 424.57(d), DMEPOS suppliers who are required to obtain a surety bond must complete this section. Furnish all requested information about the surety bond company and the surety bond. Submit a copy of the original surety bond, signed by a Delegated or Authorized Official, with this application.

☐ Check here if this supplier is not required to obtain a surety bond and skip to Section 7.

A. NAME AND ADDRESS OF SURETY BOND COMPANY

If you are changing your surety bond information, check the box below and furnish the effective date.

☐ **Change** **Effective Date (mm/dd/yyyy):** _____

Legal Business Name of Surety Bond Company as Reported to the IRS		Tax Identification Number	
Business Address Line 1 (Street Name and Number)			
Business Address Line 2 (Suite, Room, Apt. #, etc.)			
City/Town		State	ZIP Code + 4
Telephone Number	Fax Number (if applicable)		E-mail Address (if applicable)

B. SURETY BOND INFORMATION

☐ **Change** **Effective Date (mm/dd/yyyy):** _____

Amount of Surety Bond \$	Surety Bond Number
Effective Date of Surety Bond (mm/dd/yyyy)	If reporting a new bond, give cancellation date of the current bond.

ATTACHMENT 5

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SECTION 7: FINAL ADVERSE LEGAL ACTIONS

This section captures information regarding final adverse legal actions such as convictions, exclusions, revocations and suspensions. All applicable final adverse legal actions must be reported regardless of whether any records were expunged or any appeals are pending.

A. CONVICTIONS

1. If this DMEPOS supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense it must be reported below. Reportable offenses include, but are not limited to:
 - Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions;
 - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions;
 - Any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and
 - Any felony that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 CFR § 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

B. EXCLUSIONS, REVOCATIONS OR SUSPENSIONS

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any past or current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

C. FINAL ADVERSE LEGAL ACTION HISTORY

If you are reporting a new final adverse legal action, check the box below and furnish the effective date.

☐ **New** **Effective Date** (mm/dd/yyyy): _____

1. Has the supplier identified in Sections 1B/2A, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against it?
☐ YES—Continue Below ☒ NO—Skip to Section 8
2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

SECTION 8: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)

Only report organizations in this section. Individuals must be reported in Section 9. The supplier **MUST** have at least **ONE** owner or controlling entity and **ONE** managing employee reported in Section 8 and/or Section 9.

Complete this section with information about all organizations that have 5 percent or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Sections 1B/2A, as well as any information on final adverse legal actions that have been imposed against that organization. For more information on "direct" and "indirect" owners and examples of organizations that must be reported in this section, go to: <https://www.cms.gov/MedicareProviderSupEnroll>. If there is more than one organization with ownership interest or managing control, copy and complete this section for each.

OWNERSHIP INTEREST (ORGANIZATIONS)

All organizations that have any of the following must be reported:

- 5 percent or more direct or indirect ownership of the DMEPOS supplier
- A partnership interest in the DMEPOS supplier, regardless of the partners' percentage of ownership
- Managing control of the DMEPOS supplier

Owning/Managing organizations are generally one of the following types:

- Corporations (including non-profit corporations)
- Partnerships and Limited Partnerships (as indicated above)
- Limited Liability Companies
- Charitable and/or Religious Organizations
- Governmental and/or Tribal Organizations

MANAGING CONTROL (ORGANIZATIONS)

Any organization that exercises operational or managerial control over the DMEPOS supplier, or conducts the day-to-day operations of the DMEPOS supplier, is a managing organization and must be reported. The organization need not have an ownership interest in the DMEPOS supplier in order to qualify as a managing organization. For example, it could be a management services organization under contract with the DMEPOS supplier to furnish management services for this business location.

SPECIAL TYPES OF ORGANIZATIONS

Governmental/Tribal Facilities:

If a Federal, State, county, city or other level of government, the Indian Health Service (IHS), or an Indian tribe will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government, the IHS or Indian tribe must be reported as an owner or controlling entity. The DMEPOS supplier must submit a letter on the letterhead of the responsible government agency or tribal organization that attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an appointed or elected official of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare. The appointed/elected official who signed the letter must be reported in Section 9.

Indian Health Service or Tribal Facilities:

Special rules concerning insurance and licenses apply. Contact the NSC MAC concerning these rules.

Non-Profit, Charitable and Religious Organizations:

Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body must be reported in this section. While the organization must be reported in Section 8, individual board members must be reported in Section 9. Each non-profit organization must submit a copy of the IRS Form 501(c)(3) verifying its non-profit status.

SECTION 8: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) (Continued)

A. ORGANIZATION IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

☐ Check here if this section is not applicable for the supplier reported in Sections 1B/2A, and skip to Section 9.

If you are changing information about a currently reported owning or managing organization or adding or removing an owning or managing organization, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☒ Add ☐ Remove Effective Date (mm/dd/yyyy): 09/01/2013

1. Complete all identifying information below.

Legal Business Name as Reported to the Internal Revenue Service

Northwestern Memorial HealthCare

"Doing Business As" Name (if applicable)

Business Address Line 1 (Street Name and Number)

211 E. Ontario Street

Business Address Line 2 (Suite, Room, Apt. #, etc.)

Suite 1800

City/Town

Chicago

State

IL

ZIP Code + 4

60611-3242

Tax Identification Number (Required)

[REDACTED]

NPI (if issued)

N/A

Medicare Identification Number(s) (if issued)

N/A

Telephone Number

(312) 926-4505

Fax Number (if applicable)

N/A

E-mail Address (if applicable)

N/A

2. What is the above organization's ownership interest in the supplier reported in Section 1B/2A?

☒ 5% or Greater Direct/Indirect Owner ☐ Partner ☐ Government/Tribal Owner

3. What is the effective date the above organization acquired and/or ended the above ownership interest?

☒ Acquired Effective Date (mm/dd/yyyy): 09/01/2013

☐ Ended Effective Date (mm/dd/yyyy):

4. What is the above organization's managing control of the supplier reported in Section 1B/2A? (Check all that apply)

☐ Managing Organization ☐ Board of Trustees ☐ Governing Body ☐ Controlling Entity (Gov't/Tribe)

5. What is the effective date the above organization acquired and/or ended the above managing control?

☐ Acquired Effective Date (mm/dd/yyyy):

☐ Ended Effective Date (mm/dd/yyyy):

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for each organization reported in Section 8A.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ New Effective Date (mm/dd/yyyy):

1. Has the organization in Section 8A above, under any current or former name or business identity, ever had a final adverse legal action listed in Section 7 of this application imposed against it?

☐ YES—Continue Below ☒ NO—Skip to Section 9

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION
			ATTACHMENT 5

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SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

Only report individuals in this section. Organizations must be reported in Section 8. The supplier **MUST** have at least **ONE** owner or controlling entity and **ONE** managing employee reported in Section 8 and/or Section 9.

NOTE: An individual owner may also be the managing employee to satisfy this requirement.

Complete this section with information about all individuals that have 5 percent or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Sections 1B/2A, as well as any information on final adverse legal actions that have been imposed against that individual. For more information on "direct" and "indirect" owners and examples of individuals that must be reported in this section, go to: <https://www.cms.gov/MedicareProviderSupEnroll>. If there is more than one individual with ownership interest or managing control, copy and complete this section for each.

The following individuals must be reported in Section 9A:

- All persons who have a 5 percent or greater ownership (direct or indirect) interest in the DMEPOS supplier
- All officers, directors and board members if the DMEPOS supplier is a corporation (whether for-profit or non-profit)
- All managing employees of the DMEPOS supplier
- All individuals with a partnership interest, regardless of the partners' percentage of ownership; and
- All delegated and authorized officials reported in Sections 14 and 15

Example: A supplier is 100 percent owned by Company C, which itself is 100 percent owned by Individual D. Assume that Company C is reported in Section 8 as an owner of the supplier. Assume further that Individual D, as an indirect owner of the supplier, is reported in Section 9A1. Based on this example, the supplier would check the "5 Percent or Greater Direct/Indirect Owner" box in Section 9A2.

NOTE: All partners within a partnership must be reported in this application. This applies to both "General" and "Limited" partnerships. For instance, if a limited partnership has several limited partners and each of them only has a 1 percent interest in the DMEPOS supplier, each limited partner must be reported in this application, even though each owns less than 5 percent. The 5 percent threshold primarily applies to corporations and other organizations that are not partnerships.

For purposes of this application, the terms "officer," "director," and "managing employee" are defined as follows:

- The term "**Officer**" is defined as any person whose position is listed as being that of an officer in the DMEPOS supplier's "articles of incorporation" or "corporate bylaws," OR anyone who is appointed by the board of directors as an officer in accordance with the DMEPOS supplier's corporate bylaws.
- The term "**Director**" is defined as a member of the DMEPOS supplier's "board of directors." It does not necessarily include a person who may have the word "Director" in his/her job title (e.g., Departmental Director, Director of Operations).
- The term "**Managing Employee**" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of the DMEPOS supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the DMEPOS supplier.

NOTE: If a governmental or tribal organization will be legally and financially responsible for Medicare payments received (per the instructions for Governmental/Tribal Organizations in Section 8), the supplier is only required to report the appointed/elected official who signed the required letter legally and financially binding the Government/Tribal Organization and its managing employees in Section 9. Owners, partners, officers, and directors do not need to be reported.

SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you need to report more than one individual, copy and complete this section for each.

If you are changing information about a currently reported individual owner or manager or adding or removing an individual owner or manager, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☒ Add ☐ Remove Effective Date (mm/dd/yyyy): 09/01/2013

1. Complete all identifying information below.

First Name Eric	Middle Initial G.	Last Name Neilson	Jr., Sr., M.D., etc. M.D.
Social Security Number (Required) [REDACTED]		Date of Birth (mm/dd/yyyy) [REDACTED]	
Supplier Billing Number (if issued) [REDACTED]		NPI (if issued) [REDACTED]	
Telephone Number (312) 695-6609	Fax Number (if applicable) N/A	E-mail Address (if applicable) N/A	

2. What is the above individual's title? Board Member, President

3. What is the above individual's ownership interest in the supplier reported in Section 1B/2A?

☐ 5% or Greater Direct/Indirect Owner ☐ Partner

4. What is the effective date the above individual acquired and/or ended the above ownership interest?

Acquired Effective Date (mm/dd/yyyy):

☐ Ended Effective Date (mm/dd/yyyy):

5. What is the above individual's managing control of the supplier reported in Section 1B/2A? (Check all that apply).

☒ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official

☒ Director ☐ W-2 Managing Employee

6. What is the effective date the above individual acquired and/or ended the above managing control?

Acquired Effective Date (mm/dd/yyyy): 09/01/2011

☐ Ended Effective Date (mm/dd/yyyy):

7. Is the above individual also a Delegated Official or Authorized Official reported in Sections 14 or 15?

☐ Delegated Official ☐ Authorized Official ☒ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 9A above.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ New Effective Date (mm/dd/yyyy):

1. Has the individual reported in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 10

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

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**SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you need to report more than one individual, copy and complete this section for each.

If you are changing information about a currently reported individual owner or manager or adding or removing an individual owner or manager, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☒ Add ☐ Remove Effective Date (mm/dd/yyyy): 09/01/2013

1. Complete all identifying information below.

First Name Glenn	Middle Initial F.	Last Name Tilton	Jr., Sr., M.D., etc.
Social Security Number (Required) [REDACTED]		Date of Birth (mm/dd/yyyy) [REDACTED]	
Supplier Billing Number (if issued) N/A		NPI (if issued) N/A	
Telephone Number (312) 695-6609	Fax Number (if applicable) N/A	E-mail Address (if applicable) N/A	

2. What is the above individual's title? Board Member

3. What is the above individual's ownership interest in the supplier reported in Section 1B/2A?

☐ 5% or Greater Direct/Indirect Owner ☐ Partner

4. What is the effective date the above individual acquired and/or ended the above ownership interest?

Acquired Effective Date (mm/dd/yyyy):

☐ Ended Effective Date (mm/dd/yyyy):

5. What is the above individual's managing control of the supplier reported in Section 1B/2A? (Check all that apply).

☐ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official
☒ Director ☐ W-2 Managing Employee

6. What is the effective date the above individual acquired and/or ended the above managing control?

Acquired Effective Date (mm/dd/yyyy): 09/01/2013

☐ Ended Effective Date (mm/dd/yyyy):

7. Is the above individual also a Delegated Official or Authorized Official reported in Sections 14 or 15?

☐ Delegated Official ☐ Authorized Official ☒ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 9A above.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ New Effective Date (mm/dd/yyyy):

1. Has the individual reported in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 10

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

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SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you need to report more than one individual, copy and complete this section for each.

If you are changing information about a currently reported individual owner or manager or adding or removing an individual owner or manager, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☒ Add ☐ Remove Effective Date (mm/dd/yyyy): 09/01/2013

1. Complete all identifying information below.

First Name Thomas	Middle Initial A.	Last Name Cole	Jr., Sr., M.D., etc.
Social Security Number (Required) [REDACTED]		Date of Birth (mm/dd/yyyy) [REDACTED]	
Supplier Billing Number (if issued) N/A		NPI (if issued) N/A	
Telephone Number (312) 695-6609	Fax Number (if applicable) N/A	E-mail Address (if applicable) N/A	

2. What is the above individual's title? Board Member

3. What is the above individual's ownership interest in the supplier reported in Section 1B/2A?

☐ 5% or Greater Direct/Indirect Owner ☐ Partner

4. What is the effective date the above individual acquired and/or ended the above ownership interest?

Acquired Effective Date (mm/dd/yyyy):

☐ Ended Effective Date (mm/dd/yyyy):

5. What is the above individual's managing control of the supplier reported in Section 1B/2A? (Check all that apply).

☐ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official
☒ Director ☐ W-2 Managing Employee

6. What is the effective date the above individual acquired and/or ended the above managing control?

Acquired Effective Date (mm/dd/yyyy): 09/01/2013

☐ Ended Effective Date (mm/dd/yyyy):

7. Is the above individual also a Delegated Official or Authorized Official reported in Sections 14 or 15?

☐ Delegated Official ☐ Authorized Official ☒ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 9A above.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ New Effective Date (mm/dd/yyyy):

1. Has the individual reported in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against him/her?

☐ YES-Continue Below ☒ NO-Skip to Section 10

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

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SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you need to report more than one individual, copy and complete this section for each.

If you are changing information about a currently reported individual owner or manager or adding or removing an individual owner or manager, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☒ Add ☐ Remove Effective Date (mm/dd/yyyy): 09/01/2013

1. Complete all identifying information below.

First Name Stephen	Middle Initial	Last Name Crawford	Jr., Sr., M.D., etc.
Social Security Number (Required) [REDACTED]		Date of Birth (mm/dd/yyyy) [REDACTED]	
Supplier Billing Number (if issued) N/A		NPI (if issued) N/A	
Telephone Number (312) 695-6609	Fax Number (if applicable) N/A		E-mail Address (if applicable) N/A

2. What is the above individual's title? Board Member

3. What is the above individual's ownership interest in the supplier reported in Section 1B/2A?

☐ 5% or Greater Direct/Indirect Owner ☐ Partner

4. What is the effective date the above individual acquired and/or ended the above ownership interest?

Acquired Effective Date (mm/dd/yyyy):

☐ Ended Effective Date (mm/dd/yyyy):

5. What is the above individual's managing control of the supplier reported in Section 1B/2A? (Check all that apply).

☐ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official
☒ Director ☐ W-2 Managing Employee

6. What is the effective date the above individual acquired and/or ended the above managing control?

Acquired Effective Date (mm/dd/yyyy): 10/19/2005

☐ Ended Effective Date (mm/dd/yyyy):

7. Is the above individual also a Delegated Official or Authorized Official reported in Sections 14 or 15?

☐ Delegated Official ☐ Authorized Official ☒ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 9A above.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ New Effective Date (mm/dd/yyyy):

1. Has the individual reported in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 10

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

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SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you need to report more than one individual, copy and complete this section for each.

If you are changing information about a currently reported individual owner or manager or adding or removing an individual owner or manager, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☒ Add ☐ Remove Effective Date (mm/dd/yyyy): 09/01/2013

1. Complete all identifying information below.

First Name Daniel	Middle Initial M.	Last Name Derman	Jr., Sr., M.D., etc. M.D.
Social Security Number (Required) [REDACTED]		Date of Birth (mm/dd/yyyy) [REDACTED]	
Supplier Billing Number (if issued) L91278		NPI (if issued) [REDACTED]	
Telephone Number (312) 695-6609	Fax Number (if applicable) N/A	E-mail Address (if applicable) N/A	

2. What is the above individual's title? Board Member

3. What is the above individual's ownership interest in the supplier reported in Section 1B/2A?

☐ 5% or Greater Direct/Indirect Owner ☐ Partner

4. What is the effective date the above individual acquired and/or ended the above ownership interest?

Acquired Effective Date (mm/dd/yyyy):

☐ Ended Effective Date (mm/dd/yyyy):

5. What is the above individual's managing control of the supplier reported in Section 1B/2A? (Check all that apply).

☐ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official

☒ Director ☐ W-2 Managing Employee

6. What is the effective date the above individual acquired and/or ended the above managing control?

Acquired Effective Date (mm/dd/yyyy): 09/01/2013

☐ Ended Effective Date (mm/dd/yyyy):

7. Is the above individual also a Delegated Official or Authorized Official reported in Sections 14 or 15?

☐ Delegated Official ☐ Authorized Official ☒ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 9A above.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ New Effective Date (mm/dd/yyyy):

1. Has the individual reported in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 10

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you need to report more than one individual, copy and complete this section for each.

If you are changing information about a currently reported individual owner or manager or adding or removing an individual owner or manager, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☒ Add ☐ Remove Effective Date (mm/dd/yyyy): 09/01/2013

1. Complete all identifying information below.

First Name John	Middle Initial A.	Last Name Edwardson	Jr., Sr., M.D., etc. M.D.
Social Security Number (Required) [REDACTED]		Date of Birth (mm/dd/yyyy) [REDACTED]	
Supplier Billing Number (if issued) N/A		NPI (if issued) N/A	
Telephone Number (312) 695-6609	Fax Number (if applicable) N/A	E-mail Address (if applicable) N/A	

2. What is the above individual's title? Board Member

3. What is the above individual's ownership interest in the supplier reported in Section 1B/2A?

☐ 5% or Greater Direct/Indirect Owner ☐ Partner

4. What is the effective date the above individual acquired and/or ended the above ownership interest?

Acquired Effective Date (mm/dd/yyyy):

☐ Ended Effective Date (mm/dd/yyyy):

5. What is the above individual's managing control of the supplier reported in Section 1B/2A? (Check all that apply).

☐ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official
☒ Director ☐ W-2 Managing Employee

6. What is the effective date the above individual acquired and/or ended the above managing control?

Acquired Effective Date (mm/dd/yyyy): 09/01/2013

☐ Ended Effective Date (mm/dd/yyyy):

7. Is the above individual also a Delegated Official or Authorized Official reported in Sections 14 or 15?

☐ Delegated Official ☐ Authorized Official ☒ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 9A above.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ New Effective Date (mm/dd/yyyy):

1. Has the individual reported in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against him/her?

☐ YES-Continue Below ☒ NO-Skip to Section 10

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

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SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you need to report more than one individual, copy and complete this section for each.

If you are changing information about a currently reported individual owner or manager or adding or removing an individual owner or manager, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☒ Add ☐ Remove Effective Date (mm/dd/yyyy): 09/01/2013

1. Complete all identifying information below.

First Name Dean	Middle Initial M.	Last Name Harrison	Jr., Sr., M.D., etc.
Social Security Number (Required) [REDACTED]		Date of Birth (mm/dd/yyyy) [REDACTED]	
Supplier Billing Number (if issued) N/A		NPI (if issued) N/A	
Telephone Number (312) 695-6609	Fax Number (if applicable) N/A	E-mail Address (if applicable) N/A	

2. What is the above individual's title? Board Member

3. What is the above individual's ownership interest in the supplier reported in Section 1B/2A?

☐ 5% or Greater Direct/Indirect Owner ☐ Partner

4. What is the effective date the above individual acquired and/or ended the above ownership interest?

Acquired Effective Date (mm/dd/yyyy):

☐ Ended Effective Date (mm/dd/yyyy):

5. What is the above individual's managing control of the supplier reported in Section 1B/2A? (Check all that apply).

☐ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official
☒ Director ☐ W-2 Managing Employee

6. What is the effective date the above individual acquired and/or ended the above managing control?

Acquired Effective Date (mm/dd/yyyy): 12/06/2004

☐ Ended Effective Date (mm/dd/yyyy):

7. Is the above individual also a Delegated Official or Authorized Official reported in Sections 14 or 15?

☐ Delegated Official ☐ Authorized Official ☒ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 9A above.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ New Effective Date (mm/dd/yyyy):

1. Has the individual reported in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 10

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

**SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you need to report more than one individual, copy and complete this section for each.

