	Financial Systems	CENTRAL DUPAGE			u of Form CMS-2	
	eport is required by law (42 USC 1395					
paymen	ts made since the beginning of the co	st reporting period beir	ig deemed overpayments ((42 USC 1395g).	OMB NO. 0938-0 EXPI RES 03-31	
	AL AND HOSPITAL HEALTH CARE COMPLEX C	OCT DEDODT CEDTLELCATION	Dravidar CCN: 14 0242	Peri od:	Worksheet S	-2022
	TLEMENT SUMMARY	USI REPORT CERTIFICATION	Provider CCN: 14-0242	From 09/01/2021	Parts I-III	
AND SL	TEEWENT SOWWART			To 08/31/2022		pared:
					1/28/2023 6: 3) pm
	- COST REPORT STATUS					
Provi de				Date: 1/28/20	23 Time: 6	:30 pm
use onl						
	3.[0]If this is an amended 4.[F]Medicare Utilization.	Enter "F" for full or '	L" for low.	resubmitted this c	cost report	
Contrac		6. Date Received:		.NPR Date:		
use onl	y (1) As Submitted	7. Contractor No.	11 For this Dravidar CCN12	. Contractor's Vendo	or Code:	4
	(2) Settled without Audit	9. [N] Final Report for	this Provider CCN	. [U]II IIIne 5, CC	nes reopened =	nter 0.0
	(3) Settled with Audit				lles reopened =	0-9.
	(4) Reopened (5) Amended					
	(5) Allerided					
PART II	- CERTIFICATION BY A CHIEF FINANCIA	L OFFICER OR ADMINISTRAT	OR OR PROVIDER(S)			
MI SREPP	RESENTATION OR FALSIFICATION OF ANY I	NFORMATION CONTAINED IN	THIS COST REPORT MAY BE	E PUNI SHABLE BY CRI	MINAL, CIVIL A	ND
	STRATIVE ACTION, FINE AND/OR IMPRISON					
	ED OR PROCURED THROUGH THE PAYMENT DI		A KICKBACK OR WERE OTHE	RWISE ILLEGAL, CRI	MINAL, CIVIL A	ND
ADMI NI S	STRATIVE ACTION, FINES AND/OR IMPRISO	NMENT MAY RESULT.				
	CERTIFICATION BY CHIEF FINANCIAL OF	FICER OR ADMINISTRATOR ()f PROVIDER(S)			
	I HEREBY CERTIFY that I have read t	he above certification s	statement and that I hav	ve examined the acc	companyi ng	
	electronically filed or manually su	bmitted cost report and	submitted cost report a	and the Balance She	et and	
	Statement of Revenue and Expenses p	repared by CENTRAL DUPA	E HOSPITAL (14-0242)	for the cost repor	ting period	
	beginning 09/01/2021 and ending 08/					
	are true, correct, complete and pre					
	applicable instructions, except as					
	regarding the provision of health c		he services identified	in this cost repor	rt were	
	provided in compliance with such la	ws and regulations.				
S	IGNATURE OF CHIEF FINANCIAL OFFICER (OR ADMI NI STRATOR CHEC	KBOX	ELECTRONI C		
	1		2 SI	GNATURE STATEMENT		

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1			SI GNATURE STATEMENT	
1	Mai	ureen Taus	Ŷ	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Maureen Taus			2
3	Signatory Title	VICE PRESIDENT, FINANCE NMHC			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	234, 944	70, 453	0	0	1.00
2.00	Subprovider - IPF	0	57, 774	9		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	292, 718	70, 462	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

PI T	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	Provid	ler CCI	N: 14-0242	Period: From 09/01/	′2 <u>∩</u> 21	Workshe Part I	et S-2	2
						To 08/31/		Date/Ti		
	1.00	2.00		3.00			4.00	1/28/20	023 6:3	30 pm
_	Hospital and Hospital Health Care Co									
00 00	Street: 25 NORTH WINFIELD ROAD City: WINFIELD	P0 Box: 11092012 State: IL	Zip Cod	e [.] 6019	90 Coun	ty: DUPAGE				1.
		Component Name	CCN	CBS	A Provi dei	Date		ent Syst		
			Number	Numb	er Type	Certified	T V	, 0, or XVIII	N) XIX	-
		1.00	2.00	3.0	0 4.00	5.00	6. OC	_	8.00	1
	Hospital and Hospital-Based Componen			1.0-						
0 0	Hospital Subprovider - IPF	CENTRAL DUPAGE HOSPI TAL CENTRAL DUAPGE HOSPI TAL PSYCH	140242 14S242	1697 1697		07/01/1966 07/01/1985		P P	0	3.
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Subprovider - IRF Subprovider - (Other) Swing Beds - SNF Swing Beds - NF Hospital -Based SNF Hospital -Based NF Hospital -Based NF Hospital -Based HHA Separately Certified ASC Hospital -Based Health Clinic - RHC Hospital -Based Health Clinic - FOHC Hospital -Based (CMHC) I Hospital -Based (CMF) I Hospital -Based (ODF) I Hospital -Based (ODT) I Hospital -Based (OSP) I									5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 17. 17. 17.
40	Renal Dialysis									17.
00	Other									19.
						From: 1.00				
	Cost Reporting Period (mm/dd/yyyy)					09/01/2		08/31/		20.
00	Type of Control (see instructions)					2				21.
					1.00	2.00		3. 0	00	
00	Inpatient PPS Information Does this facility qualify and is it	currently receiving nav	ments fo	r	Y	N				22.
01	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to	th 42 CF this endment s for th for no October	R is for 1.	Y	Y				22.
02	reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob	er October 1. (see instr requires final uncomper port settlement? (see in " for no, for the portic er 1. Enter in column 2,	ructions) Isated ca Istructio In of the "Y" for	re ns) yes	Ν	N				22.
03								Ν		22.
04	yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49	tical ar "N" for er 1. Ent ecost ructions) 9 beds (eas no er as	Ν	Ν		Ν		22.
00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the	of admission, 2 if censu	is days,	or 3		1 N				23.