If you are changing information about a currently reported individual owner or manager or adding or removing an individual owner or manager, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☒ Add ☐ Remove Effective Date (mm/dd/yyyy): 09/01/2013

1. Complete all identifying information below.

First Name David	Middle Initial M.	Last Name Mahvi	Jr., Sr., M.D., etc. M.D.
Social Security Number (Required) [REDACTED]		Date of Birth (mm/dd/yyyy) [REDACTED]	
Supplier Billing Number (if issued) K51636		NPI (if issued) [REDACTED]	
Telephone Number (312) 695-6609	Fax Number (if applicable) N/A	E-mail Address (if applicable) N/A	

2. What is the above individual's title? Board Member

3. What is the above individual's ownership interest in the supplier reported in Section 1B/2A?

☐ 5% or Greater Direct/Indirect Owner ☐ Partner

4. What is the effective date the above individual acquired and/or ended the above ownership interest?

☒ Acquired Effective Date (mm/dd/yyyy): _____

☐ Ended Effective Date (mm/dd/yyyy): _____

5. What is the above individual's managing control of the supplier reported in Section 1B/2A? (Check all that apply).

☐ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official

☒ Director ☐ W-2 Managing Employee

6. What is the effective date the above individual acquired and/or ended the above managing control?

☒ Acquired Effective Date (mm/dd/yyyy): 12/02/2009

☐ Ended Effective Date (mm/dd/yyyy): _____

7. Is the above individual also a Delegated Official or Authorized Official reported in Sections 14 or 15?

☐ Delegated Official ☐ Authorized Official ☒ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 9A above.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ New Effective Date (mm/dd/yyyy): _____

1. Has the individual reported in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 10

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you need to report more than one individual, copy and complete this section for each.

If you are changing information about a currently reported individual owner or manager or adding or removing an individual owner or manager, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☒ Add ☐ Remove Effective Date (mm/dd/yyyy): 09/01/2013

1. Complete all identifying information below.

First Name Amy	Middle Initial S.	Last Name Paller	Jr., Sr., M.D., etc. M.D.
Social Security Number (Required) [REDACTED]		Date of Birth (mm/dd/yyyy) [REDACTED]	
Supplier Billing Number (if issued) P08835		NPI (if issued) [REDACTED]	
Telephone Number (312) 695-6609	Fax Number (if applicable) N/A	E-mail Address (if applicable) N/A	

2. What is the above individual's title? Board Member

3. What is the above individual's ownership interest in the supplier reported in Section 1B/2A?

☐ 5% or Greater Direct/Indirect Owner ☐ Partner

4. What is the effective date the above individual acquired and/or ended the above ownership interest?

Acquired Effective Date (mm/dd/yyyy): _____
☐ Ended Effective Date (mm/dd/yyyy): _____

5. What is the above individual's managing control of the supplier reported in Section 1B/2A? (Check all that apply).

☐ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official
☒ Director ☐ W-2 Managing Employee

6. What is the effective date the above individual acquired and/or ended the above managing control?

Acquired Effective Date (mm/dd/yyyy): 02/01/2004
☐ Ended Effective Date (mm/dd/yyyy): _____

7. Is the above individual also a Delegated Official or Authorized Official reported in Sections 14 or 15?

☐ Delegated Official ☐ Authorized Official ☒ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 9A above.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ New Effective Date (mm/dd/yyyy): _____

1. Has the individual reported in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 10

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you need to report more than one individual, copy and complete this section for each.

If you are changing information about a currently reported individual owner or manager or adding or removing an individual owner or manager, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☒ Add ☐ Remove Effective Date (mm/dd/yyyy): 09/01/2013

1. Complete all identifying information below.

First Name Robert	Middle Initial L.	Last Name Parkinson	Jr., Sr., M.D., etc. Jr.
Social Security Number (Required) [REDACTED]		Date of Birth (mm/dd/yyyy) [REDACTED]	
Supplier Billing Number (if issued) N/A		NBI (if issued) N/A	
Telephone Number (312) 695-6609	Fax Number (if applicable) N/A	E-mail Address (if applicable) N/A	

2. What is the above individual's title? Board Member

3. What is the above individual's ownership interest in the supplier reported in Section 1B/2A?

☐ 5% or Greater Direct/Indirect Owner ☐ Partner

4. What is the effective date the above individual acquired and/or ended the above ownership interest?

Acquired Effective Date (mm/dd/yyyy): _____
☐ Ended Effective Date (mm/dd/yyyy): _____

5. What is the above individual's managing control of the supplier reported in Section 1B/2A? (Check all that apply).

☐ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official
☒ Director ☐ W-2 Managing Employee

6. What is the effective date the above individual acquired and/or ended the above managing control?

Acquired Effective Date (mm/dd/yyyy): 09/01/2013
☐ Ended Effective Date (mm/dd/yyyy): _____

7. Is the above individual also a Delegated Official or Authorized Official reported in Sections 14 or 15?

☐ Delegated Official ☐ Authorized Official ☒ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 9A above.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ New Effective Date (mm/dd/yyyy): _____

1. Has the individual reported in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 10

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you need to report more than one individual, copy and complete this section for each.

If you are changing information about a currently reported individual owner or manager or adding or removing an individual owner or manager, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☒ Add ☐ Remove Effective Date (mm/dd/yyyy): 09/01/2013

1. Complete all identifying information below.

First Name Andrew	Middle Initial T.	Last Name Parsa	Jr., Sr., M.D., etc. M.D.
Social Security Number (Required) [REDACTED]		Date of Birth (mm/dd/yyyy) [REDACTED]	
Supplier Billing Number (if issued) [REDACTED]		NPI (if issued) [REDACTED]	
Telephone Number (312) 695-6609	Fax Number (if applicable) N/A	E-mail Address (if applicable) N/A	

2. What is the above individual's title? Board Member

3. What is the above individual's ownership interest in the supplier reported in Section 1B/2A?

☐ 5% or Greater Direct/Indirect Owner ☐ Partner

4. What is the effective date the above individual acquired and/or ended the above ownership interest?

☒ Acquired Effective Date (mm/dd/yyyy): _____

☐ Ended Effective Date (mm/dd/yyyy): _____

5. What is the above individual's managing control of the supplier reported in Section 1B/2A? (Check all that apply).

☐ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official
☒ Director ☐ W-2 Managing Employee

6. What is the effective date the above individual acquired and/or ended the above managing control?

☒ Acquired Effective Date (mm/dd/yyyy): 07/01/2013

☐ Ended Effective Date (mm/dd/yyyy): _____

7. Is the above individual also a Delegated Official or Authorized Official reported in Sections 14 or 15?

☐ Delegated Official ☐ Authorized Official ☒ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 9A above.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ New Effective Date (mm/dd/yyyy): _____

1. Has the individual reported in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 10

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you need to report more than one individual, copy and complete this section for each.

If you are changing information about a currently reported individual owner or manager or adding or removing an individual owner or manager, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☒ Add ☐ Remove Effective Date (mm/dd/yyyy): 09/01/2013

1. Complete all identifying information below.

First Name Jane	Middle Initial D.	Last Name Pigott	Jr., Sr., M.D., etc.
Social Security Number (Required) [REDACTED]		Date of Birth (mm/dd/yyyy) [REDACTED]	
Supplier Billing Number (if issued) N/A		NPI (if issued) N/A	
Telephone Number (312) 695-6609	Fax Number (if applicable) N/A	E-mail Address (if applicable) N/A	

2. What is the above individual's title? Board Member

3. What is the above individual's ownership interest in the supplier reported in Section 1B/2A?

☐ 5% or Greater Direct/Indirect Owner ☐ Partner

4. What is the effective date the above individual acquired and/or ended the above ownership interest?

Acquired Effective Date (mm/dd/yyyy):

☐ Ended Effective Date (mm/dd/yyyy):

5. What is the above individual's managing control of the supplier reported in Section 1B/2A? (Check all that apply).

☐ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official
☒ Director ☐ W-2 Managing Employee

6. What is the effective date the above individual acquired and/or ended the above managing control?

Acquired Effective Date (mm/dd/yyyy): 01/11/2012

☐ Ended Effective Date (mm/dd/yyyy):

7. Is the above individual also a Delegated Official or Authorized Official reported in Sections 14 or 15?

☐ Delegated Official ☐ Authorized Official ☒ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 9A above.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ New Effective Date (mm/dd/yyyy):

1. Has the individual reported in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 10

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you need to report more than one individual, copy and complete this section for each.

If you are changing information about a currently reported individual owner or manager or adding or removing an individual owner or manager, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☒ Add ☐ Remove Effective Date (mm/dd/yyyy): 09/01/2013

1. Complete all identifying information below.

First Name Edward	Middle Initial T.	Last Name Tilly	Jr., Sr., M.D., etc.
Social Security Number (Required) [REDACTED]		Date of Birth (mm/dd/yyyy) [REDACTED]	
Supplier Billing Number (if issued) N/A		NPI (if issued) N/A	
Telephone Number (312) 695-6609	Fax Number (if applicable) N/A	E-mail Address (if applicable) N/A	

2. What is the above individual's title? Board Member
3. What is the above individual's ownership interest in the supplier reported in Section 1B/2A?
☐ 5% or Greater Direct/Indirect Owner ☐ Partner
4. What is the effective date the above individual acquired and/or ended the above ownership interest?
Acquired Effective Date (mm/dd/yyyy): _____
☐ Ended Effective Date (mm/dd/yyyy): _____
5. What is the above individual's managing control of the supplier reported in Section 1B/2A? (Check all that apply).
☐ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official
☒ Director ☐ W-2 Managing Employee
6. What is the effective date the above individual acquired and/or ended the above managing control?
Acquired Effective Date (mm/dd/yyyy): 09/01/2013
☐ Ended Effective Date (mm/dd/yyyy): _____
7. Is the above individual also a Delegated Official or Authorized Official reported in Sections 14 or 15?
☐ Delegated Official ☐ Authorized Official ☒ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 9A above.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ New Effective Date (mm/dd/yyyy): _____

1. Has the individual reported in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against him/her?
☐ YES-Continue Below ☒ NO-Skip to Section 10
2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

**SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you need to report more than one individual, copy and complete this section for each.

If you are changing information about a currently reported individual owner or manager or adding or removing an individual owner or manager, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☒ Add ☐ Remove Effective Date (mm/dd/yyyy): 09/01/2013

1. Complete all identifying information below.

First Name Nicholas	Middle Initial J.	Last Name Volpe	Jr., Sr., M.D., etc. M.D.
Social Security Number (Required) [REDACTED]		Date of Birth (mm/dd/yyyy) [REDACTED]	
Supplier Billing Number (if issued) [REDACTED]		NPI (if issued) [REDACTED]	
Telephone Number (312) 695-6609	Fax Number (if applicable) N/A		E-mail Address (if applicable) N/A

2. What is the above individual's title? Board Member
3. What is the above individual's ownership interest in the supplier reported in Section 1B/2A?
☐ 5% or Greater Direct/Indirect Owner ☐ Partner
4. What is the effective date the above individual acquired and/or ended the above ownership interest?
Acquired Effective Date (mm/dd/yyyy): _____
☐ Ended Effective Date (mm/dd/yyyy): _____
5. What is the above individual's managing control of the supplier reported in Section 1B/2A? (Check all that apply).
☐ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official
☒ Director ☐ W-2 Managing Employee
6. What is the effective date the above individual acquired and/or ended the above managing control?
Acquired Effective Date (mm/dd/yyyy): 09/01/2010
☐ Ended Effective Date (mm/dd/yyyy): _____
7. Is the above individual also a Delegated Official or Authorized Official reported in Sections 14 or 15?
☐ Delegated Official ☐ Authorized Official ☒ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 9A above.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ New Effective Date (mm/dd/yyyy): _____

1. Has the individual reported in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against him/her?
☐ YES-Continue Below ☒ NO-Skip to Section 10
2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

**SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION
(INDIVIDUALS) (Continued)**

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you need to report more than one individual, copy and complete this section for each.

If you are changing information about a currently reported individual owner or manager or adding or removing an individual owner or manager, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☒ Add ☐ Remove Effective Date (mm/dd/yyyy): 09/01/2013

1. Complete all identifying information below.

First Name Forrest	Middle Initial	Last Name Whittaker	Jr., Sr., M.D., etc.
Social Security Number (Required) [REDACTED]		Date of Birth (mm/dd/yyyy) [REDACTED]	
Supplier Billing Number (if issued) N/A		NPI (if issued) N/A	
Telephone Number (312) 695-6609	Fax Number (if applicable) N/A	E-mail Address (if applicable) N/A	

2. What is the above individual's title? Board Member

3. What is the above individual's ownership interest in the supplier reported in Section 1B/2A?

☐ 5% or Greater Direct/Indirect Owner ☐ Partner

4. What is the effective date the above individual acquired and/or ended the above ownership interest?

Acquired Effective Date (mm/dd/yyyy): _____
☐ Ended Effective Date (mm/dd/yyyy): _____

5. What is the above individual's managing control of the supplier reported in Section 1B/2A? (Check all that apply).

☐ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official
☒ Director ☐ W-2 Managing Employee

6. What is the effective date the above individual acquired and/or ended the above managing control?

Acquired Effective Date (mm/dd/yyyy): 09/01/2013
☐ Ended Effective Date (mm/dd/yyyy): _____

7. Is the above individual also a Delegated Official or Authorized Official reported in Sections 14 or 15?

☐ Delegated Official ☐ Authorized Official ☒ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 9A above.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ New Effective Date (mm/dd/yyyy): _____

1. Has the individual reported in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against him/her?

☐ YES—Continue Below ☒ NO—Skip to Section 10

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

ATTACHMENT 5

SECTION 10: BILLING AGENCY INFORMATION

A billing agency/agent is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency/agent you must complete this section. Even if you use a billing agency/agent, you remain responsible for the accuracy of the claims submitted on your behalf.

☐ Check here if this section does not apply and skip to Section 11.

If you are changing information about your current billing agency or adding or removing a billing agency, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Add ☐ Remove Effective Date (mm/dd/yyyy): _____

BILLING AGENCY NAME AND ADDRESS

Legal Business Name as reported to the Internal Revenue Service or Individual Name as Reported to the Social Security Administration

If Individual Billing Agent: Date of Birth (mm/dd/yyyy)

Billing Agency Tax Identification Number or Billing Agent Social Security Number (required)

Billing Agency "Doing Business As" Name (if applicable)

Billing Agency Address Line 1 (Street Name and Number)

Billing Agency Address Line 2 (Suite, Room, Apt. #, etc.)

City/Town		State	ZIP Code + 4
Telephone Number	Fax Number (if applicable)	E-mail Address (if applicable)	
Billing Agency/Agent Medicare Identification Number (PTAN) (if issued)		Billing Agency/Agent National Provider Identifier (NPI) (if issued)	

SECTION 11: CONTACT PERSON INFORMATION

If questions arise while processing this application, the NSC MAC will contact the individual checked below.

☐ Contact any Delegated Official reported in Section 14

☐ Contact any Authorized Official reported in Section 15

☒ Contact the person reported below

First Name Sarah	Middle Initial J.	Last Name Kitchell	Jr., Sr., M.D., etc.
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Contact Person Address Line 1 (Street Name and Number)

28 State Street

Contact Person Address Line 2 (Suite, Room, Apt. #, etc.)

McDermott Will & Emery

City/Town Boston		State MA	ZIP Code + 4 02109
Telephone Number (617) 535-3929	Fax Number (if applicable) (617) 535-3800	E-mail Address (if applicable) skitchell@mwe.com	

Relationship or Affiliation to this Supplier (Spouse, Secretary, Attorney, Billing Agent, etc.)

Attorney

NOTE: The Contact Person reported in this section will only be authorized to discuss issues concerning this enrollment application. The NSC MAC will not discuss any other Medicare issues for this supplier with the above Contact Person.

ATTACHMENT 5

SECTION 12: SUPPORTING DOCUMENTATION INFORMATION

This section lists the documents that, if applicable, must be submitted with this completed enrollment application. If you are newly enrolling, adding a new location, reactivating or revalidating, you must provide all applicable documents. For changes, only submit documents that are applicable to the change requested. All enrolling DMEPOS suppliers are required to furnish information on all Federal, State, and local professional and business licenses, certifications, and/or registrations required to practice as a DMEPOS supplier in the State of the business location as reported in Section 1A. Check the NSC MAC website for further guidance on supplier requirements. You are responsible for furnishing and adhering to all required licensure and/or certification requirements, etc. for the supplies/services you provide.

The enrolling DMEPOS supplier may submit a notarized Certificate of Good Standing from the DMEPOS supplier's business location's State licensing/certification board or other medical association, in lieu of copies of the requested documents. This certificate cannot be more than 30 days old.

If the enrolling DMEPOS supplier has had a previously revoked or suspended license, certification, or registration reinstated, attach a copy of the reinstatement notice with this application.

MANDATORY FOR ALL NEW APPLICATIONS AND/OR ADDITIONAL LOCATIONS

☐ Copies of all Federal, State, and/or local (city/county) professional and business licenses, certifications and/or registrations for applicable specialty supplier types, products and services

☐ Copy of comprehensive liability insurance policy

NOTE: The NSC MAC must be listed as a certificate holder

☐ Written confirmation from the IRS confirming your Tax Identification Number and Legal Business Name provided in Section 1B (e.g., IRS Form CP-575)

NOTE: This information is needed if the applicant is enrolling a professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.

☐ Completed Form CMS-588, Electronic Funds Transfer Authorization Agreement. Include a voided check.

NOTE: If you currently receive payments electronically and are not making a change to your banking information, the CMS-588 is not required.

MANDATORY, IF APPLICABLE

☒ Copy of IRS Determination Letter, if supplier is registered with the IRS as non-profit (e.g., IRS Form 501(c)(3))
Written confirmation from the IRS if your business is registered as a Limited Liability Company (LLC) confirming your LLC is automatically classified as a Disregarded Entity (e.g., IRS Form 8832)

NOTE: A Disregarded Entity is an eligible entity that is not treated as a separate entity from its single owner for income tax purposes.

☐ Copies of all final adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)

☐ If Medicare payments due a supplier are being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), the supplier must provide a statement in writing **from the bank** (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.

☐ Copy of delegated official's W-2 if one has been designated

☐ Copy of your bill of sale if you purchased an existing DMEPOS supplier with an active Medicare supplier billing number

☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement, if you want to be a participating supplier

☐ Copy of Surety Bond

☐ Copy of attestation letter for government entities and tribal facilities

SECTION 13: PENALTIES FOR FALSIFYING INFORMATION ON THIS APPLICATION

This section explains the penalties for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.
2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program. The offender is subject to fines of up to \$25,000 and/or imprisonment for up to five years.
3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:
 - a) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;
 - b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
 - c) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.The Act imposes a civil penalty of \$5,000 to \$10,000 per violation, plus three times the amount of damages sustained by the Government
4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency...a claim...that the Secretary determines is for a medical or other item or service that the person knows or should know:
 - a) was not provided as claimed; and/or
 - b) the claim is false or fraudulent.This provision authorizes a civil monetary penalty of up to \$10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.
5. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.
6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to execute a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.
7. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."
Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

SECTION 14: ASSIGNMENT OF DELEGATED OFFICIAL(S) (Optional)

A **DELEGATED OFFICIAL** means an individual who is delegated the authority to report changes and updates to the supplier's enrollment record by an authorized official. The delegated official must be an individual with "ownership or control interest in" (as that term is defined in Section 1124(a)(3) of the Social Security Act) or be a W-2 managing employee of the supplier. An independent contractor is not considered employed by the supplier and therefore cannot be a delegated official.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the supplier's Medicare enrollment information. Even when delegated officials are reported in this application, the authorized official retains the authority to make changes and/or updates.