	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D		OSPITAL Provider CC	N: 14-0242	Peri od:	In Lieu		eet S-2	
					From 09/0	1/2022	Part I Date/Ti	ime Pre 023 6:3	pared:
		In-State Medicaid paid days	In-State Medicaid eligible unpaid	Out-of State Medicaid paid days	Out-of State Medicaid eligible	Medicai HMO day	d O /s Mea	ither di cai d days	
			days		unpai d				
24.00	If this provider is an IPPS hospital, enter the	1.00	2.00 2,885	3.00	4.00	<u>5.00</u> 11,3		<u>5.00</u> 172	24.00
25.00	in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid	n n O			0		0	175	24.00
	HMO paid and eligible but unpaid days in column 5.				Urban / D	ural S		- Coogr	
					1. (ural S DO	2.		
26.00	Enter your standard geographic classification (not post reporting period. Enter "1" for urban or "2" for		at the beg	ginning of	the	1			26.00
	Enter your standard geographic classification (not reporting period. Enter in column 1, "1" for urban enter the effective date of the geographic reclassi	wage) status or "2" for r fication in	rural. If a _l column 2.	opl i cabl e,		1			27.00
35.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	ne number of	perrous so	SH STATUS I		0			35.00
					Begi nr 1. (Endi 2.	<u> </u>	-
36.00	Enter applicable beginning and ending dates of SCH		cript line	36 for num		50	۷. ۲	00	36.00
	of periods in excess of one and enter subsequent da If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	er the numbe	·		us	0			37.00
37.01	Is this hospital a former MDH that is eligible for accordance with FY 2016 OPPS final rule? Enter "Y" instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number of								38.00
	enter subsequent dates.	or periods i	n excess of	f one and					38.00
	enter subsequent dates.	or periods i	n excess of	f one and	Y/		Y/ 2		
39.00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i	al payment a i), (ii), or the mileage	idjustment (iii)? En e requiremen	for low vol ter in colu nts in	ume N mn	00	<u>Y/</u> 2.	00	
	Does this facility qualify for the inpatient hospit: hospitals in accordance with 42 CFR §412.101(b)(2)(1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo	al payment a i), (ii), or the mileage iii)? Enter on adjustmer ober 1. Ente	djustment f (iii)? En e requiremen in column : ut? Enter "Y er "Y" for y	for low volu ter in colu nts in 2 "Y" for ye Y" for yes y	es or N	00	2.	00	39. 00 40. 00
	Does this facility qualify for the inpatient hospit: hospitals in accordance with 42 CFR §412.101(b)(2)(1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction	al payment a i), (ii), or the mileage iii)? Enter on adjustmer ober 1. Ente	djustment f (iii)? En e requiremen in column : ut? Enter "Y er "Y" for y	for low volu ter in colu nts in 2 "Y" for ye Y" for yes y	es or N	00 00 V	2. N XVI I I	00 I XI X	39.00
	Does this facility qualify for the inpatient hospit: hospitals in accordance with 42 CFR §412.101(b)(2)(1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo	al payment a i), (ii), or the mileage iii)? Enter on adjustmer ober 1. Ente	djustment f (iii)? En e requiremen in column : ut? Enter "Y er "Y" for y	for low volu ter in colu nts in 2 "Y" for ye Y" for yes y	es or N	00	2. N XVI I I	00 I XI X	39.00
10.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment	al payment a i), (ii), or the mileage iii)? Enter on adjustmer ober 1. Ente 1. (see inst	djustment f (iii)? En requirement in column 2 t? Enter "` ructions)	for low volu ter in colu nts in 2 "Y" for yu (" for yes yes or "N"	ann n nn es or N for	00 V 1.00	2. N XVI I I	00 I XI X	40.00
40. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exe pursuant to 42 CFR §412.348(f)? If yes, complete West	al payment a i), (ii), or the mileage iii)? Enter on adjustmer ober 1. Ente 1. (see inst ent for disp ception for	djustment 1 (iii)? En requirement in column 2 rr"Y" for ructions) proportiona extraordina	for low volu ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums	accordance	00 V 1.00	2. N N XVI I I 2. 00	00 J XIX 3.00	40.00
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40. 00 45. 00 46. 00 47. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exe pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	al payment a i), (ii), or the mileage iii)? Enter on adjustmer ober 1. Ente 1. (see inst ent for disp ception for st. L, Pt. I capital? E	idjustment i (iii)? En requirement in column 2 it? Enter "Y ructions) proportiona extraordina II and Wks inter "Y for	for low volu ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N	accordance I through	00 V 1.00 N N	2. 1 N XVI I I 2. 00 Y N	00 J J N N N	40. 00 45. 00 46. 00 47. 00
40.00 45.00 46.00 47.00 48.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octa no in column 2, for discharges on or after October Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exa pursuant to 42 CFR §412.348(f)? If yes, complete Was Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME year, and are you are impacted by CR 11642 (or appli	al payment a i), (ii), or the mileage iii)? Enter on adjustmer ober 1. Ente 1. (see inst ent for disp ception for st. L, Pt. I capital? Enter " n approved C se to columr programs in icable CRs)	idjustment i (iii)? Enter in column 2 in column 2 ir "Y" for y ructions) proportiona extraordina II and Wks inter "Y for Y" for yes ME programs 1 is "Y", the prior y	for low voluter in columnts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. or "N" for s? Enter "Y or if this year or pen	1.0 ume N es or N for N accordance tances I through " for no. no. " for yes o hospi tal ul ti mate	DO V 1.00 N N N N N	2.1 N XVIII 2.00 Y N N	00 J XIX 3.00 N N N	40.00 45.00 47.00 48.00
40. 00 45. 00 46. 00 47. 00 48. 00 56. 00	Does this facility qualify for the inpatient hospitals in accordance with 42 CFR §412.101(b)(2)(1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ior "N" for no. (see instructions) Is this hospital subject to the HAC program reductions' for no in column 1, for discharges prior to Octano in column 2, for discharges on or after October in the 42 CFR Section §412.320? (see instructions) Is this facility qualify and receive Capital payment to 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exapprsuant to 42 CFR §412.348(f)? If yes, complete Was Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital payment in the form on a column 1. For column 2, if the response the facility electing the first cost reporting GME programs trained at this facility? Enter "Y" for is or in column 2. If column 2 is of the facility? The facitity? The facility? The facitity? The faci	al payment a i), (ii), or the mileage iii)? Enter ober 1. Enter 1. (see inst ent for disp ception for st. L, Pt. I capital? Enter " n approved C se to column programs in icable CRs) olumn 2. period duri or yes or "N nth of this	djustment i (iii)? Enter in column 2 r "equirement in column 2 r "Y" for y ructions) rooportionar extraordina II and Wks inter "Y for Y" for yes ME programs 1 is "Y", the prior y MA direct (ng which ro " for no in cost repor	for low voluter in columnts in 2 "Y" for yes or "N" for yes or "N" for yes or "N" for yes or "N" for circums t. L-1, Pt. for "N" for "N" for "S? Enter "Y or if this year or pendom column 1. ting period	1.0 ume N mn N es N or N for N accordance tances I through "for no. no. "for yes o hospi tal ul timate reduction? approved If col umn ?Enter "Y	DO V 1.00 N N N N N N 1	2.1 N XVIII 2.00 Y N N	00 J XIX 3.00 N N N	39.00
40. 00 45. 00 46. 00 47. 00 48. 00 56. 00 57. 00 58. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wk: Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital payme Teaching Hospitals Is this a hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the respon- was involved in training residents in approved GME year, and are you are impacted by CR 11642 (or appl Enter "Y" for yes; otherwise, enter "N" for no in column Is this facility? Enter "Y" for yes; is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mode	al payment a i), (ii), or the mileage iii)? Enter on adjustmer ober 1. Enter 1. (see inst ent for disp ception for st. L, Pt. I capital? E nt? Enter " n approved (se to columr programs in i cable CRS) olumn 2. period duri or yes or "N nth of this "Y", complet II, if appli mbursement f	djustment i (iii)? Enter in column 2 r "quirement in column 2 r "Y" for y ructions) oroportiona extraordina 11 and Wks inter "Y for Y" for yes MA direct (ng which re " for no in cost repor e Workshee cable. for physicia	for low voluter in columnts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period t E-4. If co	1.0 ume N mn N es N or N for N accordance tances I through "for no. no. "for yes o hospital ultimate reduction? approved If column ? Enter "Y olumn 2 is	DO V 1.00 N N N N N N 1	2.1 N XVIII 2.00 Y N N	00 J XIX 3.00 N N N	40.00 40.00 45.00 45.00 46.00 47.00 48.00 56.00

ealth Financial Systems CENTRAL IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		E HOSPITAL Provider C	CN: 14-0242	Period:	u of Form CMS-2 Worksheet S-2	
			011. 14 0242	From 09/01/2021 To 08/31/2022	Part I Date/Time Pre 1/28/2023 6:3	pared:
			NAHE 413.85 Y/N	Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
0.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. CR) NAHE	see If column 1	N			60.0
augustement: Lifter i for yes of in for horn cord	Y/N	I ME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0. OC	61.0
1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.0
1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 						61.0
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		N				61.0
	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Direct GME FTE Count	
		1.00	2.00	3.00	4.00	(1.1
1.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME				0.00	0.00	61.1
FTE unweighted count. 11.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct CME FTE unweighted count.				0.00	0.00	61.2
the direct GME FTE unweighted count.			1		1.00	
ACA Provisions Affecting the Health Resources and Ser	vi ces /	Administratior	n (HRSA)			
2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	traineo tions)	d in this cost	reporting pe			62.0
2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	iram. (s	<u>seë instructio</u>		to your hospital	0.00	62.0
3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c			N	63.0

	ial Systems HOSPITAL HEALTH CARE COMP		ATA Provider CO	CN: 14-0242 P	eriod:	worksheet S-2	
					rom 09/01/2021	Part I	epared
				Unweighted	Unweighted	Ratio (col. 1,	/
				FTES	FTEs in Hospital	$(\operatorname{col} \cdot 1 + \operatorname{col} \cdot$	·
				Nonprovider Site	позрі саї	2))	
				1.00	2.00	3.00	-
Secti o	n 5504 of the ACA Base Yea	ar FTE Residents in N	onprovider Settings	This base year	is your cost	reporting	
	that begins on or after						
in the resider setting resider	in column 1, if line 63 is base year period, the num nt FTEs attributable to ro gs. Enter in column 2 the nt FTEs that trained in yo lumn 1 divided by (column	ber of unweighted no otations occurring in e number of unweighte our hospital. Enter i	n-primary care all nonprovider d non-primary care n column 3 the ratio	0. 00	0.00	0. 000000	0 64.
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3,	/
		r r ogr ann manno		FTEs	FTEs in	(col . 3 + col .)	
				Nonprovi der	Hospi tal	(4))	
				Si te			
		1.00	2.00	3.00	4.00	5.00	
is yes, trained year pr associa FTEs fo progran residen the pro column unweigl residen rotatio non-pro column unweigl residen your ho 5, the dividen	in column 1, if line 63 , or your facility d residents in the base eriod, the program name ated with primary care or each primary care m in which you trained nts. Enter in column 2, ogram code. Enter in 3, the number of nted primary care FTE nts attributable to ons occurring in all ovider settings. Enter in 4, the number of nted primary care nt FTEs that trained in ospital. Enter in column ratio of (column 3 d by (column 3 + column see instructions)			0.00 Unwei ghted FTEs	0.00 Unweighted FTEs in	0.000000 Ratio (col. 1. (col. 1 + col.	
				Nonprovi der	Hospi tal	2))	
				Site			
				1.00	2.00	3.00	
	n 5504 of the ACA Current		n Nonprovider Setting	gsEffective f	or cost report	i ng	
	s beginning on or after Ju in column 1 the number of		and a second second second				
FTEs a [.] Enter i FTEs tl	ttributable to rotations o in column 2 the number of hat trained in your hospit	occurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0. 00	0. 00	0. 00000	0 66.
(col um	n 1 divided by (column 1 +						(
		Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3, (col. 3 + col.	
				Nonprovi der	Hospi tal	(01. 3 + 01.	
				Si te			
		1.00	2.00	3.00	4.00	5.00	
	in column 1, the program			0.00	0.00	0.00000	0 67.
your pi which Enter i code. I number care F to rota non-pro column	ssociated with each of rimary care programs in you trained residents. in column 2, the program Enter in column 3, the of unweighted primary TE residents attributable attions occurring in all ovider settings. Enter in 4, the number of hted primary care nt FTEs that trained in						

Heal th	Financial Systems CENTRAL DUPAGE HOSPITAL		١r	n Lieu	of For	m CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0242				Workshe	et S-2	2
		To	09/01/ 08/31/		Part I Date/Ti	me Pre	pared:
					1/28/20		
				1.00	2.00	2 00	-
	Inpatient Psychiatric Facility PPS			1.00	2.00	3.00	-
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF	subprov	/i der?	Y			70.00
71 00	Enter "Y" for yes or "N" for no.	in the	maat	N	N		71 00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N"			N	N	0	71.00
	42 CFR 412. 424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new						
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N"		,				
	Column 3: If column 2 is Y, indicate which program year began during this cost repo	rting pe	eri od.				
	(see instructions)						-
75 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an	IDE		N	1	1	75.00
75.00	subprovider? Enter "Y" for yes and "N" for no.	I KI		IN			/5.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program	in the	most			0	76.00
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for y	es or "N	V" for				
	no. Column 2: Did this facility train residents in a new teaching program in accord		th 42				
	CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2						
	indicate which program year began during this cost reporting period. (see instructi	ons)					
				F	1. (00	-
	Long Term Care Hospital PPS						
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost repor	ting per	ri od? E	nter	N		81.00
	"Y" for yes and "N" for no.						
0E 00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for	vec or '	'N" for	no	N	1	85.00
	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 9413.40(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(N TO	110.	IN IN		86.00
00.00	\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	CTON					00.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under sect	i on			N		87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.						
			V		XI		-
	Title V and VIX Services		1.00		2.0	00	
90 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" f	or	N		Y		90.00
70.00	yes or "N" for no in the applicable column.	01					/0.00
91.00	is this hospital reimbursed for title V and/or XIX through the cost report either i	n	Ν		N		91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable column.						
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see				N		92.00
93.00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Ent	or	N		N		93.00
7 3.00	"Y" for yes or "N" for no in the applicable column.		IN		IN IN		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the		Ν		Ν		94.00
	applicable column.						
	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.0		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the		N		N		96.00
07 00	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.0	0	97.00
	Does title V or XIX follow Medicare (title XVIII) for the interns and residents pos	t	0.00 Y		Υ Υ		98.00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in						
	column 1 for title V, and in column 2 for title XIX.						
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on W		Y		Y		98.01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2	for					
98 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observatic	n	Y		Y		98.02
70.02	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column						70.02
	for title V, and in column 2 for title XIX.						
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (C		Ν		Ν		98.03
	reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in colu	mn 1					
00 01	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of		Ν		N		98.04
70.04	outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V,	and	IN IN		IN IN		70.04
	in column 2 for title XIX.						
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance		Ν		Ν		98.05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, an	din					
00.04	column 2 for title XIX.		N		N		00.00
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in		N		N		98.06
	column 2 for title XIX.						
	Rural Provi ders						1
105.00	Does this hospital qualify as a CAH?		N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of pay	ment					106.00
107 00	for outpatient services? (see instructions)						107 00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for 18 training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)						107.00
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an						
	approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?						
	Enter "Y" for yes or "N" for no in column 2. (see instructions)						1