You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the enrollment information.

The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, a delegated official certifies that he or she has read the Penalties for Falsifying Information in Section 13 and the Certification Statement in Section 15A and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier's enrollment information, the delegated official certifies that the information provided is true, correct and complete.

The signature of an authorized official in Section 14 constitutes a legal delegation of authority to all delegated official(s) assigned in Section 14. If you are delegating more than two individuals, copy and complete this section for each additional delegated individual.

NOTE: A delegated official who is being removed does not have to sign or date this application.

ASSIGNMENT OF DELEGATED OFFICIAL

All Delegated Officials must be reported in Section 9 of this application.

If you are adding or removing a delegated official, check the applicable box and furnish the effective date.

1st Delegated Official's Name and Signature

☐ Add ☐ Remove Effective Date (mm/dd/yyyy): _____

Under penalty of perjury, I, the undersigned, certify that I have read and understand the Certification Statement in Section 15A and accept the role of Delegated Official.

Delegated Official First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.
Delegated Official Signature (First, Middle, Last Name, Jr., Sr., M.D., etc.)			Date Signed (mm/dd/yyyy)
Telephone Number		E-mail Address (if applicable)	
Authorized Official's Signature Assigning this Delegation (First, Middle, Last Name, Jr., Sr., M.D., etc.)			Date Signed (mm/dd/yyyy)

2nd Delegated Official's Name and Signature

☐ Add ☐ Remove Effective Date (mm/dd/yyyy): _____

Under penalty of perjury, I, the undersigned, certify that I have read and understand the Certification Statement in Section 15A and accept the role of Delegated Official.

Delegated Official First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.
Delegated Official Signature (First, Middle, Last Name, Jr., Sr., M.D., etc.)			Date Signed (mm/dd/yyyy)
Telephone Number		E-mail Address (if applicable)	
Authorized Official's Signature Assigning this Delegation (First, Middle, Last Name, Jr., Sr., M.D., etc.)			Date Signed (mm/dd/yyyy)

All signatures must be original and signed in blue ink. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 15: AUTHORIZED OFFICIAL CERTIFICATION STATEMENT AND SIGNATURE

An **AUTHORIZED OFFICIAL** means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or 5% or greater direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's enrollment information in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

By his/her signature, an authorized official binds the supplier to all of the requirements listed in the Certification Statement and acknowledges that the supplier may be denied entry to or have its billing privileges revoked from the Medicare program if any requirements are not met. All signatures must be original and in blue ink. Faxed, photocopied, or stamped signatures will not be accepted.

By signing this application, an authorized official agrees to immediately notify the NSC MAC if any information in this application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the NSC MAC of any future changes to the information contained in this application after the supplier is enrolled in Medicare, within 30 days of the effective date of the change.

Applications submitted for initial enrollment must be signed by an Authorized Official or they will be rejected and returned unprocessed.

The certification below includes additional requirements that the supplier must meet and maintain to bill the Medicare program. Read these requirements carefully. By signing, you are attesting to having read the requirements and understanding them.

Your signature further stipulates that you agree to adhere to all of the requirements listed below and acknowledge that you may be denied entry into or have your billing privileges revoked from the Medicare program if any requirements are not met.

A. CERTIFICATION STATEMENT

You **MUST SIGN AND DATE** Section 15B of this certification statement to become enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

Under penalty of perjury, I, the undersigned, certify to the following:

1. I have read the contents of this application, and the information contained herein is true, correct and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NSC MAC of this fact immediately.
2. I agree to notify the NSC MAC of any current or future changes to the information contained in this application in accordance with the timeframes established in 42 CFR § 424.57. I understand that any change in the business structure of this supplier may require the submission of a new application.
3. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare identification number(s), and/or the imposition of fines, civil damages, and/or imprisonment.
4. I agree to abide by the Social Security Act and all applicable Medicare laws, regulations and program instructions that apply to this supplier. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.
5. Neither this supplier, nor any five percent or greater owner, partner, officer, director, managing employee, delegated official or authorized official thereof is currently sanctioned, suspended, debarred, or excluded by Medicare or any State Health Care Program (e.g., Medicaid program), or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.
6. I agree that any existing or future overpayment made to the supplier by the Medicare program may be recouped by Medicare through the withholding of future payments.
7. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
8. I authorize any national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of Medicare a copy of my most recent accreditation survey, together with any information related to the survey that Medicare may require (including corrective action plans).

ATTACHMENT 5

SECTION 15: AUTHORIZED OFFICIAL CERTIFICATION STATEMENT AND SIGNATURE
(Continued)

B. AUTHORIZED OFFICIAL SIGNATURE(S)

All Authorized Officials must be reported in Section 9 of this application.

If you are adding or removing an Authorized Official, check the applicable box and furnish the effective date.

1st Authorized Official

I have read the contents of this application and the certification statement in Section 15A of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC MAC to verify this information.

1st Authorized Official's Information and Signature

☐ Add ☐ Remove Effective Date (mm/dd/yyyy): _____

First Name (Print) Brian	Middle Initial	Last Name (Print) Walsh	Jr., Sr., M.D., etc.
Telephone Number (312) 695-0414	E-mail Address (if applicable)		Title/Position Vice President/Chief Financial Officer
Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., etc.) <i>Brian Michael Walsh</i>			Date Signed (mm/dd/yyyy) 09/26/2013

All signatures must be original and signed in blue ink. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed or copied signatures will not be accepted.

2nd Authorized Official

I have read the contents of this application and the certification statement in Section 15A of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC MAC to verify this information.

2nd Authorized Official's Information and Signature

☐ Add ☐ Remove Effective Date (mm/dd/yyyy): _____

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.
Telephone Number	E-mail Address (if applicable)		Title/Position
Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., etc.)			Date Signed (mm/dd/yyyy)

All signatures must be original and signed in blue ink. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed or copied signatures will not be accepted.

3rd Authorized Official

I have read the contents of this application and the certification statement in Section 15A of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC MAC to verify this information.

3rd Authorized Official's Information and Signature

☐ Add ☐ Remove Effective Date (mm/dd/yyyy): _____

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.
Telephone Number	E-mail Address (if applicable)		Title/Position
Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., etc.)			Date Signed (mm/dd/yyyy)

All signatures must be original and signed in blue ink. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed or copied signatures will not be accepted.

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Authority for maintenance of the system is given under provisions of sections 1102(a) (Title 42 U.S.C. 1302(a)), 1128 (42 U.S.C. 1320a-7), 1814(a) (42 U.S.C. 1395f(a)(1), 1815(a) (42 U.S.C. 1395g(a)), 1833(e) (42 U.S.C. 1395l(3)), 1871 (42 U.S.C. 1395hh), and 1886(d)(5)(F), (42 U.S.C. 1395ww(d)(5)(F) of the Social Security Act; 1842(r) (42 U.S.C. 1395u(r)); section 1124(a)(1) (42 U.S.C. 1320a-3(a)(1), and 1124A (42 U.S.C. 1320a-3a), section 4313, as amended, of the BBA of 1997; and section 31001(i) (31 U.S.C. 7701) of the DCIA (Pub. L. 104-134), as amended.

The information collected here will be entered into the Provider Enrollment, Chain and Ownership System (PECOS).

PECOS will collect information provided by an applicant related to identity, qualifications, practice locations, ownership, billing agency information, reassignment of benefits, electronic funds transfer, the NPI and related organizations. PECOS will also maintain information on business owners, chain home offices and provider/chain associations, managing/ directing employees, partners, authorized and delegated officials, supervising physicians of the supplier, ambulance vehicle information, and/or interpreting physicians and related technicians. This system of records will contain the names, social security numbers (SSN), date of birth (DOB), and employer identification numbers (EIN) and NPI's for each disclosing entity, owners with 5 percent or more ownership or control interest, as well as managing/directing employees. Managing/directing employees include general manager, business managers, administrators, directors, and other individuals who exercise operational or managerial control over the provider/ supplier. The system will also contain Medicare identification numbers (i.e., CCN, PTAN and the NPI), demographic data, professional data, past and present history as well as information regarding any adverse legal actions such as exclusions, sanctions, and felonious behavior.

The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." The CMS will only release PECOS information that can be associated with an individual as provided for under Section III "Proposed Routine Use Disclosures of Data in the System." Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. Below is an abbreviated summary of the six routine uses. To view the routine uses in their entirety go to: <http://www.cms.gov/RegulationsandGuidance/Guidance/PrivacyActSystemofRecords/downloads/0532.pdf>.

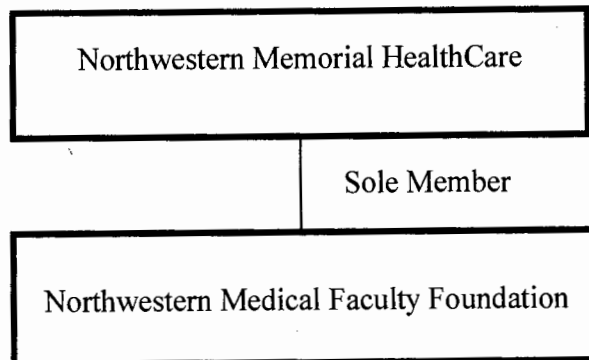
1. To support CMS contractors, consultants, or grantees, who have been engaged by CMS to assist in the performance of a service related to this collection and who need to have access to the records in order to perform the activity.
2. To assist another Federal or state agency, agency of a state government or its fiscal agent to:
 - a. Contribute to the accuracy of CMS's proper payment of Medicare benefits,
 - b. Enable such agency to administer a Federal health benefits program that implements a health benefits program funded in whole or in part with federal funds, and/or
 - c. Evaluate and monitor the quality of home health care and contribute to the accuracy of health insurance operations.
3. To assist an individual or organization for research, evaluation or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for payment related projects.
4. To support the Department of Justice (DOJ), court or adjudicatory body when:
 - a. The agency or any component thereof, or
 - b. Any employee of the agency in his or her official capacity, or
 - c. Any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or
 - d. The United States Government, is a party to litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which CMS collected the records.
5. To assist a CMS contractor that assists in the administration of a CMS administered health benefits program, or to combat fraud, waste, or abuse in such program.
6. To assist another Federal agency to investigate potential fraud, waste, or abuse in, a health benefits program funded in whole or in part by Federal funds.

The applicant should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

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 0938-1056. The time required to complete this information collection is estimated to be 4 hours per response, including the time to review instructions, search existing data 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 Reports Clearance Officer, Baltimore, Maryland 21244-1850.

DO NOT MAIL APPLICATIONS TO THIS ADDRESS. Mailing your application to this address will significantly delay application processing.

Post-Closing Structure



Internal Revenue Service
Washington, D.C. 20224

Department of the Treasury

Date: 04 DEC 1981

Employer Identification Number:

Key District:

Chicago

Accounting Period Ending:

August
Foundation Status Classification:

509(a)(1) & 170(b)(1)(A)(vi)
Advance Ruling Period Ends:

December 31, 1982

Person to Contact: William C. Gorms
(202) 583-6373

Contact Telephone Number:

Northwestern Foundation
For Research and Education
79 W. Monroe Street
Suite 700
Chicago, IL 60603

Dear Applicant:

Based on information supplied, and assuming your operations will be as stated in your application for recognition of exemption, we have determined you are exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code.

Because you are a newly created organization, we are not now making a final determination of your foundation status under section 509(a) of the Code. However, we have determined that you can reasonably be expected to be a publicly supported organization described in section 509(a)(1) and 170(b)(1)(A)(vi).

Accordingly, you will be treated as a publicly supported organization, and not as a private foundation, during an advance ruling period. This advance ruling period begins on the date of your inception and ends on the date shown above.

Within 90 days after the end of your advance ruling period, you must submit to your key District Director information needed to determine whether you have met the requirements of the applicable support test during the advance ruling period. If you establish that you have been a publicly supported organization, you will be classified as a section 509(a)(1) or 509(a)(2) organization as long as you continue to meet the requirements of the applicable support test. If you do not meet the public support requirements during the advance ruling period, you will be classified as a private foundation for future periods. Also, if you are classified as a private foundation, you will be treated as a private foundation from the date of your inception for purposes of sections 507(d) and 4940.

Grantors and donors may rely on the determination that you are not a private foundation until 90 days after the end of your advance ruling period. If you submit the required information within the 90 days, grantors and donors may continue to rely on the advance determination until the Service makes a final determination of your foundation status. However, if notice that you will no longer be treated as a section 509(a)(1) organization is published in the Internal Revenue Bulletin, grantors and donors may not rely on this determination after the date of such publication. Also, a grantor or donor may not rely on this 509(a)(1) determination if he or she was in part responsible for, or was aware of, the act or failure to act that resulted in your loss of section 509(a)(1) status, or acquired knowledge that the Internal Revenue Service had given notice that you would be removed from classification as a section 509(a)(1) organization.

(over)

M-6483 (6-77)

ATTACHMENT 5

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If your sources of support, or your purposes, character, or method of operation change, please let your key district know so that office can consider the effect of the change on your exempt status and foundation status. Also, you should inform your key District Director of all changes in your name or address.

Generally, you are not liable for social security (FICA) taxes unless you file a waiver of exemption certificate as provided in the Federal Insurance Contributions Act. If you have paid FICA taxes without filing the waiver, you should contact your key District Director. You are not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

Organizations that are not private foundations are not subject to the excise taxes under Chapter 42 of the Code. However, you are not automatically exempt from other Federal excise taxes. If you have questions about excise, employment, or other Federal taxes, contact any Internal Revenue Service office.

Donors may deduct contributions to you as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for Federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

You are required to file Form 990, Return of Organization Exempt from Income Tax, only if your gross receipts each year are normally more than \$10,000. If a return is required, it must be filed by the 15th day of the fifth month after the end of your annual accounting period. The law imposes a penalty of \$10 a day, up to a maximum of \$5,000, when a return is filed late, unless there is reasonable cause for the delay.

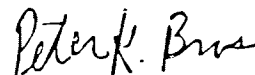
You are not required to file Federal income tax returns unless you are subject to the tax on unrelated business income under section 511 of the Code. If you are subject to this tax, you must file an income tax return on Form 990-T. In this letter, we are not determining whether any of your present or proposed activities are unrelated trade or business as defined in section 513 of the Code.

You need an employer identification number even if you have no employees. If an employer identification number was not entered on your application, a number will be assigned to you and you will be advised of it. Please use that number on all returns you file and in all correspondence with the Internal Revenue Service.

We are informing your key District Director of this action. Because this letter could help resolve any questions about your exempt status and foundation status, you should keep it in your permanent records.

If you have any questions, please contact the person whose name and telephone number are shown in the heading of this letter.

Sincerely yours,



Peter K. Bros
Chief, Rulings Section 2
Exempt Organizations
Technical Branch

M-6483 (6-77)

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Internal Revenue Service
District Director

Department of the Treasury

Date: 28 FEB 1985

Our Letter Dated: December 4, 1984

Person to Contact: Mr. E. K. 112

Contact Telephone Number:

(312) 856 1278

NORTHWESTERN MEDICAL FACULTY
FOUNDATION, INC
79 WEST MONROE STREET SUITE 700
CHICAGO, IL 60603

Gentlemen:

This modifies our letter of the above date in which we stated that you would be treated as an organization which is not a private foundation until the expiration of your advance ruling period.

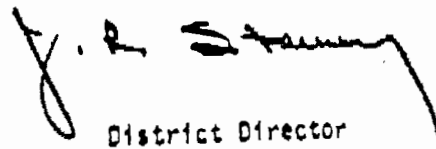
Based on the information you submitted, we have determined that you are not a private foundation within the meaning of section 509(a) of the Internal Revenue Code, because you are an organization of the type described in section 509(a)(2). Your exempt status under section 501(c)(3) of the code is still in effect.

Grantors and contributors may rely on this determination until the Internal Revenue Service publishes notice to the contrary. However, a grantor or a contributor may not rely on this determination if he or she was in part responsible for, or was aware of, the act or failure to act that resulted in your loss of section 509(a)(2) status, or acquired knowledge that the Internal Revenue Service had given notice that you would be removed from classification as a section 509(a)(2) organization.

Because this letter could help resolve any questions about your private foundation status, please keep it in your permanent records.

If you have any questions, please contact the person whose name and telephone number are shown above.

Sincerely yours,


District Director

200938 SW 67 200808
086296

3643
60611

K
IRS USE ONLY

93490-132-00616-9 A0151772 2
363097297 TE 3



Department of the Treasury
Internal Revenue Service
OGDEN UT 84201-0074

For assistance, call:
1-800-829-0115

Notice Number: CP210
Date: October 5, 2009

Taxpayer Identification Number:

Tax Form: 990
Tax Period: August 31, 2008

066742.649751.0237.006 1 AT 0.357 695



066742

NORTHWESTERN MEDICAL FACULTY
FOUNDATION INC
680 N LAKE SHORE DR STE 1118
CHICAGO IL 60611-4402934

Amount of Refund

\$673.16

Statement of Adjustment to Your Account

Balance Due on Account Before Adjustment \$11,034.38

Adjustment Computation

Penalty Decrease - Filing Late \$11,700.00

Interest Allowed \$7.54

Net Adjustment Credit \$11,707.54

Overpayment \$673.16

This is a result of your inquiry of July 31, 2009.

Interest allowed must be reported as income on your next income tax return.

Status of Your Account - Refund

We'll refund your overpayment (plus interest when applicable), if you owe no other taxes or have no other debts the law requires us to collect.

Status of Your Account (Exam)

This notice isn't the result of an examination of your return. We notify a taxpayer when we select his/her return for examination.

For tax forms, instructions and information visit www.irs.gov. (Access to this site will not provide you with your specific taxpayer account information.)

ATTACHMENT 5

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Seq. No.: A0151772

CP: 210

TIN: 36-3097297

Form: 990

Tax Period: August 31, 2008



066742

 CUT HERE

Return this voucher with your payment or correspondence.

Your Telephone Number:
()

Best Time to Call:
AM PM

☐ Correspondence enclosed:

- Write your Taxpayer Identification Number, tax period and tax form number on your inquiry or correspondence

TE 200938 102425 93490-132-00616-9

210 Internal Revenue Service
OGDEN UT 84201-0074

NORTHWESTERN MEDICAL FACULTY
FOUNDATION INC
680 N LAKE SHORE DR STE 1118
CHICAGO IL 60611-4402934



ATTACHMENT 5

363097297 SW 67 2 200808

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State of Illinois
Department of Healthcare and Family Services

ENROLLMENT DISCLOSURE STATEMENT ILLINOIS MEDICAL ASSISTANCE PROGRAM

1. Identifying Information

Provider Name Northwestern Medical Faculty Foundation	DBA Name Northwestern Medical Group	Provider No. [REDACTED] 297	NPI [REDACTED]
Provider Office Street Address 680 N Lake Shore Drive, #1118			
City, County, State Chicago, Cook County, Illinois	Zip Code 60611	Telephone (312)695-0665	

2. (a) List the name, address, and SSN/EIN of each person and/or entity with direct or indirect ownership or control interest in the disclosing entity or any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. List any additional names, addresses, and SSN/EIN under "Remarks" on page 2.

Name	Address	SSN/EIN
Northwestern Memorial HealthCare	211 E Ontario St, Ste 1800, Chicago, IL, 60611	[REDACTED] 15959

- (b) If any persons listed in 2(a) are related to each other as spouse, parent, child, sibling, grandparent, grandchild, uncle, aunt, niece, nephew, cousin or relative by marriage, list that relationship (i.e. John Smith and Mary White are siblings).

- (c) Check type of entity: ☐ Sole Proprietorship ☐ Partnership ☒ Corporation ☐ Unincorporated Associations
☐ Other, please specify _____

List the name, address, and SSN of the Directors, Officers, Partners, and Managing Employees of the Disclosing Entity. List any additional names, addresses, and SSN under "Remarks" on page 2.