Health Financial Systems CENTRAL DUPAGE	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eriod: com 09/01/2021 0 08/31/2022	Worksheet S-2 Part I Date/Time Pre 1/28/2023 6:3	epared:
			V	XI X	-
108.00 Is this a rural hospital qualifying for an exception to the C	CRNA fee sche	edul e? See 42	1.00 N	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3.00	4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration)for the current cost reporting period? Enter "Y complete Worksheet E, Part A, lines 200 through 218, and Work applicable.	" for yes or	"N" for no. If	yes,	N	110.00
			1.00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in th			N	2.00	111.00
Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	umn 1 is Y, icipating ir	enter the column 2.			
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Healt demonstration for any portion of the current cost reporting p Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceas participation in the demonstration, if applicable.	oeriod? "Y", enter e	N			112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N		C	115.00
in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (i psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub.15-1, chapter 22, §2208.1.	or E only) B" percent ncludes S) based on				
116.00 Is this facility classified as a referral center? Enter "Y" f "N" for no.	for yes or	N			116.00
117.00 Is this facility legally-required to carry malpractice insura	ance? Enter	N			117.00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence poli if the policy is claim-made. Enter 2 if the policy is occurre		2			118.00
		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00 545,943	2.00 4,053,394	3. 00 7, 444, 788	110.01
		545, 945	4,053,394	7,444,700	
118.02 Are malpractice premiums and paid losses reported in a cost c	contor other	than the	1.00 N	2.00	118.02
Administrative and General? If yes, submit supporting schedu and amounts contained therein.			i v		
119. OO DO NOT USE THIS LINE 120. OO Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y alifies for t	(" for yes or he Outpatient	Ν	Ν	119.00 120.00
121.00 Did this facility incur and report costs for high cost implan	ntable device	es charged to	Y		121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1			Ν		122.00
the Worksheet A line number where these taxes are included.					1
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ent	er the certi	fication date			126.00
in column 1 and termination date, if applicable, in column 2.					
127.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.					127.00
128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.		ication date			128.00
129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		cation date in			129.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider C	JN: 14-0242	From O	n: 09/01/2021 08/31/2022	Worksheet S Part I Date/Time P 1/28/2023 6	repared
					1.00	2.00	_
30.00 If this is a Medicare certified pa			ti fi cati on				130. C
date in column 1 and termination c 31.00 f this is a Medicare certified ir date in column 1 and termination c	testinal transplant cent	ter, enter the c	erti fi cati o	on			131. C
32.00 If this is a Medicare certified is in column 1 and termination date,	let transplant center, e	enter the certif	ïcation da [.]	te			132.0
33.00 Removed and reserved 34.00 If this is an organ procurement or and termination date, if applicabl All Providers	ganization (OPO), enter		in column [·]	1			133. C 134. C
40.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. I	f yes, and home	office cos		Y		140. C
1.00		00	ugh 142 th		3.00	of the	
If this facility is part of a chai home office and enter the home off				e name ar	iu auuress	or the	
41.00Name: NORTHWESTERN MEMORIAL	Contractor's Name: N			ictor's Nu	umber: 0013	31	141.0
HEALTHCARE 42.00 Street: 251 E HURON STREET	PO Box:						142.0
43. 00 Ci ty: CHI CAGO		L	Zip Co	de:	6061	1	143.0
						1.00	_
44.00 Are provider based physicians' cos	ts included in Worksheet	t A?				1.00 Y	144. (
15.00 f costs for renal services are cl	aimed on Wkst A line -	14 are the cost	c for		1.00 Y	2.00 N	145. (
inpatient services only? Enter "Y" no, does the dialysis facility inc	lude Medicare utilizatio						
no, does the dialysis facility inc period? Enter "Y" for yes or "N"	lude Medicare utilizatic for no in column 2. y changed from the previ column 1. (See CMS Pub.	on for this cost ously filed cos	reporting t report?		N	1.00	146.
no, does the dialysis facility inc period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/c	lude Medicare utilizatic for no in column 2. y changed from the previ column 1. (See CMS Pub. ld/yyyy) in column 2.	on for this cost ously filed cos 15-2, chapter	reporting t report? 40, §4020)		N	1.00 N	
no, does the dialysis facility inc period? Enter "Y" for yes or "N" 16.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/c 17.00 Was there a change in the statisti 18.00 Was there a change in the order of	Hude Medicare utilization for no in column 2. Ny changed from the previncolumn 1. (See CMS Pub. Nd/yyyy) in column 2. Cal basis? Enter "Y" for allocation? Enter "Y" for	on for this cost ously filed cos 15-2, chapter r yes or "N" for for yes or "N" f	reporting t report? 40, §4020) no. or no.	lf	N	N N	147. 148.
no, does the dialysis facility inc period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/c 47.00 Was there a change in the statisti 48.00 Was there a change in the order of	Hude Medicare utilization for no in column 2. Ny changed from the previncolumn 1. (See CMS Pub. Nd/yyyy) in column 2. Cal basis? Enter "Y" for allocation? Enter "Y" for	on for this cost ously filed cos 15-2, chapter - yes or "N" for for yes or "N" f Enter "Y" for y	reporting t report? 40, §4020) no. or no. or no. es or "N"	lf for no.		N N N	146. 147. 148. 149.
 no, does the dialysis facility inc period? Enter "Y" for yes or "N" 16.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/c) 17.00 Was there a change in the statisti 18.00 Was there a change in the order of 19.00 Was there a change to the simplifi 	Iude Medicare utilizatio for no in column 2. y changed from the previ column 1. (See CMS Pub. d/yyyy) in column 2. cal basis? Enter "Y" for allocation? Enter "Y" f ed cost finding method?	on for this cost ously filed cos 15-2, chapter - yes or "N" for For yes or "N" f Enter "Y" for y Part A 1.00	reporting t report? 40, §4020) no. or no. es or "N" 1 Part E 2.00	1 f	<u>Fitle V</u> 3.00	N N Title XIX 4.00	147. 148. 149.
no, does the dialysis facility inc period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in	Hude Medicare utilization for no in column 2. y changed from the previ- column 1. (See CMS Pub. (d/yyyy) in column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	on for this cost ously filed cos 15-2, chapter - yes or "N" for For yes or "N" f Enter "Y" for y Part A 1.00 an exemption fro	reporting t report? 40, §4020) inno. ior no. ies or "N" i Part E 2.00 om the appl	If for no. 3 1 ication c	Title V 3.00 of the low	N N Title XIX 4.00 er of	147. 148. 149.
 no, does the dialysis facility inc period? Enter "Y" for yes or "N" 16.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/c) 17.00 Was there a change in the statisting 18.00 Was there a change in the order of 19.00 Was there a change to the simplification 19.00 Was there	Hude Medicare utilization for no in column 2. y changed from the previ- column 1. (See CMS Pub. (d/yyyy) in column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	on for this cost ously filed cos 15-2, chapter for yes or "N" for for yes or "N" f Enter "Y" for y Part A 1.00 an exemption from h component for N	reporting t report? 40, §4020) in no. ior no. es or "N" in Part E 2.00 m the appl Part A and N	If for no. 3 1 ication c	Title V 3.00 of the low (See 42 C N	N N Title XIX 4.00 er of FR N	147. 148. 149. 155.
 no, does the dialysis facility inc period? Enter "Y" for yes or "N" 16.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/c) 17.00 Was there a change in the statisti 18.00 Was there a change in the order of 19.00 Was there a change to the simplifi Does this facility contain a provicosts or charges? Enter "Y" for yes 	Hude Medicare utilization for no in column 2. y changed from the previ- column 1. (See CMS Pub. (d/yyyy) in column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	on for this cost ously filed cos 15-2, chapter - yes or "N" for For yes or "N" f Enter "Y" for y Part A 1.00 an exemption fro	reporting t report? 40, §4020) ano. or no. es or "N" a Part E 2.00 m the appl Part A and	If for no. 3 1 ication c	Title V 3.00 of the low (See 42 C	N N Title XIX 4.00 er of FR	147. 148. 149. 155. 155. 156.
no, does the dialysis facility inc period? Enter "Y" for yes or "N" 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/c 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi Does this facility contain a provi costs or charges? Enter "Y" for ye §413.13) 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER	Hude Medicare utilization for no in column 2. y changed from the previ- column 1. (See CMS Pub. (d/yyyy) in column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	on for this cost ously filed cos 15-2, chapter for yes or "N" for for yes or "N" for Enter "Y" for y Part A 1.00 an exemption from component for N N N	reporting t report? 40, §4020) inno. ior no. es or "N" i Part E 2.00 om the appl Part A and N N N	If for no. 3 1 ication c	Fitle V 3.00 of the low (See 42 C N N N	N N Title XIX 4.00 er of FR N N N	147. 148. 149. 155. 155. 156. 157. 158.
no, does the dialysis facility inc period? Enter "Y" for yes or "N" 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/c 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi Does this facility contain a provi costs or charges? Enter "Y" for yes §413.13) 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF	Hude Medicare utilization for no in column 2. y changed from the previ- column 1. (See CMS Pub. (d/yyyy) in column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	on for this cost ously filed cos 15-2, chapter for yes or "N" for for yes or "N" f Enter "Y" for y Part A 1.00 an exemption from N N N N	reporting t report? 40, §4020) c no. cor no. cor no. cos or "N" cos Part E 2.00 m the appl Part A and N N N N	If for no. 3 1 ication c	Title V 3.00 of the low (See 42 C N N N N	N N Title XIX 4.00 er of FR N N N	147. 148. 149. 155. 156. 156. 157. 158. 159.
no, does the dialysis facility inc period? Enter "Y" for yes or "N" 64.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi Does this facility contain a provi costs or charges? Enter "Y" for ye §413.13) 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC	Hude Medicare utilization for no in column 2. y changed from the previ- column 1. (See CMS Pub. (d/yyyy) in column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	on for this cost ously filed cos 15-2, chapter for yes or "N" for for yes or "N" for Enter "Y" for y Part A 1.00 an exemption from component for N N N	reporting t report? 40, §4020) inno. ior no. es or "N" i Part E 2.00 om the appl Part A and N N N	If for no. 3 1 ication c	Fitle V 3.00 of the low (See 42 C N N N	N N Title XIX 4.00 er of FR N N N	147. 148. 149. 155. 155. 156. 157. 158. 159. 160.
 no, does the dialysis facility inc period? Enter "Y" for yes or "N" 60.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/or 77.00 Was there a change in the statisti 18.00 Was there a change in the order of 99.00 Was there a change to the simplifi Does this facility contain a provi costs or charges? Enter "Y" for yes §413.13) 55.00 Hospital 66.00 Subprovider - IPF 77.00 Subprovider - IRF 88.00 SUBPROVIDER 99.00 SNF 00.00 HOME HEALTH AGENCY 11.00 CORF 	Hude Medicare utilization for no in column 2. y changed from the previ- column 1. (See CMS Pub. (d/yyyy) in column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	on for this cost ously filed cos 15-2, chapter for yes or "N" for for yes or "N" f Enter "Y" for y Part A 1.00 an exemption from N N N N	reporting t report? 40, §4020) r no. or no. es or "N" r Part E 2.00 m the appl Part A and N N N N N N N N	If for no. 3 1 ication c	Title V 3.00 of the low (See 42 C N N N N N N N N N	N N Title XIX 4.00 er of FR N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 161.
 no, does the dialysis facility inc period? Enter "Y" for yes or "N" 60.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/or 77.00 Was there a change in the statisti 80.00 Was there a change in the order of 99.00 Was there a change to the simplifi Does this facility contain a provi costs or charges? Enter "Y" for yes §413.13) 50.00 Hospital 60.00 Subprovider - IPF 67.00 Subprovider - IRF 80.00 SUBPROVIDER 99.00 SNF 60.00 SNF 60.00 SMF 61.00 CMHC 61.10 CORF 61.20 OUTPATIENT PHYSICAL THERAPY 	Hude Medicare utilization for no in column 2. y changed from the previ- column 1. (See CMS Pub. (d/yyyy) in column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	on for this cost ously filed cos 15-2, chapter for yes or "N" for for yes or "N" f Enter "Y" for y Part A 1.00 an exemption from N N N N	reporting t report? 40, §4020) c no. cor no. es or "N" c Part E 2.00 m the appl Part A and N N N N N N N N N N	If for no. 3 1 ication c	Fitle V 3.00 of the low (See 42 C N N N N N N N N N N N N	N N N Title XIX 4.00 er of FR N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 161.
no, does the dialysis facility inc period? Enter "Y" for yes or "N" 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/c 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi Does this facility contain a provi costs or charges? Enter "Y" for ye §413.13) 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC 1.10 CORF 1.20 OUTPATIENT PHYSICAL THERAPY 1.30 OUTPATIENT OCCUPATIONAL THERAPY	Hude Medicare utilization for no in column 2. y changed from the previ- column 1. (See CMS Pub. (d/yyyy) in column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	on for this cost ously filed cos 15-2, chapter for yes or "N" for for yes or "N" f Enter "Y" for y Part A 1.00 an exemption from N N N N	reporting t report? 40, §4020) r no. or no. es or "N" r Part E 2.00 m the appl Part A and N N N N N N N N	If for no. 3 1 ication c	Title V 3.00 of the low (See 42 C N N N N N N N N N	N N Title XIX 4.00 er of FR N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 161. 161. 161.
no, does the dialysis facility inc period? Enter "Y" for yes or "N" 6. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/c 7. 00 Was there a change in the statisti 8. 00 Was there a change in the order of 9. 00 Was there a change to the simplifi Does this facility contain a provi costs or charges? Enter "Y" for ye §413. 13) 5. 00 Hospital 6. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 0. 00 HOME HEALTH AGENCY 1. 00 CMHC 1. 10 CORF 1. 20 OUTPATIENT PHYSICAL THERAPY 1. 30 OUTPATIENT OCCUPATIONAL THERAPY	Hude Medicare utilization for no in column 2. y changed from the previ- column 1. (See CMS Pub. (d/yyyy) in column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	on for this cost ously filed cos 15-2, chapter for yes or "N" for for yes or "N" f Enter "Y" for y Part A 1.00 an exemption from N N N N	reporting t report? 40, §4020) fno. for no. res or "N" f Part E 2.00 m the appl Part A and N N N N N N N N N N N N N	If for no. 3 1 ication c	Fitle V 3.00 of the low (See 42 C N N N N N N N N N N N N N N	N N Title XIX 4.00 er of FR N N N N N N N N N N N N N N N N	147. 148. 149. 155. 155. 156. 157. 158. 159. 160. 161. 161. 161.
 no, does the dialysis facility inc period? Enter "Y" for yes or "N" 16. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o 17. 00 Was there a change in the statisti 18. 00 Was there a change in the order of 99. 00 Was there a change in the order of 19. 00 Was there a change to the simplifi Does this facility contain a provi costs or charges? Enter "Y" for yes §413. 13) 100 Subprovider - IPF 100 Subprovider - IRF 100 SUBPROVIDER 100 CMHC 100 CMHC 100 CMHC 100 CMF 120 OUTPATIENT PHYSICAL THERAPY 130 OUTPATIENT SPEECH PATHOLOGY 	Hude Medicare utilization for no in column 2. y changed from the previ- column 1. (See CMS Pub. (d/yyyy) in column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	on for this cost ously filed cos 15-2, chapter for yes or "N" for for yes or "N" f Enter "Y" for y Part A 1.00 an exemption from N N N N	reporting t report? 40, §4020) fno. for no. res or "N" f Part E 2.00 m the appl Part A and N N N N N N N N N N N N N	If for no. 3 1 ication c	Fitle V 3.00 of the low (See 42 C N N N N N N N N N N N N N N	N N Title XIX 4.00 er of FR N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 161. 161. 161.
 no, does the dialysis facility inc period? Enter "Y" for yes or "N" 16. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/c 17. 00 Was there a change in the statisti 18. 00 Was there a change in the order of 19. 00 Was there a change to the simplifi Does this facility contain a provi costs or charges? Enter "Y" for yes §413. 13) 15. 00 Hospital 66. 00 Subprovider - IPF 	Ude Medicare utilization for no in column 2. y changed from the previ- column 1. (See CMS Pub. d/yyyy) in column 2. cal basis? Enter "Y" for fallocation? Enter "Y" f ed cost finding method? der that qualifies for a so r "N" for no for each	on for this cost ously filed cos 15-2, chapter for yes or "N" for Enter "Y" for y Part A 1.00 an exemption fron n component for N N N N N	reporting t report? 40, §4020) c no. cor no. es or "N" cor Part E 2.00 m the appl Part A and N N N N N N N N N N N N N N N N	If	Title V 3.00 of the low (See 42 C N N N N N N N N N N N N N N N N N N	N N Title XIX 4.00 er of FR N N N N N N N N N N N N N N N N	147. 148. 149.
no, does the dialysis facility inc period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/or 77.00 Was there a change in the statisti 18.00 Was there a change in the order of 19.00 Was there a change in the order of 19.00 Was there a change to the simplifi Does this facility contain a provi costs or charges? Enter "Y" for yes §413.13) 15.00 Hospital 16.00 Subprovider - IPF 17.00 Subprovider - IPF 18.00 SUBPROVIDER 19.00 SNF 10.00 SNF 10.00 SNF 11.10 CORF 11.20 OUTPATIENT PHYSICAL THERAPY 11.30 OUTPATIENT PHYSICAL THERAPY 11.30 OUTPATIENT SPEECH PATHOLOGY Multicampus 55.00 Is this hospital part of a Multica	Hude Medicare utilization for no in column 2. y changed from the previ- column 1. (See CMS Pub. d/yyyy) in column 2. cal basis? Enter "Y" for allocation? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a sor "N" for no for each mpus hospital that has contended Name	on for this cost ously filed cos 15-2, chapter for yes or "N" for for yes or "N" for Enter "Y" for y Part A 1.00 an exemption from component for N N N N N N N N N N N N N N N	reporting t report? 40, §4020) fno. for no. res or "N" f Part E 2.00 m the appl Part A and N N N N N N N N N N N N N N N N N N N	If	Fitle V 3.00 of the low (See 42 C N N N N N N N N N N N N N	N N Title XIX 4.00 er of FR N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 161. 161. 161. 161. 161. 161
 no, does the dialysis facility inc period? Enter "Y" for yes or "N" 16. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/or 17. 00 Was there a change in the statisti 18. 00 Was there a change in the statisti 18. 00 Was there a change in the order of 19. 00 Was there a change to the simplifi Does this facility contain a provi costs or charges? Enter "Y" for yes §413. 13) 15. 00 Hospital 16. 00 Subprovider - IPF 17. 00 Subprovider - IRF 18. 00 SUBPROVIDER 19. 00 SNF 10 OONF 10 CORF 11. 20 OUTPATIENT PHYSICAL THERAPY 13. 30 OUTPATIENT PHYSICAL THERAPY 14. 40 OUTPATIENT SPEECH PATHOLOGY Multicampus 35. 00 Is this hospital part of a Multica 	Hude Medicare utilization for no in column 2. y changed from the previ- column 1. (See CMS Pub. d/yyyy) in column 2. cal basis? Enter "Y" for allocation? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a so r "N" for no for each mpus hospital that has co	on for this cost ously filed cos 15-2, chapter for yes or "N" for for yes or "N" for Enter "Y" for y Part A 1.00 an exemption from N N N N N N N N	reporting t report? 40, §4020) f no. for no. res or "N" f Part E 2.00 m the appl Part A and N N N N N N N N N N N N N N N N N N	If	Fitle V 3.00 of the low (See 42 C N N N N N N N N N N N N N	N N N Title XIX 4.00 er of FR N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 161. 161. 161. 161. 161. 161