Name	Address	SSN
Please See Exhibit 2(c).		

- (d) Are any of the individuals/entities listed in 2(a) also current or previous owners of other Medicare/Medicaid entities?

☒ Yes

☐ No

If yes, for each affiliation list the individual/entity name from 2(a); the name, address, and provider number of the affiliated entity, along with the affiliation date. List any additional information as needed under "Remarks" on page 2.

Individual/Entity (2(a))	Name of Affiliated Entity	Affiliated Entity's Address	Affiliated Entity's Provider Number	Date of Affiliation
Please See Exhibit 2(d).				

ATTACHMENT 5

ENROLLMENT DISCLOSURE STATEMENT

3. Has there been a change in ownership or control for the disclosing entity within the last year? ☒ Yes ☐ No

If yes, give date and name of prior owner(s) Please See Exhibit 3.

If the prior owner is a relative of anyone listed in 2(a), state the individual from 2(a) and the relationship (spouse, parent, child, sibling, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage).

4. List any person who: (1) Has ownership or control interest in the disclosing entity, or is an agent, or managing employee of the disclosing entity; and (2) Has been convicted of a criminal offense:

Name	Ownership Interest/Position	Criminal Offense	Date
None			

5. List any person who: (1) Has ownership or control interest in the disclosing entity, or is an agent, or managing employee of the disclosing entity; and (2) Has been sanctioned (previously or currently) by any health care related program including, but not limited to, Medicare, Medicaid, or the Title XX services program since the inception of those Programs.

Name	Sanction	Date	State
None			

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT WITH THE DEPARTMENT.

Brian M. Walsh

Name of Authorized Representative (Typed)

Signature

CFO, Treasurer, Vice President, Financial Services

Title

Date

Remarks:

NMFF's Medicare Group PTAN for Cook County, IL: 522620.

ATTACHMENT 5

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EXHIBIT 2(C)

Northwestern Medical Faculty Foundation –

Name, Address, and SSN of Directors, Officers, and Managing Employees

Officer Position	Name	SSN	Address
Chair	Eric Neilson, M.D.	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
Vice Chair	Glenn Tilton	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
President	David Mahvi, M.D.	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
Treasurer, Chief Financial Officer, Vice President, Financial Services	Brian Walsh	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
Secretary, Vice President, Legal Services, and General Counsel	Danae Prousis	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
Vice President, Information Services and Chief Information Officer	Carl Christensen	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
Vice President, Regional Medical Practice	Howard Chrisman, M.D.	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
Chief Compliance Officer and Chief Privacy Officer	Robert Rosa, M.D.	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
Chief Medical Officer	Philip Roemer, M.D.	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
	Thomas Cole	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
	Stephen Crawford	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
	Daniel Derman, M.D.	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
	John Edwardson	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
	Dean Harrison	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
	David Mahvi, M.D.	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
	Robert Parkinson, Jr.	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
	Amy Paller, M.D.	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
	Andrew Parsa, M.D.	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
	Jane Pigott	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
	Edward Tilly	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
	Nicholas Volpe, M.D.	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611
	Forrest Whittaker	[REDACTED]	680 North Lake Shore Drive, Suite 1118 Chicago, IL 60611

ATTACHMENT 5

EXHIBIT 2(D)

Individual/Entity	Name of Affiliated Entity	Affiliated Entity's Address	Affiliated Entity's Provider Number	Date of Affiliation
Northwestern Memorial HealthCare	Northwestern Memorial Hospital	251 E. Huron Chicago, IL 60611	Medicare #: [REDACTED] [REDACTED] EIN: [REDACTED]	09/01/1972
Northwestern Memorial HealthCare	Northwestern Lake Forest Hospital	660 North Westmoreland Road Lake Forest, IL 60045	Medicare #: [REDACTED] [REDACTED] EIN: 3 [REDACTED]	02/01/2010

EXHIBIT 3

Northwestern Medical Faculty Foundation ("NMFF") experienced a change of control on September 1, 2013 when Northwestern Memorial HealthCare became the sole corporate member of NMFF. Prior to this change of control, NMFF, as an Illinois not-for-profit corporation, had no owners by definition. Rather, NMFF had several hundred individual physician corporate "members," as such term is understood in the Illinois Not-for-Profit Corporation Act.

Northwestern Memorial HealthCare
Audited Financial Statement

CONSOLIDATED FINANCIAL STATEMENTS
AND SUPPLEMENTARY INFORMATION

Northwestern Memorial HealthCare and Subsidiaries
Years Ended August 31, 2012 and 2011
With Reports of Independent Auditors

Ernst & Young LLP

Northwestern Memorial HealthCare and Subsidiaries

Consolidated Financial Statements
and Supplementary Information

Years Ended August 31, 2012 and 2011

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Ernst & Young LLP
155 North Wacker Drive
Chicago, IL 60606-1787
Tel: +1 312 879 2000
Fax: +1 312 879 4000
www.ey.com

Report of Independent Auditors

The Board of Directors
Northwestern Memorial HealthCare

We have audited the accompanying consolidated balance sheets of Northwestern Memorial HealthCare (an Illinois not-for-profit corporation) and Subsidiaries (Northwestern Memorial) as of August 31, 2012 and 2011, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of Northwestern Memorial's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of Northwestern Memorial's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Northwestern Memorial HealthCare and Subsidiaries as of August 31, 2012 and 2011, and the consolidated results of their operations and changes in net assets and their cash flows for the years then ended, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 1 to the consolidated financial statements, NMHC changed its presentation of the provision for uncollectible accounts as a result of the adoption of the amendments to the Financial Accounting Standards Board's Accounting Standards Codification resulting from Accounting Standards Update 2011-07, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities*, effective September 1, 2010.

Ernst & Young LLP

November 29, 2012

Northwestern Memorial HealthCare and Subsidiaries

Consolidated Balance Sheets
(In Thousands)

	August 31	
	2012	2011
Assets		
Current assets:		
Cash and cash equivalents	\$ 139,343	\$ 131,311
Short-term investments	112,925	85,188
Current portion of investments, including assets limited as to use	89,247	91,138
Patient accounts receivable, net of estimated uncollectibles of \$39,036 and \$32,338 in 2012 and 2011, respectively	279,775	232,460
Current portion of pledges and grants receivable, net	9,257	16,250
Current portion of insurance recoverable	13,060	14,433
Inventories	31,528	31,715
Other current assets	33,138	28,239
Total current assets	708,273	630,734
Investments, including assets limited as to use, less current portion	2,430,351	2,247,163
Property and equipment, at cost:		
Land	237,953	227,820
Buildings	1,668,000	1,613,399
Equipment and furniture	522,343	509,021
Construction-in-progress	46,573	90,101
	2,474,869	2,440,341
Less accumulated depreciation	1,116,818	1,100,060
	1,358,051	1,340,281
Prepaid pension cost	30,814	53,216
Insurance recoverable, less current portion	74,444	71,249
Other assets, net	99,751	98,495
Total assets	\$ 4,701,684	\$ 4,441,138

	August 31	
	2012	2011
Liabilities and net assets		
Current liabilities:		
Accounts payable	\$ 81,070	\$ 87,535
Accrued salaries and benefits	94,948	85,044
Grants and academic support payable, current portion	37,588	28,250
Accrued expenses and other current liabilities	34,871	42,575
Due to third-party payors	207,440	177,399
Current accrued liabilities under self-insurance programs	65,633	72,462
Current maturities of long-term debt	14,500	13,710
Total current liabilities	536,050	506,975
Long-term debt, less current maturities	806,155	821,354
Accrued liabilities under self-insurance programs, less current portion	420,941	414,173
Grants and academic support payable, less current portion	97,254	36,068
Due to insureds	62,415	45,303
Interest rate swaps	104,503	73,845
Pension liability	3,863	—
Other liabilities	51,929	70,372
Total liabilities	2,083,110	1,968,090
Net assets:		
Unrestricted:		
Undesignated	2,182,940	2,075,713
Board-designated	138,600	130,618
Total unrestricted	2,321,540	2,206,331
Temporarily restricted	155,263	140,388
Permanently restricted	141,771	126,329
Total net assets	2,618,574	2,473,048
Total liabilities and net assets	\$ 4,701,684	\$ 4,441,138

See accompanying notes to consolidated financial statements.

Northwestern Memorial HealthCare and Subsidiaries

Consolidated Statements of Operations
and Changes in Net Assets
(In Thousands)

	Year Ended August 31	
	2012	2011
Revenue		
Patient service revenue	\$ 1,614,123	\$ 1,593,596
Provision for uncollectible accounts	32,072	33,196
Net patient revenue	1,582,051	1,560,400
Rental and other revenue	100,996	101,792
Net assets released from donor restrictions and federal and state grants	18,493	21,466
Total revenue	1,701,540	1,683,658
Expenses		
Salaries and professional fees	587,971	563,583
Employee benefits	186,633	188,614
Supplies	268,197	263,831
Purchased services	173,545	170,876
Depreciation	145,686	138,249
Insurance	59,711	75,766
Rent and utilities	41,486	40,978
Repairs and maintenance	45,581	44,327
Interest	29,701	28,824
Illinois Hospital Assessment	41,395	41,395
Other	33,326	34,812
Total expenses	1,613,232	1,591,255
Operating income	88,308	92,403
Nonoperating gains (losses)		
Investment return	150,762	237,074
Change in fair value of interest rate swaps	(30,533)	4,527
Grants and academic support provided	(106,708)	(55,560)
Other	19,970	9,432
Total nonoperating gains, net	33,491	195,473
Excess of revenue over expenses	121,799	287,876

Continued on next page.

Northwestern Memorial HealthCare and Subsidiaries

Consolidated Statements of Operations
and Changes in Net Assets (continued)

(In Thousands)

	Year Ended August 31	
	2012	2011
Unrestricted net assets		
Excess of revenue over expenses	\$ 121,799	\$ 287,876
Net assets released from restrictions used for property and equipment additions	1,579	380
Postretirement-benefit-related changes other than net periodic pension cost	(8,044)	40,165
Other	(125)	(127)
Increase in unrestricted net assets	115,209	328,294
Temporarily restricted net assets		
Contributions	34,021	22,578
Investment return	9,715	16,146
Net assets released from restrictions used for:		
Operating expenses, charity care, and research and education	(27,232)	(22,118)
Property and equipment additions	(1,579)	(380)
Change in fair value of split-interest agreements	81	(192)
Other	(131)	(146)
Increase in temporarily restricted net assets	14,875	15,888
Permanently restricted net assets		
Contributions	16,347	19,683
Change in fair value of split-interest agreements	(1,025)	993
Other	120	(250)
Increase in permanently restricted net assets	15,442	20,426
Change in total net assets	145,526	364,608
Net assets, beginning of year	2,473,048	2,108,440
Net assets, end of year	\$ 2,618,574	\$ 2,473,048

See accompanying notes to consolidated financial statements.

Northwestern Memorial HealthCare and Subsidiaries

Consolidated Statements of Cash Flows

(In Thousands)

	Year Ended August 31	
	2012	2011
Operating activities		
Change in total net assets	\$ 145,526	\$ 364,608
Adjustments to reconcile change in total net assets to net cash provided by operating activities:		
Postretirement-benefit-related changes other than net periodic pension cost	8,044	(40,165)
Change in fair value of interest rate swaps	30,658	(4,402)
Net investment return and net change in unrealized investment gains/losses	(153,602)	(246,873)
Restricted contributions and realized investment return	(56,299)	(49,409)
Depreciation and amortization	145,356	137,639
Provision for uncollectible accounts	32,164	33,296
Change in operating assets and liabilities:		
Patient accounts receivable	(79,479)	(47,610)
Due to third-party payors	29,790	22,255
Grants and academic support payable	70,524	(4,972)
Other operating assets and liabilities	11,649	55,697
Net cash provided by operating activities	184,331	220,064
Investing activities		
Purchases of trading securities	(589,584)	(410,539)
Sales of trading securities	410,091	296,581
Unrestricted realized investment return	124,061	95,477
Capital expenditures, net	(163,456)	(178,886)
Net cash used in investing activities	(218,888)	(197,367)
Financing activities		
Payments of long-term debt	(13,710)	(13,140)
Restricted contributions and realized investment return	56,299	49,409
Net cash provided by financing activities	42,589	36,269
Net increase in cash and cash equivalents	8,032	58,966
Cash and cash equivalents, beginning of year	131,311	72,345
Cash and cash equivalents, end of year	\$ 139,343	\$ 131,311

See accompanying notes to consolidated financial statements.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (In Thousands)

Years Ended August 31, 2012 and 2011

1. Organization and Summary of Significant Accounting Policies

Northwestern Memorial HealthCare (NMHC) serves as the sole corporate member of Northwestern Memorial Hospital (NMH), Northwestern Lake Forest Hospital (NLFH), and Northwestern Memorial Foundation (the Foundation). NMH's subsidiary corporations are Northwestern HealthCare Corporation (NHC), Northwestern Memorial Physicians Group (NMPG), and Northwestern Memorial Insurance Company (NMIC). NLFH's subsidiary corporation is Lake Forest Health and Fitness Institute (HFI). NMH and NLFH are both members of the obligated group (Obligated Group) for all of the outstanding bonds of NMH and NLFH.

NMH is a major academic medical center located in the Streeterville neighborhood of Chicago, providing a complete range of adult inpatient and outpatient services, primarily to residents of Chicago and surrounding areas, in an educational and research environment. It is licensed for 894 beds. NMH, whose origins date back to 1849, is the primary teaching hospital for Northwestern University's Feinberg School of Medicine (FSM).

NLFH is a community hospital located in Lake Forest, Illinois, providing a complete range of adult inpatient and outpatient services, as well as skilled nursing care, primarily to residents of Lake Forest and the surrounding area. It is licensed for 117 acute care beds and 84 skilled nursing care beds.

The Foundation carries out fund-raising and other related development activities to promote and support the tax-exempt interests and purposes of NMH and NLFH.

Basis of Presentation

The accompanying consolidated financial statements include the accounts of NMHC, the Foundation, NMH and its subsidiaries, and NLFH and its subsidiary (collectively referred to herein as Northwestern Memorial). All significant intercompany transactions and balances have been eliminated in consolidation.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

Charity Care and Community Benefit

Northwestern Memorial provides care to patients regardless of their ability to pay. Northwestern Memorial developed a Free and Discounted Care Policy (the Policy) for both the uninsured and the underinsured. Under the Policy, patients are offered discounts of up to 100% of charges on a sliding scale, which is based on income as a percentage of the Federal Poverty Level guidelines (up to 600%). The Policy also contains provisions that are responsive to those patients subject to catastrophic healthcare expenses and uninsured patients not covered by the provisions above. Since Northwestern Memorial does not pursue collection of these amounts, they are not reported as net patient revenue, and the cost of providing such care is recognized within operating expenses.

Northwestern Memorial estimates the direct and indirect costs of providing charity care by applying a cost to gross charges ratio to the gross uncompensated charges associated with providing charity care to patients. Northwestern Memorial also receives certain funds to offset or subsidize charity care services provided. These funds are primarily received from investment return on free care endowment funds. The cost of providing charity care was \$57,738 and \$50,105 for the years ended August 31, 2012 and 2011, respectively. In addition, funds received to offset or subsidize charity care were \$491 and \$496 for the years ended August 31, 2012 and 2011, respectively. In filing the Annual Non Profit Hospital Community Benefits Plan Report to the Illinois Attorney General for the year ended August 31, 2011, Northwestern Memorial reported total community benefit of \$279,435 (unaudited), including unreimbursed cost of charity care of \$51,787 (unaudited), which is calculated using a different methodology than that used for the consolidated financial statements. Management is currently collecting the information needed to file the 2012 report.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include highly liquid short-term investments with maturities of 90 days or less from the date of purchase.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

Patient Accounts Receivable

Patient accounts receivable are stated at net realizable value. Northwestern Memorial maintains allowances for uncollectible accounts and for estimated losses resulting from a payor's inability to make payments on accounts. Northwestern Memorial estimates the allowance for uncollectible accounts based on management's assessment of historical and expected net collections considering historical and current business and economic conditions, trends in healthcare coverage, and other collection indicators. Accounts receivable are charged to the allowance for uncollectible accounts when they are deemed uncollectible.

Assets Limited as to Use

Assets limited as to use consist primarily of investments designated by the appropriate board of directors (the Board) for certain medical education and healthcare programs. The appropriate Board retains control of these investments and may, at its discretion, subsequently use them for other purposes. In addition, assets limited as to use include investments held by trustees under debt agreements and for self-insurance and collateral related to interest rate swaps.

Investments

Investments in equity securities with readily determinable fair values and all investments in debt securities are reported at fair value based on quoted market prices. Unless in pension plan assets, alternative investments are reported using the equity method. Alternative investments include common collective trusts, commingled funds, 103-12 entities and other limited partnership interests in hedge funds, private equity, venture capital and real estate funds. Alternative investments in the pension plan are reported at fair value based on net asset value (NAV) per share or equivalent.

Derivative Instruments

Derivative instruments, specifically interest rate swaps, are recorded on the consolidated balance sheets at fair value. The change in the fair value of derivative instruments is recorded in nonoperating gains (losses).

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

Inventories

Inventories, consisting primarily of pharmaceuticals and other medical supplies, are stated at the lower of cost on the first-in, first-out method or fair value.

Property and Equipment

Property and equipment are stated at cost and are depreciated using the straight-line method over the estimated useful lives of the assets. Typical useful lives are 5 to 40 years for buildings and building service equipment and 3 to 20 years for equipment and furniture. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Asset Impairment

Northwestern Memorial considers whether indicators of impairment are present and performs the necessary tests to determine if the carrying value of an asset is appropriate. Impairment write-downs are recognized in operating income at the time the impairment is identified. There was no impairment of long-lived assets in 2012 or 2011.

Deferred Charges

Deferred finance charges and bond discount or premium are amortized or accreted using the effective interest method or the bonds outstanding method, which approximates the effective interest method, over the life of the related debt.

Net Assets

Resources are classified for reporting purposes into four net asset categories as general unrestricted, board-designated unrestricted, temporarily restricted, and permanently restricted, according to the absence or existence of board designations or donor-imposed restrictions. Board-designated net assets are unrestricted net assets that have been set aside by the Board for specific purposes. Temporarily restricted net assets are those assets, including contributions and accumulated investment returns, whose use has been limited by donors for a specific purpose or time period. Permanently restricted net assets are those for which donors require the principal of the gifts to be maintained in perpetuity to provide a permanent source of income.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

Any changes in donor restrictions that change the net asset category of previously recorded contributions are recorded as other in the accompanying consolidated statements of operations and changes in net assets in the period communicated by the donor.

Net Patient Revenue

Northwestern Memorial has agreements with third-party payors that provide for payments to Northwestern Memorial at amounts different from its established rates. Payment arrangements include prospectively determined rates per admission or visit, reimbursed costs, discounted charges, and per diem rates. Net patient revenue is reported at the estimated net amount due from patients and third-party payors for services rendered, including estimated adjustments under reimbursement agreements with third-party payors, certain of which are subject to audit by administering agencies. These adjustments are accrued on an estimated basis and are adjusted, as needed, in future periods.

EHR Incentive Payments

The American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH). The provisions were designed to increase the use of electronic health record (EHR) technology and establish the requirements for a Medicare and Medicaid incentive payment program beginning in 2011 for eligible providers that adopt and meaningfully use certified EHR technology. Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. Initial Medicaid payments are available to providers that adopt, implement, or upgrade certified EHR technology. Providers must demonstrate meaningful use of such technology in subsequent years to qualify for additional Medicaid incentive payments.