Health Financial Systems	CENTRAL DUPAGE	HOSPI TAL	In Lie	u of Form CM	IS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFIC	CATION DATA	Provider CCN: 14-0242	Period: From 09/01/2021 To 08/31/2022	Worksheet S Part I Date/Time F 1/28/2023 6	Prepared:
				1.00	
Health Information Technology (HIT) incentiv			ent Act		
167.00 Is this provider a meaningful user under §18				N	167.00
168.00 f this provider is a CAH (line 105 is "Y") reasonable cost incurred for the HIT assets), enter the		168.00
168.01 If this provider is a CAH and is not a meaning	•		r a hardshin		168.01
exception under §413. 70(a) (6) (ii)? Enter "Y"					100.01
169.00 If this provider is a meaningful user (line transition factor. (see instructions)				0.	. 00169. 00
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning d period respectively (mm/dd/yyyy)	ate and ending da	te for the reporting			170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provider have section 1876 Medicare cost plans reported on "Y" for yes and "N" for no in column 1. If c 1876 Medicare days in column 2. (see instruc	Wkst. S-3, Pt. I, olumn 1 is yes, ei	line 2, col. 6? Enter	on		0 171.00

IOSPI T	Financial Systems CENTRAL DUPAG	E HOSPITAL Provider C	CN: 14-0242	Period:	u of Form CMS- Worksheet S-:	
				From 09/01/2021 To 08/31/2022	Part II Date/Time Pro 1/28/2023 6:	
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	esponses. Ent	er all dates in ⁻	the	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c	beginning of	the cost	N		1.0
	Treporting period? IT yes, enter the date of the change in c	orunn 2. (See	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home c or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members c of directors through ownership, control, or family and other	offices, drug ler or its of the board	Y			3.0
	relationships? (see instructions)		Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports		1			
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	Y	A		4.0
. 00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit rec		Y			5.0
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities	0 16 1				
. 00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: IT yes, Is	s the provide	er N		6.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		wed during th	N Ne N		7. C 8. C
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	araduate medio	cal education	n N		9.0
0.00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c	IS.		N		10.0
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11. (
				_	Y/N	
	Bad Debts				1.00	_
2.00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12. 0 13. 0
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? It	fyes, see ir	nstructions.	Ν	14.0
5.00	Did total beds available change from the prior cost reporti	<u>v</u> 1		structions. Par	N	15.0
		Y/N	t A Date	Y/N	Date	-
		1.00	2.00	3.00	4.00	
6.00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16.0
7.00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for	Y	12/09/2022	Y	12/09/2022	17. (
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
8.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18. (
9.00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CO	CN: 14-0242	Period: From 09/01/2021	Worksheet S Part II	
				To 08/31/2022	Date/Time P 1/28/2023 6	
		Descri	ption	Y/N	Y/N	
		()	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			Ν	Ν	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	IOSPI TALS)			
	Capital Related Cost		,			
22.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense	due to apprais	sals made du	ring the cost		23.00
	reporting period? If yes, see instructions.					
24.00	Were new leases and/or amendments to existing leases entere	ed into during	this cost r	eporting period?		24.00
25.00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repor	sting poriod	2 If yos soo		25.00
20.00	instructions.	the cost reput	ting period	: 11 yes, see		20.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporti	ng period?	lfyes, see		26.00
	instructions.		5 1	J		
27.00	Has the provider's capitalization policy changed during the	e cost reportir	ng period? I	fyes, submit		27.00
	сору.					_
~~ ~~	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	iterea into aur	ring the cos	t reporting		28.00
29.00	Did the provider have a funded depreciation account and/or	bond funds (De	ht Service	Pasarya Fund)		29.00
27.00	treated as a funded depreciation account? If yes, see instr		Service	Reserve runu)		2 7.00
30.00	Has existing debt been replaced prior to its scheduled matu		debt? If yes	s, see		30.00
	instructions.	5	5			
31.00	Has debt been recalled before scheduled maturity without is	suance of new	debt? If yes	s, see		31.00
	instructions.					_
22.00	Purchased Services	uises from ista				
32.00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ea through c	ontractual		32.00
33 00	If line 32 is yes, were the requirements of Sec. 2135.2 app		na to compet	itive bidding? If		33.00
00.00	no, see instructions.		ig to compet	renve bruuring. In		00.00
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an ar	rangement with	n provi der-b	ased physi ci ans?		34.00
	If yes, see instructions.					
35.00	If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based		35.00
	physicians during the cost reporting period? If yes, see in	istructions.		Y/N	Date	
				1.00	2.00	
	Home Office Costs			1.00	2.00	
	Were home office costs claimed on the cost report?					36.00
	If line 36 is yes, has a home office cost statement been pr	epared by the	home office	?		37.00
	lf yes, see instructions.					
~~ ~~	If line 36 is yes, was the fiscal year end of the home off	ice different	from that o	f		38.00
38.00	the provider? If yes, enter in column 2 the fiscal year end					00.00
		er chain compor	ients? If ye	S,		39.00
	If line 36 is yes, did the provider render services to othe			1		1
39. 00	see instructions.	home office?	If ves see			40.00
39. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	lf yes, see			40.00
39. 00	see instructions.	home office?	lfyes, see			40.00
39. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?		2.	00	40.00
39.00 40.00	see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information	1.		2.	00	_
39.00 40.00	see instructions. If line 36 is yes, did the provider render services to the instructions. <u>Cost Report Preparer Contact Information</u> Enter the first name, last name and the title/position				00	_
39.00 40.00	see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	1.		2.	00	
39.00 40.00 41.00	see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	1. BRANDON		2.	00	41.00
39.00 40.00 41.00	see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	1.		2.	00	40.00
39. 0040. 0041. 0042. 00	see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	1. BRANDON		2.		41.00