Northwestern Memorial recognizes HITECH incentive payments as revenue under the grant accounting model when it is reasonably assured that the meaningful use objectives have been achieved. Northwestern Memorial recognized incentive payments totaling \$5,422 and \$0 for the years ended August 31, 2012 and 2011, respectively, as net assets released from donor restrictions and federal and state grants in the accompanying consolidated statements of operations and changes in net assets. Northwestern Memorial's compliance with the meaningful use criteria is subject to audit by the federal government.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

Contributions

Unrestricted gifts, other than long-lived assets, are recorded as a component of other nonoperating gains in the accompanying consolidated statements of operations and changes in net assets. Unrestricted gifts of long-lived assets such as land, buildings, or equipment are recorded at fair value as an increase in unrestricted net assets. Contributions are reported as either temporarily or permanently restricted net assets if they are received with donor restrictions. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the accompanying consolidated statements of operations and changes in net assets as net assets released from restrictions.

Unconditional promises to give cash or other assets are reported as pledges receivable and contributions within the appropriate net asset category. An allowance for uncollectible pledges receivable is estimated based on historical experience and other collection indicators. Pledges receivable with payment terms extending beyond one year are discounted using market rates of return reflecting the terms and credit of the pledges at the time a pledge is made.

Northwestern Memorial is a beneficiary of several split-interest agreements, primarily perpetual trusts held by others. The Foundation recognizes its interest in these perpetual trusts as temporarily or permanently restricted net assets based on the Foundation's percentage of the fair value of the trusts' assets.

Nonoperating Gains (Losses)

Nonoperating gains (losses) consist primarily of investment returns (including realized gains and losses; net change in unrealized investment gains and losses; changes in Northwestern Memorial's proportionate share of its equity interest in alternative investments, interest, and dividends), unrestricted contributions received, grants and academic support provided to external organizations, net assets released from restriction and used for grants and academic support, and changes in fair value of interest rate swaps.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued)

(In Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

Excess of Revenue Over Expenses

The accompanying consolidated statements of operations and changes in net assets include the excess of revenue over expenses. Changes in unrestricted net assets, which are excluded from the excess of revenue over expenses, consist primarily of contributions of long-lived assets (including assets acquired using contributions, which, by donor restriction, are to be used for the purposes of acquiring such assets), transfers between net asset categories based on changes in donor restrictions, and postretirement-benefit-related changes other than net periodic pension cost.

New Accounting Pronouncements

In January 2010, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2010-06, *Improving Disclosures about Fair Value Measurements* (ASU 2010-06). ASU 2010-06 amends Accounting Standards Codification (ASC) 820, *Fair Value Measurement*, to require a number of additional disclosures regarding fair value measurements. These disclosures include the amounts of significant transfers between Level 1 and Level 2 of the fair value hierarchy and the reasons for these transfers; the reasons for any transfer in or out of Level 3; and information in the reconciliation of recurring Level 3 measurements about purchases, sales, issuances, and settlements on a gross basis, as well as clarification on previous reporting requirements. This new guidance is effective for the first reporting period, including interim periods, beginning after December 15, 2009, for all disclosures except the requirement to separately disclose purchases, sales, issuances, and settlements of recurring Level 3 measurements, which was effective for Northwestern Memorial in fiscal year 2012. Northwestern Memorial adopted this guidance in fiscal year 2010, with the exception of the additional Level 3 disclosures, which were adopted in fiscal year 2012. The adoption of ASU 2010-06 had no effect on the consolidated financial statements of Northwestern Memorial.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

In August 2010, the FASB issued ASU 2010-23, *Measuring Charity Care for Disclosure* (ASU 2010-23). The provisions of ASU 2010-23 are intended to reduce the diversity in how charity care is calculated and disclosed across healthcare entities that provide it. Charity care is required to be measured at cost, defined as the direct and indirect costs of providing the charity care. Funds received to offset or subsidize the cost of charity care provided, for example from gifts or grants restricted for charity care, should be separately disclosed. As a healthcare entity does not recognize revenue when charity care is provided, this update only requires enhanced disclosures and has no effect on the consolidated statements of operations and changes in net assets. This new guidance is effective for fiscal years beginning after December 15, 2010, with retrospective application required and with early application permitted. Northwestern Memorial adopted this guidance in fiscal year 2012. The adoption of ASU 2010-23 had no effect on the consolidated financial statements of Northwestern Memorial.

In August 2010, the FASB issued ASU 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries* (ASU 2010-24). ASU 2010-24 prohibits the netting of insurance recoveries against a related claim liability and requires the claim liability to be reported without consideration of insurance recoveries unless a right of setoff exists. This guidance is effective for fiscal years, and interim periods within those years, beginning after December 15, 2010, with early application permitted. Northwestern Memorial has adopted this guidance in fiscal year 2012. The effect of the adoption of ASU 2010-24 resulted in an increase in current portion of insurance recoverable of \$836 and an increase in insurance recoverable, less current portion of \$1,686, with offsetting increases in current accrued liabilities under self-insurance programs of \$836 and in accrued liabilities under self-insurance programs, less current portion of \$1,686 as of September 1, 2011. There was no effect on the consolidated statements of operations and changes in net assets or consolidated statements of cash flows.

In December 2010, the FASB issued ASU 2010-29, *Disclosure of Supplementary Pro Forma Information for Business Combinations* (ASU 2010-29). ASU 2010-29 clarifies the disclosure requirement for pro forma revenue and earnings for comparative current and prior reporting periods. Pro forma information should be disclosed as though the business combination(s) that occurred during the current year had occurred as of the beginning of the comparable prior fiscal year only. ASU 2010-29 also expands the disclosures to include a description of the nature and amount of material, nonrecurring pro forma adjustments directly attributable to the business combination(s). This guidance is effective for business combinations for which the acquisition date is on or after the beginning of the first annual reporting period beginning on or after

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

December 15, 2010, with early adoption permitted. This guidance was effective for and adopted by Northwestern Memorial in fiscal year 2012. The adoption of ASU 2010-29 had no effect on the consolidated financial statements of Northwestern Memorial.

In May 2011, the FASB issued ASU 2011-04, *Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRSs* (ASU 2011-04). ASU 2011-04 changes the wording used to describe many of the requirements in U.S. GAAP for measuring fair value and for disclosing information about fair value measurements. This update was issued to improve the comparability of fair value measurements presented and disclosed in financial statements prepared in accordance with U.S. GAAP and International Financial Reporting Standards (IFRS). ASU 2011-04 includes amendments that clarify the FASB's intent about the application of existing measurement and disclosure and changes certain principles and requirements for measuring fair value and for disclosing information about fair value measurements. This new guidance is effective for interim and annual periods beginning after December 15, 2011. Early application is not permitted. This guidance was effective for and adopted by Northwestern Memorial in the third quarter of fiscal year 2012. This adoption had no effect on the consolidated financial position and the consolidated results of their operations and changes in net assets.

In July 2011, the FASB issued ASU 2011-07, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* (ASU 2011-07). ASU 2011-07 requires healthcare entities that recognize significant amounts of patient service revenue at the time of service, even though they do not assess the patient's ability to pay, to present the provision for bad debts related to patient service revenue as a deduction from patient service revenue on the statement of operations. In addition, enhanced disclosure about the entity's policies for recognizing revenue and assessing bad debts, including disclosures of patient service revenue (net of contractual allowances and discounts) as well as qualitative and quantitative information about changes in the allowance for doubtful accounts, is required. This new guidance is effective for fiscal years and interim periods within those fiscal years beginning after December 15, 2011, with early adoption permitted. Northwestern Memorial adopted this guidance as of and for the year ended August 31, 2012, with retrospective application to all periods presented. The adoption of ASU 2011-07 had the effect of reducing net patient revenue by \$33,196 with offsetting reduction in operating expenses for the year ended August 31, 2011, on the consolidated statements of operations and changes in net assets of Northwestern Memorial. There was no effect on operating income. The provision for non-patient related doubtful accounts of \$100 is included in other operating expenses.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

In December 2011, the FASB issued ASU 2011-11, *Disclosures about Offsetting Assets and Liabilities* (ASU 2011-11). ASU 2011-11 enhances disclosures about financial and derivative instruments that are either offset on the statement of financial position or subject to an enforceable master netting agreement or similar agreement, irrespective of whether they are offset on the statement of financial position. This new guidance is effective for fiscal years and interim periods within those years beginning on or after January 1, 2013. This guidance will be effective for Northwestern Memorial in fiscal year 2014. Northwestern Memorial is evaluating the effect this guidance will have on its consolidated financial statement disclosures.

2. Investments and Other Financial Instruments

The composition of investments and cash and cash equivalents at August 31 is as follows:

	2012	2011
Measured at fair value:		
Cash and short-term investments	\$ 304,586	\$ 235,892
Equity securities	50,496	43,510
Mutual funds	736,486	608,099
Common collective trusts	72,893	192,900
Commingled funds	199,661	212,726
103-12 entities	123,182	131,546
Corporate bonds	60,861	37,403
U.S. government and agency issues	818	—
Foreign government issues	1,388	573
	<u>1,550,371</u>	<u>1,462,649</u>
Accounted for under the equity method:		
Alternative investments	1,221,495	1,092,151
	<u>\$ 2,771,866</u>	<u>\$ 2,554,800</u>

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

2. Investments and Other Financial Instruments (continued)

Investments and other financial instruments consist of the following:

	2012	2011
Assets limited as to use:		
Trustee-held funds	\$ 26,296	\$ 7,247
Self-insurance programs	540,796	498,098
Board-designated funds	138,600	130,618
Total assets limited as to use	705,692	635,963
Donor-restricted funds	245,498	215,594
Unrestricted, undesignated funds	1,568,408	1,486,744
Total investments, excluding short-term investments	2,519,598	2,338,301
Other financial instruments:		
Cash and cash equivalents and short-term investments	252,268	216,499
	<u>\$ 2,771,866</u>	<u>\$ 2,554,800</u>

The composition and presentation of investment returns are as follows for the years ended August 31:

	2012	2011
Interest and dividend income	\$ 14,935	\$ 40,682
Investment expenses	(4,547)	(3,988)
Realized gains on alternative investments, net	34,925	21,266
Realized gains on other investments, net	85,622	43,338
Net increase in unrealized gains on alternative investments	30,680	86,883
Net increase in unrealized gains on other investments	(1,138)	65,039
	<u>\$ 160,477</u>	<u>\$ 253,220</u>
Reported as:		
Nonoperating investment return	\$ 150,762	\$ 237,074
Temporarily restricted – investment return	9,715	16,146
	<u>\$ 160,477</u>	<u>\$ 253,220</u>

Northwestern Memorial's investments measured at fair value include mutual funds; common equities; corporate and U.S. government debt issues; state, municipal, and foreign government debt issues; commingled funds; common collective trusts; and 103-12 entities.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

2. Investments and Other Financial Instruments (continued)

Commingled investments, common collective trusts, and 103-12 investment entities are commingled investment funds formed from the pooling of investments under common management. Unlike a mutual fund, these investments are not a registered investment company and, therefore, are exempt from registering with the Securities and Exchange Commission.

The investment strategy for the mutual funds, commingled funds, common collective trusts, and 103-12 investment entities involves maximizing the overall returns by investing in a wide variety of assets, including domestic large cap equities, domestic small cap equities, international developed equities, natural resources, and private equity limited partnerships (LPs).

Northwestern Memorial's non-pension plan investments measured under the equity method of accounting include absolute return hedge funds, equity long/short hedge funds, real estate, natural resources, and private equity limited partnerships, collectively referred to as alternative investments. Alternative investments in the pension plan assets are measured at fair value.

Absolute return hedge funds include funds with the ability to opportunistically allocate capital among several strategies. The funds typically diversify across strategies in an effort to deliver consistently positive returns regardless of the movement within global markets. These funds generally exhibit relatively low volatility and are generally redeemable quarterly with a 60-day notice period. Equity long/short hedge funds include hedge funds that invest both long and short in U.S. and international equities. These funds typically focus on diversifying or hedging across particular sectors, regions, or market capitalizations and are generally redeemable quarterly with a 60-day notice period.

Real estate includes LPs that invest in land and buildings and seek to improve property level operations by increasing lease rates, recapitalizing properties, rehabilitating aging/distressed properties, and repositioning properties to attract higher-quality tenants. Real estate LPs typically use moderate leverage. Natural resources include a diverse set of LPs that invest in oil and natural gas-related companies, commodity-oriented companies, and timberland. Private equity includes LPs formed to make equity and debt investments in operating companies that are not publicly traded. These LPs typically seek to influence decision-making within the operating companies. Investment strategies in this category may include venture capital, buyouts, and distressed debt. These three categories of investments can never be redeemed with the funds. Distributions from each fund will be received as the underlying assets of the fund are expected to be liquidated periodically over the lives of the LPs, which generally run 10 to 12 years.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

2. Investments and Other Financial Instruments (continued)

Certain alternative investments are subject to various redemption restrictions. As of August 31, 2012, \$631,905 of these alternative investments cannot be redeemed for at least one year from the balance sheet date. In addition, \$520,753 is subject to redemption limits and lockup provisions that expire within one year of the balance sheet date.

At August 31, 2012, Northwestern Memorial had commitments to fund an additional \$244,234 to alternative investment entities, which is expected to occur over the next 12 years.

3. Fair Value Measurements

Northwestern Memorial follows the requirements of ASC 820 in regards to measuring the fair value of certain assets and liabilities as well as disclosures about fair value measurements. ASC 820 defines fair value as the price that would be received for an asset or paid for a transfer of a liability in an orderly transaction on the measurement date.

The methodologies used to determine fair value of assets and liabilities reflect market participant objectives and are based on the applications of a three-level valuation hierarchy that prioritizes observable market inputs over unobservable inputs. The three levels are defined as follows:

- Level 1 – Inputs to the valuation methodology are quoted prices (unadjusted) for identical assets or liabilities in active markets.
- Level 2 – Inputs to the valuation methodology include quoted prices for similar assets or liabilities in active markets and inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the financial instrument. Examples of Level 2 inputs are quoted prices for similar assets or liabilities in nonactive markets or pricing models with inputs that are observable for substantially the full term of the asset or liability.
- Level 3 – Inputs to the valuation methodology are significant to the fair value of the asset or the liability and less observable. These inputs reflect the assumptions market participants would use in the estimation of the fair value of the asset or the liability.

Fair Values

A financial instrument's categorization within the valuation hierarchy is based on the lowest level of input that is significant to the fair value measurement.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

3. Fair Value Measurements (continued)

The following table presents the financial instruments measured at fair value on a recurring basis as of August 31, 2012:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	\$ 139,343	\$ -	\$ -	\$ 139,343
Investments:				
Short-term investments:				
Currency	7,592	-	-	7,592
Fixed income	-	105,333	-	105,333
Total short-term investments	7,592	105,333	-	112,925
Mutual funds:				
Fixed income	346,876	-	-	346,876
International equities	84,175	-	-	84,175
U.S. equities	305,435	-	-	305,435
Total mutual funds	736,486	-	-	736,486
Common collective trusts:				
International equities	-	39,892	-	39,892
U.S. equities	-	33,001	-	33,001
Total common collective trusts	-	72,893	-	72,893
Commingled funds:				
International equities	-	21,321	-	21,321
Natural resources	-	26,495	-	26,495
Global equities	-	151,845	-	151,845
Total commingled funds	-	199,661	-	199,661
Bonds:				
Corporate bonds	-	60,861	-	60,861
U.S. government and agencies issue	-	818	-	818
Foreign government issues	-	1,388	-	1,388
Total bonds	-	63,067	-	63,067
Equity securities	50,443	53	-	50,496
103-12 entities - international equities	-	123,182	-	123,182
Cash equivalents in investment accounts	52,318	-	-	52,318
Total investments	846,839	564,189	-	1,411,028
Beneficial interests in trusts	-	11,594	-	11,594
Total assets	\$ 986,182	\$ 575,783	\$ -	\$ 1,561,965
Liabilities				
Interest rate swaps	\$ -	\$ 104,503	\$ -	\$ 104,503

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

3. Fair Value Measurements (continued)

The following table presents the financial instruments measured at fair value on a recurring basis as of August 31, 2011:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	\$ 131,311	\$ -	\$ -	\$ 131,311
Investments:				
Short-term investments:				
Currency	12,174	-	-	12,174
Fixed income	-	73,014	-	73,014
Total short-term investments	12,174	73,014	-	85,188
Mutual funds:				
Fixed income	376,590	-	-	376,590
International equities	68,748	-	-	68,748
U.S. equities	162,761	-	-	162,761
Total mutual funds	608,099	-	-	608,099
Common collective trusts:				
International equities	-	40,065	-	40,065
U.S. equities	-	152,835	-	152,835
Total common collective trusts	-	192,900	-	192,900
Commingled funds:				
International equities	-	74,106	-	74,106
Natural resources	-	22,439	-	22,439
Global equities	-	116,181	-	116,181
Total commingled funds	-	212,726	-	212,726
Bonds:				
Corporate bonds	-	37,403	-	37,403
Foreign government issues	-	573	-	573
Total bonds	-	37,976	-	37,976
Equity securities	43,461	49	-	43,510
103-12 entities - international equities	-	131,546	-	131,546
Cash equivalents in investment accounts	19,393	-	-	19,393
Total investments	683,127	648,211	-	1,331,338
Beneficial interests in trusts	-	12,010	-	12,010
Total assets	\$ 814,438	\$ 660,221	\$ -	\$ 1,474,659
Liabilities				
Interest rate swaps	\$ -	\$ 73,845	\$ -	\$ 73,845

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

3. Fair Value Measurements (continued)

There were no transfers into or out of Level 2 or Level 1 during the year ended August 31, 2012.

Reconciliation to the Consolidated Balance Sheets

A reconciliation of the fair value of assets to the consolidated balance sheets at August 31, 2012 and 2011, is as follows:

	<u>2012</u>	<u>2011</u>
Short-term investments measured at fair value	\$ 112,925	\$ 85,188
Investments, including assets limited as to use measured at fair value	<u>1,298,103</u>	<u>1,246,150</u>
Total investments at fair value	<u>1,411,028</u>	<u>1,331,338</u>
Alternative investments accounted for under equity method included in investments, including assets limited as to use	<u>1,221,495</u>	<u>1,092,151</u>
Total investments	<u>\$ 2,632,523</u>	<u>\$ 2,423,489</u>
Other long-term assets:		
Beneficial interests in trusts at fair value	\$ 11,594	\$ 12,010
Other long-term assets, net	<u>88,157</u>	<u>86,485</u>
Total other long-term assets	<u>\$ 99,751</u>	<u>\$ 98,495</u>

Valuation Techniques and Inputs

Beneficial Interests in Trusts – The fair value of beneficial interests in trusts is based on either the Foundation's percentage of the fair value of the trusts' assets or the Foundation's percentage of the fair value of the trusts' assets adjusted for any outstanding liabilities (discounted using a rate per IRS regulations), based on each trust arrangement.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

3. Fair Value Measurements (continued)

Interest Rate Swaps – The fair value of interest rate swaps is based on generally accepted valuation techniques, including discounted cash flow analysis on the expected cash flows of each derivative and quoted prices from dealer counterparties and other independent market sources. The valuation incorporates observable interest rates and yield curves for the full term of the swaps. The valuation is also adjusted to incorporate nonperformance risk for NMH or the respective counterparty. The adjustment is based on the credit spread for entities with similar credit characteristics as NMH or market-related data for the respective counterparty. Northwestern Memorial pays fixed rates ranging from 3.3% to 3.9% and receives cash flows based on rates equal to 63% of London Interbank Offered Rate (LIBOR) plus 28 basis points.

Investments – The fair value of Level 1 investments, which consist of equity securities and certain mutual funds, is based on quoted market prices that are valued on a daily basis. Level 2 investments consist of U.S. government securities, corporate bonds, commingled funds, common collective trusts, interest in 103-12 entities, and fixed income instruments issued by municipalities and foreign government agencies. The fair value of the U.S. government securities and corporate bonds is established based on values obtained from nationally recognized pricing services that value the investments based on similar securities and matrix pricing of similar quality and maturity securities. The fair values of commingled funds, common collective trusts, and 103-12 entities are based on either the fair value of the underlying investments of the fund, as determined by the fund, or based on the ownership interest in the NAV per share or its equivalent, of the respective fund.