Heal th	Financial Systems CENTRAL DUF	AGE HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0242	Period: From 09/01/2021	Worksheet S-2 Part II	
			To 08/31/2022		pared: <u>0 pm</u>
		3.00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	PROGRAM MANAGER - FINANCE			41.00
	held by the cost report preparer in columns 1, 2, and 3,				
	respecti vel y.				
42.00	Enter the employer/company name of the cost report				42.00
	preparer.				
43.00	Enter the telephone number and email address of the cost				43.00
	report preparer in columns 1 and 2, respectively.				

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	N: 14-0242	Period: From 09/01/2021 To 08/31/2022	Worksheet S-3 Part I Date/Time Pre 1/28/2023 6:3	pared:
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	30.00	272	99, 28	0.00	0	2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	•
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		272	99, 28	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	36	13, 14	0. 00	0	8.00
9.00	CORONARY CARE UNIT	32.00	16	5,84	0. 00	0	9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	23	8, 39	95 0.00	0	12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		347	126, 65	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	48	17, 52	20	0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24.10 25.00	HOSPICE (non-distinct part) CMHC - CMHC	30.00					24.10
25.00	CMHC - CORF	99, 10				0	25.00
25.10	CMHC - OUTPATIENT PHYSICAL THERAPY	99. 10 99. 20				0	25.10
25.20	CMHC - OUTPATTENT PHILSTCAL HIERAPT	99.20 99.30				0	25.20
25.30	CMHC - OUTPATTENT OCCUPATIONAL THENAFT	99. 30 99. 40				0	25.30
26.00	RURAL HEALTH CLINIC	77.40				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
27.00	Total (sum of lines 14-26)	07.00	395			0	27.00
28.00	Observation Bed Days		0,0			0	
29.00	Ambul ance Trips					, v	29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room		-				32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33 01	LTCH site neutral days and discharges						33.0

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 09/01/2021 To 08/31/2022	Worksheet S-3 Part I Date/Time Pre 1/28/2023 6:3	epared
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	26, 507	3, 547	77, 85	7		1.0
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)	14 505	11 250				
2.00 8.00	HMO and other (see instructions)	14, 595	11, 350				2.0
	HMO I PF Subprovider	0	1, 366				3. C
. 00 . 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF	0	0 0		0		5.0
5.00 5.00	Hospital Adults & Peds. Swing Bed SNI Hospital Adults & Peds. Swing Bed NF	0	0		0		6.0
. 00 . 00	Total Adults and Peds. (exclude observation	26, 507	3, 547	77, 85			7.0
. 00	beds) (see instructions)	20, 307	5, 547	77,00	1		/.0
8. 00	INTENSIVE CARE UNIT	2, 771	360	8, 73	1		8.0
. 00	CORONARY CARE UNIT	0	0	3, 12			9.0
0.00	BURN INTENSIVE CARE UNIT				-		10.0
1.00	SURGICAL INTENSIVE CARE UNIT						11.
2.00	NEONATAL INTENSIVE CARE UNIT	0	115	7,67	0		12.
3.00	NURSERY		1, 941	4, 95	6		13.0
4.00	Total (see instructions)	29, 278	5, 963	102, 33	9 0.00	3, 102. 13	14.
5.00	CAH visits	0	0		0		15.
6.00	SUBPROVIDER - IPF	1, 155	550	8, 32	4 0.00	88. 81	16.
7.00	SUBPROVI DER – I RF						17.
8.00	SUBPROVI DER						18.
9.00	SKILLED NURSING FACILITY						19.
0. 00	NURSING FACILITY						20.
1.00	OTHER LONG TERM CARE						21.
2.00	HOME HEALTH AGENCY						22.
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.
4.00				22			24.
4.10 5.00	HOSPICE (non-distinct part) CMHC - CMHC			33	4		24. 25.
5.00	CMHC - CORF	0	0		0 0.00	0.00	
5. 20	CMHC - CORF CMHC - OUTPATIENT PHYSICAL THERAPY	0	0		0.00		
5.20	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0		0 0.00		
5.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0		0 0.00		
6.00	RURAL HEALTH CLINIC	Ŭ	0		0.00	0.00	26.
6.25	FEDERALLY QUALIFIED HEALTH CENTER	О	0		0 0.00	0.00	
7.00	Total (sum of lines 14-26)	-	-		0.00		
8.00	Observation Bed Days		0	16, 44			28.
9.00	Ambul ance Trips	160					29.
0. 00	Employee discount days (see instruction)				0		30.
1.00	Employee discount days - IRF				0		31.
2.00	Labor & delivery days (see instructions)	0	173	94	3		32.
2. 01	Total ancillary labor & delivery room				0		32.
	outpatient days (see instructions)						
3.00	LTCH non-covered days	0					33.
3.01	LTCH site neutral days and discharges	0					33.

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC,	AL DATA	Provider C	CN: 14-0242	Period: From 09/01/2021 To 08/31/2022	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre 1/28/2023 6:30	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		0	6, 0 [,] 2, 6 [,]		20, 730	1.00 2.00 3.00 4.00 5.00 6.00 7.00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT NURSERY Total (see instructions)	0.00	0	6, 04	13 591	20, 730	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
$\begin{array}{c} 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 24.\ 10\\ \end{array}$	CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part)	0.00	0	1:	25 64	1, 167	15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 24.00 24.10
25. 00 25. 10 25. 20 25. 30 25. 40 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	CMHC - CMHC CMHC - CORF CMHC - OUTPATIENT PHYSICAL THERAPY CMHC - OUTPATIENT OCCUPATIONAL THERAPY CMHC - OUTPATIENT SPEECH PATHOLOGY RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0.00 0.00 0.00 0.00 0.00 0.00					25. 00 25. 10 25. 20 25. 30 26. 00 26. 25 27. 00 28. 00 28. 00 30. 00 31. 00 32. 01
33. 00 33. 01	LTCH non-covered days LTCH site neutral days				0		33. C 33. C