Northwestern Memorial's investments are exposed to various kinds and levels of risk. Equity securities and equity mutual funds expose Northwestern Memorial to market risk, performance risk, and liquidity risk. Market risk is the risk associated with major movements of the equity markets. Performance risk is that risk associated with a company's operating performance. Fixed income securities and fixed income mutual funds expose Northwestern Memorial to interest rate risk, credit risk, and liquidity risk. As interest rates change, the value of many fixed income securities is affected, including those with fixed interest rates. Credit risk is the risk that the obligor of the security will not fulfill its obligations. Liquidity risk is affected by the willingness of market participants to buy and sell particular securities. Liquidity risk tends to be higher for equities related to small capitalization companies and certain alternative investments. Due to the volatility in the capital markets, there is a reasonable possibility of subsequent changes in fair value, resulting in additional gains and losses in the near term.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

3. Fair Value Measurements (continued)

The carrying values of cash and cash equivalents, accounts receivable, accounts payable, accrued expenses and other current liabilities, and short-term borrowings are reasonable estimates of their fair values due to the short-term nature.

The estimated fair value of the long-term debt portfolio, including the current portion, was \$871,382 and \$874,400 at August 31, 2012 and 2011, respectively. The fair value of this Level 2 liability is based on quoted market prices for the same or similar issues and the relationship of those bond yields with various market indices. The market data used to determine yield and calculate fair value represents Aa/AA-rated tax-exempt municipal healthcare bonds. The effect of third-party credit valuation adjustments, if any, is immaterial.

The fair value of pledges receivable, a Level 2 asset, is based on discounted cash flow analysis and approximated the carrying value at August 31, 2012 and 2011.

4. Self-Insurance Liabilities and Related Insurance Recoverables

NMH retains certain levels of professional and general liability risks covering itself and NMPG. NMH also retains certain levels of workers' compensation risks. For those risks, NMH has established trust funds to pay claims and related costs.

NMIC provides coverage, on a claims-made basis, in excess of the amounts retained by NMH for professional and general liability claims occurring and reported between October 1, 2002 and November 1, 2004. NMIC is fully reinsured for these risks.

Effective November 1, 2004, NMIC provides, on a claims-made basis, professional and general liability coverage to NMH and professional liability coverage to Northwestern Medical Faculty Foundation, Inc. (NMFF) under a joint indemnification program. NMFF is an unconsolidated, not-for-profit, multi-specialty group practice, which serves as the clinical faculty practice plan arm of FSM and is one of the faculty components of the academic medical center. NMIC also provides excess general liability coverage to otherwise commercially insured NMHC subsidiaries. NMIC receives funding from the covered entities for the risk it covers under its indemnity policies. Under the terms of a mutual funding agreement, NMH is required to maintain cash and investments, and NMFF is required to maintain a deposit at NMIC sufficient to fund actuarially determined tail liabilities, to be covered by NMIC upon any cancellation, nonrenewal, or other termination for any reason of NMIC's ongoing joint coverage of both NMH

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

4. Self-Insurance Liabilities and Related Insurance Recoverables (continued)

and NMFF. NMFF also maintains a deposit at NMIC at a level deemed actuarially sufficient to fund its premium obligations under a premium funding arrangement. Total NMFF deposits at NMIC, which are reported as due to insureds in the accompanying consolidated balance sheets, amounted to \$62,415 and \$45,303 at August 31, 2012 and 2011, respectively.

NLFH retains certain levels of professional and general liability risks for occurrences on or after January 1, 2003. Prior to June 1, 2011, NLFH purchased commercial insurance for risks in excess of its self-insured retention levels. For the period June 1, 2011 to June 1, 2012, NMIC provides professional and general liability coverage to NLFH in excess of its self-insured retention levels. NMIC is fully reinsured for these risks. Effective June 1, 2012, NMIC provides, on a claims-made basis, professional and general liability coverage to NLFH through an integrated program shared by NMH and NMFF. NLFH purchased tail coverage for claims incurred but not reported as of December 31, 2002.

Northwestern Memorial's self-insurance liability and related amounts recoverable from reinsurers are reported in the accompanying consolidated balance sheets at present value based on a discount rate of 1.5% and 3.0% as of August 31, 2012 and 2011, respectively. This discount rate is based on several factors, including rolling averages of risk-free rates based on estimated payment patterns of the underlying liability. The undiscounted gross liabilities for the self-insured programs were \$520,866 and \$549,206 at August 31, 2012 and 2011, respectively. The estimated undiscounted amounts recoverable from reinsurers were \$93,708 and \$96,907 at August 31, 2012 and 2011, respectively. Provisions for the professional and general liability risks are based on an actuarial estimate of losses using actual loss data adjusted for industry trends and current conditions and on an evaluation of claims by Northwestern Memorial's legal counsel. The provision for estimated self-insured claims includes estimates of ultimate costs for both reported claims and claims incurred but not reported.

NMH purchased tail coverage for risks in excess of its self-insured retentions following the expiration of the claims-made professional and general liability program covering the period from October 1, 1999 to October 1, 2002. In conjunction with this transaction, NMH recorded a deferred gain that is being amortized over the estimated runoff period. The balance of the deferred gain was \$3,121 and \$4,582 at August 31, 2012 and 2011, respectively.

In the opinion of management, based in part on the advice of outside legal counsel, adequate provision has been made at August 31, 2012, for all claims incurred to date. Management further believes that the ultimate disposition of these claims will not have a material adverse effect on the financial position of Northwestern Memorial.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(In Thousands)

5. Employee Benefits Obligations

There are two noncontributory defined benefit pension plans (the Plans) maintained within the Northwestern Memorial HealthCare controlled group that covered specified employees of controlled group organizations. The sponsors for the Plans approved resolutions to amend the Plans effective at the end of the day on December 31, 2012. The amendments implement a hard freeze, such that no participant will earn any additional or new benefits under the Plans on and after January 1, 2013, and no compensation earned or service performed by any Plan participant on and after January 1, 2013, will count for any purpose other than continued vesting under the Plans in benefits earned prior to 2013.

The following table summarizes the change in the projected benefit obligation:

	NMH		NLFH	
	2012	2011	2012	2011
Projected benefit obligation, beginning of year	\$ 414,020	\$ 398,443	\$ 101,995	\$ 93,853
Service cost	17,426	18,509	4,135	4,111
Interest cost	21,306	20,532	5,285	4,859
Curtailement gain	(43,638)	—	(5,106)	—
Net actuarial loss (gain)	46,983	(6,241)	17,157	1,599
Expenses paid	(927)	—	—	—
Benefits paid	(13,711)	(17,223)	(2,739)	(2,427)
Projected benefit obligation, end of year	\$ 441,459	\$ 414,020	\$ 120,727	\$ 101,995

The following table summarizes the changes in the Plans' assets:

	NMH		NLFH	
	2012	2011	2012	2011
Plan assets at fair value, beginning of year	\$ 456,904	\$ 422,507	\$ 112,327	\$ 97,917
Actual return on the Plans' assets, net of expenses	29,080	51,620	7,276	11,837
Employer contribution	—	—	—	5,000
Benefits paid	(13,711)	(17,223)	(2,739)	(2,427)
Plan assets at fair value, end of year	\$ 472,273	\$ 456,904	\$ 116,864	\$ 112,327

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued)

(In Thousands)

5. Employee Benefits Obligations (continued)

The following table sets forth the Plans' funded status, as well as recognized amounts in the consolidated balance sheets as of August 31:

	NMH		NLFH	
	2012	2011	2012	2011
Plan assets at fair value	\$ 472,273	\$ 456,904	\$ 116,864	\$ 112,327
Projected benefit obligation	441,459	414,020	120,727	101,995
Funded status recognized as prepaid pension cost/ (pension payable)	\$ 30,814	\$ 42,884	\$ (3,863)	\$ 10,332

The accumulated benefit obligations of the Plans are \$562,003 and \$480,742 as of August 31, 2012 and 2011, respectively.

Included in unrestricted net assets are the Plans' amounts that have not yet been recognized in net periodic pension cost at August 31 as follows:

	NMH		NLFH	
	2012	2011	2012	2011
Unrecognized prior service cost	\$ (13)	\$ (648)	\$ —	\$ —
Unrecognized actuarial loss	(117,037)	(117,449)	(19,784)	(6,709)
	\$ (117,050)	\$ (118,097)	\$ (19,784)	\$ (6,709)

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

5. Employee Benefits Obligations (continued)

Changes in the Plans' assets and benefit obligations recognized in unrestricted net assets during 2012 and 2011 include the following:

	NMH		NLFH	
	2012	2011	2012	2011
Current year actuarial (loss) gain	\$ (50,541)	\$ 26,818	\$ (13,075)	\$ 3,017
Effect of curtailment accounting on gain	43,638	—	—	—
Recognized actuarial loss	7,315	11,501	—	—
Current year amortization of prior service cost	125	125	—	—
Current year amortization of curtailment accounting credit	510	—	—	—
	<u>\$ 1,047</u>	<u>\$ 38,444</u>	<u>\$ (13,075)</u>	<u>\$ 3,017</u>

The Plans' prior service cost and actuarial loss included in unrestricted net assets expected to be recognized in net periodic pension cost during 2013 are \$125 and \$7,315, respectively.

Net periodic pension cost included in operating results for the years ended August 31 consists of the following:

	NMH		NLFH	
	2012	2011	2012	2011
Service cost of benefits earned during the year	\$ 17,426	\$ 18,509	\$ 4,135	\$ 4,111
Interest cost of projected benefit obligation	21,306	20,532	5,285	4,859
Expected return on the Plans' assets	(33,564)	(31,044)	(8,301)	(7,221)
Recognized actuarial loss	7,315	11,501	—	—
Amortization of prior service costs	125	125	—	—
Recognized loss due to curtailment	510	—	—	—
Net periodic pension cost	<u>\$ 13,118</u>	<u>\$ 19,623</u>	<u>\$ 1,119</u>	<u>\$ 1,749</u>

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

5. Employee Benefits Obligations (continued)

The following table sets forth the weighted-average assumptions used to determine the projected benefit obligation and benefit cost as of August 31:

	2012	2011
Used to determine projected benefit obligation		
Discount rate	4.25%	5.25%
Rate of compensation increase	3.50	3.50
	2012	2011
Used to determine benefit cost		
Discount rate	5.25%	5.25%
Expected long-term rate of return on the Plans' assets	7.50	7.50
Rate of compensation increase	3.50	3.50

The expected long-term rate of return on assets is determined based on a capital market asset model, which assumes that future returns are based on long-term, historical performance as adjusted for contemporary dividend yields. The adjusted historical returns were weighted by the current long-term asset allocation targets and reduced by 100 basis points to produce a more normal risk premium. Northwestern Memorial's investment advisor assisted with the analysis.

The Plans' asset allocation and investment strategies are designed to earn returns on plan assets consistent with a reasonable and prudent level of risk. Investments are diversified across classes, sectors, and manager style to minimize the risk of loss. Northwestern Memorial uses investment managers specializing in each asset category and, where appropriate, provides the investment manager with specific guidelines that include allowable and/or prohibited investment types. Northwestern Memorial regularly monitors manager performance and compliance with investment guidelines.

The target allocation of the Plans' assets as of August 31 is as follows:

	2012	2011
Cash and cash equivalents	—%	—%
Equity securities	42	42
Alternative investments	44	44
Fixed income	14	14
	100%	100%

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(In Thousands)

5. Employee Benefits Obligations (continued)

The following table presents the Plans' financial instruments as of August 31, 2012, measured at fair value on a recurring basis by the valuation hierarchy described in Note 4:

	Level 1	Level 2	Level 3	Total
103-12 investment entities:				
International equities	\$ —	\$ 35,169	\$ —	\$ 35,169
Private equity	—	—	1,910	1,910
Total 103-12 investment entities	—	35,169	1,910	37,079
Common collective trusts:				
Fixed income	—	5,965	—	5,965
International equities	—	21,815	—	21,815
Private equity	—	—	2,961	2,961
U.S. equities	—	12,928	—	12,928
Total common collective trusts	—	40,708	2,961	43,669
U.S. government debt:				
Treasury notes	—	1,257	—	1,257
Corporate debt:				
Corporate debt instruments – other	—	8,020	—	8,020
Corporate debt instruments – preferred	—	8,043	—	8,043
Total corporate debt	—	16,063	—	16,063
Equity securities:				
U.S. equities	15,018	16	—	15,034
Hedge funds and other:				
Absolute return hedge fund	—	8,222	63,681	71,903
Equity long/short hedge fund	—	7,821	75,986	83,807
Fixed income	—	1,377	—	1,377
Natural resources	—	3,387	3,579	6,966
Total hedge funds and other	—	20,807	143,246	164,053
Interest in limited partnerships:				
Natural resources	—	—	17,807	17,807
Private equity	—	36,866	68,249	105,115
Real estate	—	—	21,846	21,846
Total interest in limited partnerships	—	36,866	107,902	144,768
Mutual funds:				
Fixed income	57,694	—	—	57,694
International equities	30,607	—	—	30,607
U.S. equities	78,913	—	—	78,913
Total mutual funds	167,214	—	—	167,214
Grand total	\$ 182,232	\$ 150,886	\$ 256,019	\$ 589,137

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

5. Employee Benefits Obligations (continued)

The following table presents the Plans' financial instruments as of August 31, 2011, measured at fair value on a recurring basis by the valuation hierarchy described in Note 4:

	Level 1	Level 2	Level 3	Total
103-12 investment entities:				
International equities	\$ —	\$ 42,949	\$ —	\$ 42,949
Private equity	—	—	2,223	2,223
Total 103-12 investment entities	—	42,949	2,223	45,172
Common collective trusts:				
Fixed income	—	5,782	—	5,782
International equities	—	23,659	—	23,659
Private equity	—	—	3,593	3,593
U.S. equities	—	44,081	—	44,081
Total common collective trusts	—	73,522	3,593	77,115
Corporate debt:				
Corporate debt instruments – other	—	2,922	—	2,922
Corporate debt instruments – preferred	—	6,903	—	6,903
Total corporate debt	—	9,825	—	9,825
Equity securities:				
U.S. equities	12,641	15	—	12,656
Hedge funds and other:				
Absolute return hedge fund	—	—	65,649	65,649
Equity long/short hedge fund	—	—	66,573	66,573
Fixed income	—	1,551	—	1,551
Natural resources	—	—	10,591	10,591
Total hedge funds and other	—	1,551	142,813	144,364
Interest in limited partnerships:				
Natural resources	—	—	17,009	17,009
Private equity	—	25,247	71,825	97,072
Real estate	—	—	18,857	18,857
Total interest in limited partnerships	—	25,247	107,691	132,938
Mutual funds:				
Fixed income	66,592	—	—	66,592
International equities	23,739	—	—	23,739
U.S. equities	56,830	—	—	56,830
Total mutual funds	147,161	—	—	147,161
Grand total	\$ 159,802	\$ 153,109	\$ 256,320	\$ 569,231

ATTACHMENT 6

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

5. Employee Benefits Obligations (continued)

The fair value of Level 1 investments, which consist of equity securities and certain mutual funds, is based on quoted market prices and are valued on a daily basis. Level 2 investments consist of U.S. government securities, corporate bonds, commingled funds, common collective trusts, interest in 103-12 entities, and fixed income instruments issued by municipalities or foreign government agencies. Included in Level 2 investments are certain hedge funds and limited partnerships that can be liquidated without restrictions. The fair value of the U.S. government securities and corporate bonds is established based on values obtained from nationally recognized pricing services that value the investments based on similar securities and matrix pricing of similar quality and maturity securities. The fair values of the commingled funds, common collective trusts, and 103-12 entities are based on either the fair value of the underlying investments of the fund, as determined by the fund, or based on the Master Trust's ownership interest in the NAV per share of its equivalent of the respective fund. The Plans utilize the NAV as the practical expedient for the fair value estimate as permitted. All Level 2 investments can be redeemed without restrictions on the financial statement date or shortly thereafter.

The fair value of Level 3 investments, which primarily consist of alternative investments (principally limited partnership interests in hedge, private equity, real estate, and natural resources funds) and certain common collective trusts and 103-12 investments, are based on NAV. The fair values of the securities held by limited partnerships that do not have readily determinable fair values are determined by the general partner taking into consideration, among other things, the financial performance of underlying investments, recent sales prices of underlying investments, and other pertinent information. In addition, actual market exchanges at period-end provide additional observable market inputs of the exit price. NAV is calculated by the investment's management monthly for all of the Master Trust's alternative investments other than limited partnerships, whose NAV is calculated on a quarterly basis. The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Plans believe its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different estimate of fair value at the reporting date.

All financial instruments with redemption restrictions in the near future or early withdrawal fees are categorized as Level 3 investments. Some of the redemption restrictions are temporary in nature. If restrictions expire and an investment can be redeemed at NAV, such investment is reclassified from Level 3 to Level 2 of the fair value hierarchy. During the years ended August 31, 2012 and 2011, \$28,405 and \$0 was transferred from Level 3 to Level 2, respectively.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

5. Employee Benefits Obligations (continued)

Investments in LPs, which cannot be redeemed on request, totaled \$100,971 as of August 31, 2012. Certain marketable alternative investments are subject to various redemption restrictions. As of August 31, 2012, \$38,481 of these alternative investments cannot be redeemed for at least one year. In addition, \$156,774 is subject to redemption limits and lockup provisions that expire within one year of the balance sheet date.

The table below sets forth a summary of changes in the fair value of the Plans' Level 3 assets for the period from September 1, 2010 to August 31, 2012:

	103-12 Investment Entities	Common Collective Trusts	Hedge Funds and Other	Interest in Limited Partnerships	Total
Value at September 1, 2010	\$ 2,237	\$ 3,802	\$ 121,375	\$ 84,874	\$ 212,288
Gain (loss) realized on assets sold during the period	239	642	(2,219)	6,333	4,995
Change in unrealized (loss) gain related to holdings at August 31, 2011	(119)	(697)	11,310	4,514	15,008
Purchases at cost	51	165	24,400	21,742	46,358
Sales at cost	(185)	(319)	(12,053)	(9,772)	(22,329)
Value at August 31, 2011	2,223	3,593	142,813	107,691	256,320
Gain realized on assets sold during the period	299	512	5	6,470	7,286
Change in unrealized (loss) gain related to holdings at August 31, 2012	(477)	(874)	6,520	992	6,161
Purchases at cost	64	65	15,227	19,027	34,383
Sales at cost	(199)	(335)	(1,889)	(17,303)	(19,726)
Transfers to Level 2	—	—	(19,430)	(8,975)	(28,405)
Value at August 31, 2012	\$ 1,910	\$ 2,961	\$ 143,246	\$ 107,902	\$ 256,019

The Plans' assets are managed solely in the interest of the Plans' participants and their beneficiaries. The assets are invested with the investment objective of funding the accumulated and projected retirement benefit obligations of the Plans consistent with the Plans' long-term rate-of-return assumption. A time horizon of greater than five years is assumed, and therefore, interim volatility in returns is regarded with appropriate perspective.

Northwestern Memorial has no current plans to contribute to the Plans during the year ending August 31, 2013.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(In Thousands)

5. Employee Benefits Obligations (continued)

Benefit payments, which reflect future service, as appropriate, are expected to be paid as follows:

	NMH	NLFH
Year ending August 31:		
2013	\$ 16,223	\$ 3,167
2014	17,149	3,561
2015	19,773	4,018
2016	20,905	4,466
2017	21,054	4,917
2018-2022	123,135	29,926

Northwestern Memorial also maintains defined contribution plans covering substantially all of its full-time and part-time employees. For 2012, contributions are limited to 80% of each covered employee's salary and a matching portion of 50% of the first 6% of the employee's contribution per pay period, with an annual maximum of \$7.5 per employee. In addition, a non-elective provision for those employees who are not participants in the defined benefit plans provides for employer contributions of 1% to 2% of each employee's salary provided they are employed as of December 31 of the plan year and have one thousand hours of service in the plan year. Effective January 1, 2013, the employer matching portion will be 100% of the first 6% of the employee's contribution per pay period, subject to the 2013 IRS limits. The non-elective provision will be eliminated and the final 2012 contribution will be made in early 2013. Employer contributions related to these defined contribution plans included in employee benefits expense in the accompanying consolidated statements of operations and changes in net assets totaled \$13,220 and \$10,862 in 2012 and 2011, respectively.

NMHC also maintains other noncontributory postretirement benefit plans (the Noncontributory Plans) for certain executive employees.

Included in unrestricted net assets are unrecognized actuarial gain of \$787 at August 31, 2012, and an unrecognized actuarial loss of \$3,376 at August 31, 2011, respectively, for the Noncontributory Plans that have not yet been recognized in net periodic pension cost.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(In Thousands)

5. Employee Benefits Obligations (continued)

Changes in the Noncontributory Plans' assets and benefit obligations recognized in unrestricted net assets during 2012 and 2011 include the following:

	<u>2012</u>	<u>2011</u>
Current year actuarial gain (loss)	\$ 1,313	\$ (2,811)
Recognized actuarial net loss	<u>2,850</u>	<u>1,515</u>
	<u>\$ 4,163</u>	<u>\$ (1,296)</u>

As of August 31, 2012 and 2011, the Noncontributory Plans' unfunded projected benefit obligation amounted to \$19,376 and \$18,814, respectively, and is included in other long-term liabilities in the accompanying consolidated balance sheets. The weighted-average discount rate utilized in determining the actuarial present value was 4.25% and 5.25% in 2012 and 2011, respectively. The Noncontributory Plans' actuarial loss included in unrestricted net assets expected to be recognized in net periodic pension cost during 2013 is \$1,371.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(In Thousands)

6. Long-Term Debt

Long-term debt consists of the following at August 31:

	<u>2012</u>	<u>2011</u>
Revenue Bonds, Series 2009A, payable in annual installments through August 15, 2039 (fixed coupon rates range from 5.00% to 6.00%)	\$ 342,260	\$ 353,470
Revenue Bonds, Series 2009B, payable in annual installments through August 15, 2039 (fixed coupon rates range from 5.00% to 6.00%)	96,100	96,100
Variable-Rate Demand Revenue Bonds, Series 2008A, payable in annual installments through August 15, 2038 (weighted-average interest rate was 0.13% in 2012 and 0.18% in 2011)	78,775	78,775
Variable-Rate Demand Revenue Bonds, Series 2007A, payable in annual installments through August 15, 2042 (weighted-average interest rate was 0.14% in 2012 and 0.21% in 2011)	210,600	211,600
Revenue Bonds, Series 2003 (Lake Forest Hospital), payable in annual installments through July 1, 2033 (fixed coupon rates range from 4.50% to 6.00%)	25,950	26,250
Variable-Rate Demand Revenue Bonds, Series 2002C, payable in annual installments beginning August 15, 2026 through August 15, 2032 (weighted-average interest rate was 0.13% in 2012 and 0.18% in 2011)	33,000	33,000
Revenue Bonds, Series 2002A (Lake Forest Hospital), payable in annual installments through July 1, 2029 (fixed coupon rates range from 5.75% to 6.25%)	40,850	42,050
	<u>827,535</u>	<u>841,245</u>
Less:		
Unamortized discount, net	6,880	6,181
Current maturities	14,500	13,710
	<u>\$ 806,155</u>	<u>\$ 821,354</u>

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(In Thousands)

6. Long-Term Debt (continued)

NMH currently has a line of credit available for operations in the amount of \$50,000, which expires in July 2015. Under this committed line of credit, NMH has the option to borrow at various rates expressed as an adjustment to the LIBOR, prime rate, or other bank-offered rates. At August 31, 2012 and 2011, no amount was borrowed under the available line of credit.

NMH has standby bond purchase agreements (SBPAs) with multiple banks that cover all of its variable-rate demand revenue bonds (VRDBs). The short-term credit rating for each series of VRDBs is based on the respective bank's short-term credit rating. The long-term credit rating for each series of VRDBs is based on NMH's long-term credit rating. Changes in credit ratings may impact the interest paid on or remarketing of the VRDBs. The banks provide liquidity support in the event of a failed remarketing as follows:

	<u>Par Value</u>	<u>Expiration Date</u>
Series 2008A	\$ 78,775	July 2014
Series 2002C	33,000	July 2014
Series 2007A	210,600	December 2014

The SBPAs require NMH to maintain reporting, financial, and other covenants. If an SBPA is not renewed or replaced prior to its expiration, or if some portion, or all, of the related VRDBs are not successfully remarketed ("failed remarketing") during the term of the SBPAs, the related VRDBs convert to a term loan at the earlier of the expiration date of the related SBPA or after 90 consecutive days of failed remarketing. Principal payments on the term loan would then be payable over a three-year term. The earliest principal payment on any term loan associated with the bonds is 367 days from the failed remarketing date. Therefore the VRDBs, less any current portion, are classified as long-term debt in the accompanying consolidated balance sheets.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

6. Long-Term Debt (continued)

Scheduled principal repayments for the next five years, assuming remarketing of VRDBs, on long-term debt are as follows:

Year ending August 31:	
2013	\$ 14,500
2014	15,220
2015	15,985
2016	16,785
2017	17,645

The provisions under the respective debt agreements require the Obligated Group to maintain reporting, financial, and other covenants. At August 31, 2012, the Obligated Group was in compliance with these provisions.

Northwestern Memorial paid interest of \$40,012 in 2012 and \$41,418 in 2011 (which includes \$10,570 and \$10,639, respectively, for net swap payments included in other operating expense in the accompanying consolidated statements of operations and changes in net assets). Northwestern Memorial capitalized interest of \$2,452 and \$3,299 in 2012 and 2011, respectively.

7. Derivatives

Northwestern Memorial's only derivative financial instruments are interest rate swaps, which NMH maintains on its VRDBs for the sole purpose of risk management. These bonds expose NMH to variability in interest payments due to changes in interest rates. Management believes that it is prudent to limit the variability of its interest payments. To meet this objective and to take advantage of low interest rates, NMH entered into various interest rate swap agreements to manage fluctuations in cash flows resulting from interest rate risk. These swaps limit the variable-rate cash flow exposure on the VRDBs to synthetically fixed cash flows. By using interest rate swaps to manage the risk of changes in interest rates, NMH exposes itself to credit risk and market risk. Credit risk is the risk that a counterparty will fail to perform under the terms of a derivative contract. When the fair value of a swap is positive, the counterparty owes NMH, which creates credit risk for NMH. When the fair value of a swap is zero or negative, the counterparty does not owe NMH. NMH minimizes the credit risk in its swap contracts by entering into transactions that require the counterparty to post collateral for the benefit of NMH based on the credit rating of the counterparty and the fair value of the swap contract. The

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

7. Derivatives (continued)

aggregate fair value of the swaps on the consolidated balance sheets as of August 31, 2012 and 2011, reflects a reduction of \$9,497 and \$6,858, respectively, for nonperformance risk. Market risk is the adverse effect on the value of a financial instrument that results from a change in interest rates. The market risk associated with interest rate changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken. Management also mitigates risk through periodic reviews of their swap positions in the context of their total blended cost of capital.

The following is a summary of the outstanding positions under existing interest rate swap agreements at August 31, 2012 and 2011:

Notional Amount		Maturity Date	Rate Paid	Rate Received
2012	2011			
\$ 35,250	\$ 35,250	May 2035	3.310%	63% of LIBOR + 28 bps
35,250	35,250	May 2035	3.310	63% of LIBOR + 28 bps
43,200	43,200	May 2035	3.313	63% of LIBOR + 28 bps
105,300	105,800	August 2042	3.889	63% of LIBOR + 28 bps
105,300	105,800	August 2042	3.889	63% of LIBOR + 28 bps
<u>\$ 324,300</u>	<u>\$ 325,300</u>			

The fair value of derivative instruments at August 31 is as follows:

	Balance Sheet Location	Liabilities	
		2012	2011
Derivatives not designated as hedging instruments:	Interest rate swaps		
Interest rate contracts	liabilities	\$ 104,503	\$ 73,845

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

7. Derivatives (continued)

The effects of derivative instruments on the consolidated statements of operations and changes in net assets for 2012 and 2011 are as follows:

	Amount of Gain (Loss) Recognized in Excess of Revenue Over Expenses on Derivatives	
Interest Rate Contracts	2012	2011
Derivatives not designated as hedging instruments:		
Operating expense – other	\$ (10,570)	\$ (10,639)
Nonoperating – change in fair value of interest rate swaps	(30,533)	4,527

NMH's derivative instruments contain provisions that require NMH's debt to maintain an investment-grade credit rating from certain major credit rating agencies. If NMH's debt were to fall below investment grade, it would be in violation of these provisions, and the counterparties to the derivative instruments could request immediate payment or demand immediate and ongoing collateralization on derivative instruments in net liability positions. NMH has posted collateral of \$20,451 and \$1,172 as of August 31, 2012 and 2011, respectively. If the credit risk-related contingent features underlying these agreements were triggered to the fullest extent on August 31, 2012, NMH would be required to post \$114,000 of collateral to its counterparties.

8. Income Tax Status

NMHC, NMH, NLFH, the Foundation, HFI, and NMPG are qualified under the Internal Revenue Code (the Code) as tax-exempt organizations and are exempt from tax on income related to their tax-exempt purposes under Section 501(a) of the Code. Accordingly, no income taxes are provided for the majority of the income in the accompanying consolidated financial statements for these corporations. NMHC, NMH, NLFH, HFI, and the Foundation had unrelated business income (UBI) generated primarily through limited partnerships within the investment portfolio and the sale of certain services that are not directly related to patient care. NMHC, NMH, NLFH, HFI, and the Foundation have unused net operating loss carryforwards available to offset the UBI tax. The net operating loss carryforwards expire through 2029. The deferred tax

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

8. Income Tax Status (continued)

assets associated with these net operating loss carryforwards of \$4,708 and \$5,395 at August 31, 2012 and 2011, respectively, are offset by valuation allowances on the consolidated balance sheets of \$4,708 and \$5,395, respectively.

In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax asset will not be realized. The ultimate realization of deferred tax assets is dependent on the generation of future taxable income during the periods in which those temporary differences become deductible.

NMIC is incorporated under the laws of the Cayman Islands. The Cayman Islands government imposes no tax on income or capital gains, and NMIC has received an undertaking from the Cayman Islands government exempting it from future income and capital gains taxes until March 25, 2023. However, NMIC is subject to U.S. federal corporate taxation to the extent that it generates net income that is effectively connected with a U.S. trade or business. NMIC is not engaged in any such trade or business in the U.S. In addition, distributions that NMH receives from NMIC are treated as dividends and, as such, are not taxable to NMH. Therefore, no income tax provision has been recorded related to NMIC and its operations.

Interest and penalties on income taxes, when incurred, are included in operating expenses.

9. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at August 31, 2012 and 2011:

	2012	2011
Healthcare services:		
Purchase of property and equipment	\$ 15,287	\$ 16,313
Operating expenses and charity care	49,820	74,251
Research, education, and other	90,156	49,824
	<u>\$ 155,263</u>	<u>\$ 140,388</u>

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

9. Temporarily and Permanently Restricted Net Assets (continued)

Net assets were released from donor restrictions by incurring expenditures for the following purposes:

	2012	2011
Healthcare services:		
Purchase of property and equipment	\$ 1,579	\$ 380
Operating expenses and charity care	8,286	10,493
Research, education, and other	18,946	11,625
	<u>\$ 28,811</u>	<u>\$ 22,498</u>

Permanently restricted net assets at August 31, 2012 and 2011, are summarized below, the income from which is expendable to support:

	2012	2011
Healthcare services:		
Purchase of property and equipment	\$ 13,415	\$ 15,408
Operating expenses and charity care	68,754	78,828
Research, education, and other	59,602	32,093
	<u>\$ 141,771</u>	<u>\$ 126,329</u>

Northwestern Memorial's endowment consists of individual donor-restricted funds established for a variety of purposes. Net assets associated with endowment funds are classified and reported based on the donor-imposed restrictions.

Northwestern Memorial has interpreted the Uniform Prudent Management of Institutional Funds Act of 2006 (UPMIFA), as adopted by the State of Illinois, as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, Northwestern Memorial classifies as permanently restricted net assets the original value of gifts donated to the permanent endowment, the original value of subsequent gifts to the permanent endowment, and accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the organization in a manner consistent with the donor intent or, where silent,

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

9. Temporarily and Permanently Restricted Net Assets (continued)

standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, Northwestern Memorial considers the following factors in making a determination to appropriate or accumulate donor-restricted funds:

- The duration and preservation of the fund
- The purposes of Northwestern Memorial and the endowment fund
- General economic conditions
- The possible effects of inflation and deflation
- The expected total return from income and the appreciation of investments
- Other resources of Northwestern Memorial
- The investment policies of Northwestern Memorial

Northwestern Memorial has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that must be held in perpetuity or for a donor-specified period. Under this policy, the endowment assets are invested in a manner that is intended to produce a real return, net of inflation and investment management costs, of at least 6% over the long term. Actual returns in any given year may vary from this amount.

To satisfy its long-term rate-of-return objectives, Northwestern Memorial relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). Northwestern Memorial targets a diversified asset allocation that places an emphasis on equity-based and alternative investments to achieve its long-term objective within prudent risk constraints.

Northwestern Memorial has a policy of appropriating for distribution each year no more than 4% of the endowment fund balance at the midpoint of the preceding fiscal year. In establishing this policy, Northwestern Memorial considered the long-term expected return on its endowment with the objective of maintaining the purchasing power of the endowment assets.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(In Thousands)

9. Temporarily and Permanently Restricted Net Assets (continued)

The changes in endowment net assets for the years ended August 31, 2012 and 2011, are summarized below:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, September 1, 2010	\$ 43,406	\$ 105,903	\$ 149,309
Contributions	1,573	19,683	21,256
Change in value of trusts	44	993	1,037
Investment return	12,968	—	12,968
Appropriation for expenditure	(5,035)	—	(5,035)
Other	(123)	(250)	(373)
Endowment net assets, August 31, 2011	52,833	126,329	179,162
Contributions	(535)	16,347	15,812
Change in value of trusts	(62)	(1,025)	(1,087)
Investment return	8,269	—	8,269
Appropriation for expenditure	(5,199)	—	(5,199)
Other	(322)	120	(202)
Endowment net assets, August 31, 2012	<u>\$ 54,984</u>	<u>\$ 141,771</u>	<u>\$ 196,755</u>

10. Pledges Receivable

As of August 31, 2012, donor-restricted pledges are expected to be realized as follows:

Less than one year	\$ 2,366
One to five years	19,813
Thereafter	4,683
Total pledges receivable	26,862
Less discount and allowance	(4,247)
Net pledges receivable	<u>\$ 22,615</u>

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Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

11. Net Patient Revenue

Northwestern Memorial recognizes patient revenue associated with services provided to patients who have third-party payor coverage with Medicare, Medicaid, Blue Cross, other managed care programs, and other third-party payors on the basis of the contractual rates for the services rendered at the time services are provided. Payment arrangements with those payors include prospectively determined rates per admission or visit, reimbursed costs, discounted charges, and per diem rates. Reported costs and/or services provided under certain of the arrangements are subject to retroactive audit and adjustment. Net patient revenue decreased by \$1,605 in 2012 and increased by \$7,366 in 2011 as a result of changes in estimates due to final cost report settlements and the disposition of other payor audits and settlements. Changes in Medicare and Medicaid programs and reduction in funding levels could have an adverse effect on Northwestern Memorial.

Northwestern Memorial also provides care to self-pay patients. Under its Free and Discounted Care Policy (the Policy), Northwestern Memorial provides medically necessary care to patients in its community with inadequate financial resources at discounts of up to 100% of charges using a sliding scale that is based on patient household income as a percentage (up to 600%) of the Federal Poverty Level guidelines. The Policy also contains a catastrophic financial assistance provision that limits a patient's total financial responsibility to Northwestern Memorial. Since Northwestern Memorial does not pursue collection of these amounts, they are not reported as patient revenue. The Policy has not changed in fiscal year 2012 or 2011. NLFH adopted this policy in June 2011. Northwestern Memorial recognizes patient revenue on services provided to these patients at the discounted rate at the time services are rendered.

Patient revenue, net of contractual allowances and discounts, is reduced by the provision for bad debts, and net patient accounts receivable are reduced by an allowance for uncollectible accounts. These amounts are based primarily on management's assessment of historical and expected write-offs and net collections along with the aging status for each major payor source. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for uncollectible accounts. Based on historical experience, a portion of Northwestern Memorial's self-pay patients who do not qualify for charity care will be unable or unwilling to pay for the services provided. Thus, a provision is recorded for bad debts in the period services are provided related to these patients. After all reasonable collection efforts have been exhausted in accordance with Northwestern Memorial's policies, accounts receivable are written off and charged against the allowance for uncollectible accounts.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

11. Net Patient Revenue (continued)

Northwestern Memorial has determined, based on an assessment at the reporting-entity level, that patient service revenue is primarily recorded prior to assessing the patient's ability to pay, and as such, the entire provision for bad debts is recorded as a deduction from patient service revenue in the accompanying consolidated statements of operations and changes in net assets.

For the years ended August 31, 2012 and 2011, patient service revenue (including patient copays and deductibles), net of contractual allowances and discounts (but before the provision for uncollectible accounts) by primary payor source was as follows:

	2012	2011
Medicare	\$ 365,081	\$ 347,610
Medicaid	151,854	153,627
Other third-party payors	1,081,831	1,073,666
Patients	15,357	18,693
	<u>\$ 1,614,123</u>	<u>\$ 1,593,596</u>

Medicaid patient service revenue includes revenue received through the Illinois Hospital Assessment Program (see Note 12).

Northwestern Memorial grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. At August 31, 2012 and 2011, patient accounts receivable, including patient copays and deductibles by major primary payor source, before deducting estimated uncollectibles, was as follows:

	2012	2011
Medicare	14%	16%
Medicaid	21	15
Blue Cross	21	23
Other managed care	30	29
Other third-party payors	7	10
Patients	7	7
	<u>100%</u>	<u>100%</u>

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

11. Net Patient Revenue (continued)

Patient accounts receivable net of contractual adjustments were \$318,811 and \$264,798 as of August 31, 2012 and 2011, respectively, or 19.8% and 16.6% of patient revenue for the fiscal years then ended. The related allowance for uncollectible accounts was \$39,036 and \$32,338, or 12.2% and 12.2% of the related patient accounts receivable net of contractual adjustments as of August 31, 2012 and 2011, respectively. The allowance for uncollectible accounts remained consistent as a percent of the related accounts receivable net of contractual allowances between August 31, 2012 and 2011.

12. Illinois Hospital Assessment Program

In December 2008, the Illinois Hospital Assessment Program (HAP) was approved by the Federal Centers for Medicare and Medicaid Services for the period July 1, 2008 through June 30, 2013. Under HAP, the state receives additional federal Medicaid funds for the state's healthcare system, administered by the Illinois Department of Healthcare and Family Services. HAP includes both a payment to NMH and NLFH from the state and an assessment (the provider tax) against NMH and NLFH, which is paid to the state in the same year. Included in the accompanying consolidated statements of operations and changes in net assets for the years ended August 31, 2012 and 2011, respectively, are \$57,915 and \$58,255 of patient service revenue and \$41,395 and \$41,395 of assessment.

13. Functional Expenses

Northwestern Memorial provides general healthcare services primarily to residents within its geographic location and supports research and education programs. For the years ended August 31, 2012 and 2011, expenses related to providing these services were as follows:

	2012	2011
Healthcare services	\$ 1,259,815	\$ 1,254,836
Research and education	64,030	64,471
Fund-raising	7,532	5,842
General, administrative, and other	281,855	266,106
	<u>\$ 1,613,232</u>	<u>\$ 1,591,255</u>

The research and education costs include \$7,553 and \$3,448 of expenses supported by federal, state, and corporate grants and \$11,393 and \$8,178 of expenses supported by other donor-restricted funds in 2012 and 2011, respectively.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

14. Commitments and Contingencies

Consistent with its mission, Northwestern Memorial from time to time provides academic, program, and other support to other not-for-profit entities. The present value of the total remaining commitments related to this support are \$134,842 and \$64,318 at August 31, 2012 and 2011, respectively, which are reported as grants and academic support payable in the accompanying consolidated balance sheets.

As of August 31, 2012, approximately 15% of Northwestern Memorial employees were represented by a collective bargaining agreement. This collective bargaining agreement does not expire within one year.

Various capital projects are currently being constructed that are expected to open over the next three years. The total estimated cost of these projects is approximately \$496,000. As of August 31, 2012, project commitments totaled \$322,857, of which \$113,555 has been incurred.

As part of the affiliation agreement with Lake Forest Hospital in 2010, Northwestern Memorial committed to a plan to refurbish or replace existing inpatient and outpatient facilities on the Lake Forest Campus within ten years of the affiliation date ("Replacement Project"). The planning process for the Replacement Project is progressing on schedule. Any Replacement Project plans will be subject to obtaining a certificate of need along with other governmental approvals.

Certain Northwestern Memorial buildings are located on land leased from Northwestern University under various lease agreements. The principal lease requires annual payments of \$314 through 2074. At August 31, 2012, minimum future rental payments under other noncancelable operating leases, which consist primarily of leases for office space and equipment, some of which include renewal options, are as follows:

Year ending August 31:	
2013	\$ 10,546
2014	9,705
2015	8,996
2016	8,779
2017	8,526
Thereafter	39,827

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

14. Commitments and Contingencies (continued)

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is a reasonable possibility that recorded amounts will change by a material amount in the near term. During the last few years, as a result of nationwide investigations by governmental agencies, various healthcare organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties, and potential exclusion from the Medicare and Medicaid programs. In addition, an increasing number of the operations or practices of not-for-profit healthcare providers has been challenged or questioned to determine if they are consistent with the regulatory requirements for nonprofit tax-exempt organizations. These challenges are broader than concerns about compliance with federal and state statutes and regulations of core business practices of the healthcare organizations. Areas that have come under examination have included pricing practices, billing and collection practices, charitable care, community benefit, executive compensation, exemption of property from real property taxation, and others. Northwestern Memorial expects that the level of review and audit to which it and other healthcare providers are subject will increase. There can be no assurance that regulatory authorities will not challenge Northwestern Memorial's compliance with these laws and regulations, and it is not possible to determine the effect, if any, such claims or penalties would have on Northwestern Memorial.

In August 2011, the Illinois Department of Revenue (the Department) denied property tax exemption applications submitted by NMH and two other unaffiliated hospitals. The NMH denial related to its application for an exemption for the Prentice Women's Hospital pavilion (Prentice pavilion) for the 2007 tax year.

NMH also filed property tax exemption applications for the Prentice pavilion for the 2009 and 2010 tax years. Nevertheless, in October 2011, NMH received from the Cook County Assessor's Office (the Assessor) notices of intent to list omitted assessments for the Prentice pavilion for 2008, 2009, and 2010, and the Assessor issued proposed assessments for the Prentice pavilion for 2011. On March 30, 2012, NMH filed a property tax exemption application for the Prentice pavilion for the 2011 tax year. On July 5, 2012, NMH received tax bills for the Prentice pavilion for 2008 through 2011.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

14. Commitments and Contingencies (continued)

On June 14, 2012, Illinois Governor Pat Quinn signed legislation (Public Act 97-688) establishing clear criteria for property, sales, and use tax exemptions for not-for-profit hospitals. The legislation expressly applies to exemption applications, such as those filed by NMH regarding the Prentice pavilion and other Illinois hospitals, that have either not been decided by the Illinois Department of Revenue or for which such Department decisions are not final and non-appealable. NMH sought and received property tax exemptions for the Prentice pavilion for 2007 and subsequent years pursuant to the recent legislation. As a result, no property tax will be due for the Prentice pavilion for tax years 2007-2011.

On February 8, 2010, NMH and NMHC were served as defendants in a lawsuit filed by a former NMH clinical coordinator alleging that employees were not compensated for all time worked. The former employee seeks to represent a class of all NMH hourly employees in over 20 different job classifications. In August 2011, NMHC was dismissed from the case, and the court conditionally certified a narrower-than-petitioned-for collective action consisting of NMH non-union, direct patient care employees. The opt-in period has closed, with approximately 132 of 4,360 (approximately 3%) eligible current and former employees opting in as plaintiffs. On October 24, 2012, the parties mediated the claims outlined in the aforementioned lawsuit. The mediation resulted in a settlement (subject to Court approval), pursuant to which NMH has agreed to settle and release all outstanding claims related to the litigation. The settlement is made without any admission of liability by NMH. Management has accrued amounts estimated to be payable under the proposed settlement as of August 31, 2012; any changes in the final settlement amount will be accrued at the time of final settlement.

On October 25, 2012, NMH received a copy of the complaint in the lawsuit captioned, *United States of America Ex Rel. Audra Soulias v. Northwestern University and Northwestern Memorial Hospital*, 10-cv-07233 (N.D. Ill.). Plaintiff Soulias originally filed the lawsuit in November, 2010, but the case remained under seal until July 9, 2012, at which time the United States Department of Justice declined to intervene in the suit. The complaint alleges that NMH violated the False Claims Act by submitting Medicare claims for services that were part of federally funded clinical research, and thus caused the Federal Government to pay twice for the same patient care services. The case is currently pending in the United States District Court for the Northern District of Illinois Eastern Division. NMH has yet to respond to the complaint or to conduct any formal discovery, and accordingly at this time management is unable to determine what effects, if any, this matter may have on the consolidated financial statements.

Northwestern Memorial HealthCare and Subsidiaries

Notes to Consolidated Financial Statements (continued) (In Thousands)

14. Commitments and Contingencies (continued)

Northwestern Memorial is a defendant in other various lawsuits arising in the ordinary course of business. Although the outcome of these lawsuits cannot be predicted with certainty, management believes the ultimate disposition of such matters will not have a material effect on Northwestern Memorial's financial condition or operations.

15. Elmhurst Memorial Healthcare

In February 2012, NMHC and Elmhurst Memorial Healthcare (EMHC), the corporate parent of Elmhurst Memorial Hospital, executed a non-binding letter of intent that provided for a period of exclusive discussions regarding a potential affiliation. On June 28, 2012, NMHC and EMHC announced they had terminated the letter of intent, ending the period of exclusive discussions.

16. Subsequent Events

Northwestern Memorial evaluated events and transactions occurring subsequent to August 31, 2012 through November 29, 2012, the date of issuance of the consolidated financial statements. During this period, there were no subsequent events requiring recognition in the consolidated financial statements that have not been recorded. In September 2012, Northwestern Memorial signed an Alignment Agreement with NMFF and Northwestern University (NU) that furthers the mutual purpose and mission of the entities. This alignment agreement provides for a one-time grant for research of \$167,000 by Northwestern Memorial to NU and provides for ongoing funding to NU toward clinical program development called for in the shared strategic plan. This ongoing funding consists of 0.5% of Northwestern Memorial's net patient revenue (excluding HAP revenue) and 10% of Northwestern Memorial operating income up to a 5% operating margin and 20% of operating income that exceeds a 5% operating margin. There were no other unrecognized subsequent events requiring disclosure except as previously disclosed in Note 14.

Supplementary Information



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Report of Independent Auditors on Supplementary Information

The Board of Directors
Northwestern Memorial HealthCare

Our audits were conducted for the purpose of forming an opinion on the basic consolidated financial statements as a whole. The accompanying consolidating balance sheet and statement of revenue and expenses are presented for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Ernst & Young LLP

November 29, 2012

Northwestern Memorial HealthCare and Subsidiaries

Consolidating Balance Sheet
(In Thousands)

August 31, 2012

	Northwestern Memorial Hospital and Subsidiaries	Northwestern Lake Forest Hospital and Subsidiary	Northwestern Memorial HealthCare	Northwestern Memorial Foundation	Consolidating Entries	Consolidated
Assets						
Current assets:						
Cash and cash equivalents	\$ 92,067	\$ 24,588	\$ 1,029	\$ 21,659	\$ -	\$ 139,343
Short-term investments	112,898	27	-	-	-	112,925
Current portion of investments, including assets limited as to use	83,480	5,767	-	-	-	89,247
Patient accounts receivable, net	246,794	32,981	-	-	-	279,775
Current portion of pledges and grants receivable, net	998	15	-	8,244	-	9,257
Current portion of insurance recoverable	11,760	1,300	-	-	-	13,060
Inventories	26,793	4,735	-	-	-	31,528
Other current assets	27,340	2,081	3,776	3,233	(3,292)	33,138
Due from affiliates	8,406	250	2,773	-	(11,429)	-
Total current assets	610,536	71,744	7,578	33,136	(14,721)	708,273
Investments, including assets limited as to use, less current portion	1,687,975	145,816	18,019	578,541	-	2,430,351
Property and equipment, at cost:						
Land	182,420	55,533	-	-	-	237,953
Buildings	1,508,294	159,479	-	227	-	1,668,000
Equipment and furniture	332,828	31,205	158,102	208	-	522,343
Construction-in-progress	45,430	1,143	-	-	-	46,573
	2,068,972	247,360	158,102	435	-	2,474,869
Less accumulated depreciation	943,441	46,715	126,396	266	-	1,116,818
	1,125,531	200,645	31,706	169	-	1,358,051
Prepaid pension cost	30,814	-	-	-	-	30,814
Insurance recoverable, less current portion	69,580	4,864	-	-	-	74,444
Other assets, net	45,557	518	8,214	45,462	-	99,751
Interest in unrestricted net assets of the Foundation	397,234	-	-	-	(397,234)	-
Interest in restricted net assets of the Foundation	256,487	-	-	-	(256,487)	-
Total assets	\$ 4,223,714	\$ 423,587	\$ 65,517	\$ 657,308	\$ (668,442)	\$ 4,701,684

Northwestern Memorial HealthCare and Subsidiaries

Consolidating Balance Sheet (continued)

(In Thousands)

August 31, 2012

	Northwestern Memorial Hospital and Subsidiaries	Northwestern Lake Forest Hospital and Subsidiary	Northwestern Memorial HealthCare	Northwestern Memorial Foundation	Consolidating Entries	Consolidated
Liabilities and net assets						
Current liabilities:						
Accounts payable	\$ 70,978	\$ 8,062	\$ 1,940	\$ 90	\$ -	\$ 81,070
Accrued salaries and benefits	69,793	11,661	13,094	400	-	94,948
Grants and academic support payable, current portion	36,523	-	-	1,065	-	37,588
Accrued expenses and other current liabilities	32,004	4,640	259	1,260	(3,292)	34,871
Due to third-party payors	181,969	25,471	-	-	-	207,440
Current accrued liabilities under self-insurance programs	60,926	4,707	-	-	-	65,633
Current maturities of long-term debt	12,810	1,690	-	-	-	14,500
Due to affiliates	661	2,556	7,995	217	(11,429)	-
Total current liabilities	465,664	58,787	23,288	3,032	(14,721)	536,050
Long-term debt, less current maturities	740,523	65,632	-	-	-	806,155
Accrued liabilities under self-insurance programs, less current portion	398,889	22,052	-	-	-	420,941
Grants and academic support payable, less current portion	96,699	-	-	555	-	97,254
Due to insureds	62,415	-	-	-	-	62,415
Interest rate swaps	104,503	-	-	-	-	104,503
Pension liability	-	3,863	-	-	-	3,863
Other liabilities	21,446	377	30,106	-	-	51,929
Total liabilities	1,890,139	150,711	53,394	3,587	(14,721)	2,083,110
Net assets:						
Unrestricted:						
Undesignated	1,927,089	243,728	12,123	258,634	(258,634)	2,182,940
Board-designated	138,600	-	-	138,600	(138,600)	138,600
Total unrestricted	2,065,689	243,728	12,123	397,234	(397,234)	2,321,540
Temporarily restricted	151,292	3,971	-	139,892	(139,892)	155,263
Permanently restricted	116,594	25,177	-	116,595	(116,595)	141,771
Total net assets	2,333,575	272,876	12,123	653,721	(653,721)	2,618,574
Total liabilities and net assets	\$ 4,223,714	\$ 423,587	\$ 65,517	\$ 657,308	\$ (668,442)	\$ 4,701,684

Northwestern Memorial HealthCare and Subsidiaries
Consolidating Statement of Revenue and Expenses
(In Thousands)

Year Ended August 31, 2012

	Northwestern Memorial Hospital and Subsidiaries	Northwestern Lake Forest Hospital and Subsidiary	Northwestern Memorial HealthCare	Northwestern Memorial Foundation	Consolidating Entries	Consolidated
Revenue						
Patient service revenue	\$ 1,389,271	\$ 224,858	\$ -	\$ -	\$ (6)	\$ 1,614,123
Provision for uncollectible accounts	24,476	7,596	-	-	-	32,072
Net patient revenue	1,364,795	217,262	-	-	(6)	1,582,051
Rental and other revenue	89,900	24,474	160,911	7,340	(181,629)	100,996
Net assets released from donor restrictions and federal and state grants	16,259	2,234	-	-	-	18,493
Total revenue	1,470,954	243,970	160,911	7,340	(181,635)	1,701,540
Expenses						
Salaries and professional fees	436,440	86,456	62,819	2,256	-	587,971
Employee benefits	128,888	24,986	31,808	951	-	186,633
Supplies	233,766	33,332	872	269	(42)	268,197
Purchased services	238,981	50,970	43,381	2,696	(162,483)	173,545
Depreciation	114,149	20,766	10,745	26	-	145,686
Insurance	58,805	2,665	39	58	(1,856)	59,711
Rent and utilities	32,073	6,771	12,068	488	(9,914)	41,486
Repairs and maintenance	38,141	6,116	1,321	3	-	45,581
Interest	25,832	3,869	-	-	-	29,701
Illinois Hospital Assessment	36,438	4,957	-	-	-	41,395
Other	29,438	4,179	(864)	573	-	33,326
Total expenses	1,372,951	245,067	162,189	7,320	(174,295)	1,613,232
Operating income (loss)	98,003	(1,097)	(1,278)	20	(7,340)	88,308
Nonoperating gains (losses)						
Investment return	111,322	8,759	1,175	29,506	-	150,762
Change in fair value of interest rate swaps	(30,533)	-	-	-	-	(30,533)
Grants and academic support provided	(101,884)	(104)	(8)	(4,712)	-	(106,708)
Change in interest in unrestricted net assets of the Foundation	29,056	-	-	-	(29,056)	-
Other	8,829	(395)	(47)	4,243	7,340	19,970
Total nonoperating gains, net	16,790	8,260	1,120	29,037	(21,716)	33,491
Excess (deficit) of revenue over expenses	\$ 114,793	\$ 7,163	\$ (158)	\$ 29,057	\$ (29,056)	\$ 121,799

Obligated Group
Combining Balance Sheet
(In Thousands)

August 31, 2012

	Northwestern Memorial Hospital	Northwestern Lake Forest Hospital	Combining Entries	Obligated Group
Assets				
Current assets:				
Cash and cash equivalents	\$ 89,641	\$ 20,874	\$ —	\$ 110,515
Short-term investments	112,898	27	—	112,925
Current portion of investments, including assets limited as to use	34,317	5,767	—	40,084
Patient accounts receivable, net	238,785	32,981	—	271,766
Current portion of pledges and grants receivable, net	998	15	—	1,013
Current portion of insurance recoverable	42,778	1,300	—	44,078
Inventories	25,659	4,708	—	30,367
Other current assets	14,353	1,920	—	16,273
Due from affiliates	10,933	4,920	(430)	15,423
Total current assets	570,362	72,512	(430)	642,444
Investments, including assets limited as to use, less current portion	1,434,403	145,816	—	1,580,219
Property and equipment, at cost:				
Land	182,420	54,533	—	236,953
Buildings	1,502,264	146,086	—	1,648,350
Equipment and furniture	328,558	31,017	—	359,575
Construction-in-progress	45,430	1,143	—	46,573
	2,058,672	232,779	—	2,291,451
Less accumulated depreciation	936,678	43,046	—	979,724
	1,121,994	189,733	—	1,311,727
Prepaid pension cost	30,814	—	—	30,814
Insurance recoverable, less current portion	226,268	4,864	—	231,132
Other assets, net	24,585	518	—	25,103
Interest in unrestricted net assets of the Foundation	397,234	—	—	397,234
Interest in restricted net assets of the Foundation	256,487	—	—	256,487
Total assets	\$ 4,062,147	\$ 413,443	\$ (430)	\$ 4,475,160

Obligated Group

Combining Balance Sheet (continued) (In Thousands)

August 31, 2012

	Northwestern Memorial Hospital	Northwestern Lake Forest Hospital	Combining Entries	Obligated Group
Liabilities and net assets				
Current liabilities:				
Accounts payable	\$ 69,364	\$ 7,953	\$ -	\$ 77,317
Accrued salaries and benefits	63,747	11,552	-	75,299
Grants and academic support payable, current portion	36,523	-	-	36,523
Accrued expenses and other current liabilities	27,603	4,173	-	31,776
Due to third-party payors	181,969	25,471	-	207,440
Current accrued liabilities under self-insurance programs	55,626	4,707	-	60,333
Current maturities of long-term debt	12,810	1,690	-	14,500
Due to affiliates	1	2,552	(430)	2,123
Total current liabilities	447,643	58,098	(430)	505,311
Long-term debt, less current maturities	740,523	65,632	-	806,155
Accrued liabilities under self-insurance programs, less current portion	388,805	22,052	-	410,857
Grants and academic support payable, less current portion	96,699	-	-	96,699
Interest rate swaps	104,503	-	-	104,503
Pension liability	-	3,863	-	3,863
Other liabilities	18,221	377	-	18,598
Total liabilities	1,796,394	150,022	(430)	1,945,986
Net assets:				
Unrestricted:				
Undesignated	1,859,229	234,273	-	2,093,502
Board-designated	138,600	-	-	138,600
Total unrestricted	1,997,829	234,273	-	2,232,102
Temporarily restricted	151,330	3,971	-	155,301
Permanently restricted	116,594	25,177	-	141,771
Total net assets	2,265,753	263,421	-	2,529,174
Total liabilities and net assets	\$ 4,062,147	\$ 413,443	\$ (430)	\$ 4,475,160

Obligated Group

Combining Statement of Revenue and Expenses (In Thousands)

Year Ended August 31, 2012

	Northwestern Memorial Hospital	Northwestern Lake Forest Hospital	Combining Entries	Obligated Group
Revenue				
Patient service revenue	\$ 1,324,519	\$ 224,858	\$ -	\$ 1,549,377
Provision for uncollectible accounts	23,365	7,596	-	30,961
Net patient revenue	1,301,154	217,262	-	1,518,416
Rental and other revenue	70,600	17,147	(97)	87,650
Net assets released from donor restrictions and federal and state grants	15,615	2,234	-	17,849
Total revenue	1,387,369	236,643	(97)	1,623,915
Expenses				
Salaries and professional fees	395,379	82,962	-	478,341
Employee benefits	120,417	24,686	-	145,103
Supplies	227,679	32,962	(42)	260,599
Purchased services	231,486	50,354	(54)	281,786
Depreciation	113,464	19,344	-	132,808
Insurance	32,560	2,468	-	35,028
Rent and utilities	30,576	6,853	(1)	37,428
Repairs and maintenance	37,558	5,999	-	43,557
Interest	25,832	3,869	-	29,701
Illinois Hospital Assessment	36,438	4,957	-	41,395
Other	28,552	3,588	-	32,140
Total expenses	1,279,941	238,042	(97)	1,517,886
Operating income (loss)	107,428	(1,399)	-	106,029
Nonoperating gains (losses)				
Investment return	90,257	9,042	-	99,299
Change in fair value of interest rate swaps	(30,533)	-	-	(30,533)
Grants and academic support provided	(101,884)	(104)	-	(101,988)
Change in interest in unrestricted net assets of the Foundation	29,056	-	-	29,056
Other	8,838	(395)	-	8,443
Total nonoperating gains, net	(4,266)	8,543	-	4,277
Excess of revenue over expenses	\$ 103,162	\$ 7,144	\$ -	\$ 110,306

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