	Financial Systems AL WAGE INDEX INFORMATION		CENTRAL DUPA	Provider C	F	Period: From 09/01/2021 To 08/31/2022		pared
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
00	Total salaries (see instructions)	200.00	253, 292, 055	0	253, 292, 055	5 6, 637, 157. 90	38. 16	1. C
00	Non-physician anesthetist Part		C	0		0.00	0.00	2.0
00	A Non-physician anesthetist Part		C	0		0.00	0.00	3.0
	В		-					
00	Physician-Part A - Administrative		C			0.00	0.00	4.0
01 00	Physicians - Part A - Teaching Physician and Non		C 3, 779, 152	-		0.00 2 10,937.40		
	Physician-Part B							
00	Non-physician-Part B for hospital-based RHC and FQHC		C	0		0.00	0.00	6.0
00	services Interns & residents (in an	21.00	C	0	(0.00	0.00	7.0
	approved program)	21.00	-	_				
01	Contracted interns and residents (in an approved programs)		C	0 0	(0.00	0.00	7.0
00	Home office and/or related organization personnel		C	0	0	0.00	0.00	8.0
00	SNF	44.00	0	0	(0.00		
0. 00	Excluded area salaries (see instructions)		8, 118, 457	62, 737	8, 181, 194	4 213, 461. 00	38. 33	10.0
I. 00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		18, 516, 929	0	18, 516, 929	9 112, 683. 57	164.33	1 1 1 1
	Care							
2. 00	Contract labor: Top level management and other management and administrative services		C	0		0.00	0.00	12.
8.00	Contract Labor: Physician-Part		174, 240	0	174, 240	880.00	198.00	13.
. 00	A - Administrative Home office and/or related organization salaries and		C	0 0	(0.00	0.00	14.
1. 01	wage-related costs Home office salaries		61, 679, 794	0	61, 679, 794	4 1, 347, 288. 00	45.78	14
1. 02	Related organization salaries		C	0	(0.00	0.00	14.
5.00	Home office: Physician Part A - Administrative		C	0		0.00	0.00	15.
5.00	Home office and Contract Physicians Part A - Teaching		C	0	(0.00	0.00	16.
5. 01	Home office Physicians Part A		C	0	0	0.00	0.00	16.
5. 02	- Teaching Home office contract		C	0		0. 00	0.00	16.
	Physicians Part A - Teaching WAGE-RELATED COSTS							
7.00	Wage-related costs (core) (see		66, 955, 147	0	66, 955, 147	7		17.
. 00	instructions) Wage-related costs (other)							18.
. 00	(see instructions) Excluded areas		2, 269, 793	0	2, 269, 793	3		19.
. 00	Non-physician anesthetist Part A		2,207,773	0	(5		20.
. 00	Non-physician anesthetist Part B		C	0	(D		21.
. 00	Physician Part A - Administrative		C	0	0	D		22.
. 01	Physician Part A - Teaching		C	0	(D		22.
. 00 . 00	Physician Part B Wage-related costs (RHC/FQHC)		1, 048, 489		1,048,489	7		23. 24.
. 00	Interns & residents (in an		C	0		Ď		25.
. 50	approved program) Home office wage-related		10, 569, 200	0	10, 569, 200	D		25.
	(core)		,,					
. 51	Related organization wage-related (core)		Ĺ	, 0				25.
. 52	Home office: Physician Part A - Administrative - wage-related (core)		C	0	(25.

Heal th Fi	nancial Systems		CENTRAL DUPA	GE HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	WAGE INDEX INFORMATION			Provider C		Period: From 09/01/2021 To 08/31/2022		pared:
		Wkst. A Line		Reclassi fi cati		Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53 Ho	ome office: Physicians Part A		0	0		0		25.53
-	Teaching - wage-related							
	core)							
	ERHEAD COSTS - DIRECT SALARI							
	nployee Benefits Department	4.00		0		0 0.00		26.00
27.00 Ac	dministrative & General	5.00	17, 040, 541	-3, 131, 468	13, 909, 07			
	dministrative & General under		0	0		0 0.00	0.00	28.00
	ontract (see inst.)							
	aintenance & Repairs	6.00		0		0 0.00		29.00
30.00 Op	peration of Plant	7.00	2, 484, 654	108, 396	2, 593, 05	0 70, 844. 51	36.60	30.00
	aundry & Linen Service	8.00	298, 117	8, 600	306, 71	7 14, 179. 30	21.63	31.00
	busekeepi ng	9.00	5, 315, 585	172, 944	5, 488, 52	9 254, 035. 04	21.61	32.00
33.00 Ho	ousekeeping under contract		0	0		0 0.00	0.00	33.00
	see instructions)							
	etary	10.00	3, 540, 031	-1, 189, 324	2, 350, 70	7 111, 880. 88	21.01	34.00
35.00 Di	etary under contract (see		0	0		0 0.00	0.00	35.00
	nstructions)							
	afeteria	11.00	0	1, 293, 777	1, 293, 77			36.00
	aintenance of Personnel	12.00	0	0		0 0.00		
	ursing Administration	13.00	1, 572, 832	110, 723	1, 683, 55			38.00
	entral Services and Supply	14.00	3, 303, 485	107, 242	3, 410, 72	7 149, 057. 07		
40.00 Ph	narmacy	15.00	7, 473, 536	294, 770	7, 768, 30	6 134, 826. 71	57.62	40.00
	edical Records & Medical	16.00	1, 500	0	1, 50	0 0.00	0.00	41.00
	ecords Library							
	ocial Service	17.00		165, 852	4, 715, 55			42.00
43.00 Ot	ther General Service	18.00	0	0		0.00	0.00	43.00

Heal th	Financial Systems		CENTRAL DUPA	GE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 09/01/2021 To 08/31/2022		pared:
		Worksheet A	Amount	Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		249, 512, 903	0	249, 512, 90	3 6, 626, 220. 50	37.66	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		8, 118, 457	62, 737	8, 181, 19	4 213, 461. 00	38. 33	2.00
3.00	Subtotal salaries (line 1 minus line 2)		241, 394, 446	-62, 737	241, 331, 70	9 6, 412, 759. 50	37.63	3.00
4.00	Subtotal other wages & related costs (see inst.)		80, 370, 963	0	80, 370, 96	3 1, 460, 851. 57	55.02	4.00
5.00	Subtotal wage-related costs (see inst.)		77, 524, 347	0	77, 524, 34	7 0.00	32.12	5.00
6.00	Total (sum of lines 3 thru 5)		399, 289, 756	-62, 737	399, 227, 01	9 7, 873, 611. 07	50. 70	6.00
7.00	Total overhead cost (see instructions)		45, 579, 980	-2, 058, 488	43, 521, 49	2 1, 067, 545. 08	40. 77	7.00

Heal th	Financial Systems	CENTRAL DUPAGE	HOSPI TAL			In Lie	u of Form CMS-	2552-10
HOSPI T	AL WAGE RELATED COSTS		Provi der	CCN:	14-0242	Peri od:	Worksheet S-3	
						From 09/01/2021	Part IV	
						To 08/31/2022	Date/Time Pre 1/28/2023 6:3	
							Amount	
							Reported	
							1.00	
	PART IV - WAGE RELATED COSTS							
	Part A - Core List							
	RETIREMENT COST							
1.00	401K Employer Contributions						17, 458, 430	•
2.00	Tax Sheltered Annuity (TSA) Employer Contribu						0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see i						0	
4.00	Qualified Defined Benefit Plan Cost (see ins						0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External C)rgani zati on)						
5.00	401K/TSA Plan Administration fees						0	
6.00	Legal /Accounting/Management Fees-Pension Plan						0	
7.00	Employee Managed Care Program Administration	Fees					0	7.00
	HEALTH AND INSURANCE COST							
8.00	Health Insurance (Purchased or Self Funded)						0	
8.01	Health Insurance (Self Funded without a Third						0	
8.02	Health Insurance (Self Funded with a Third Pa	arty Administrato	r)				19, 756, 506	•
8.03	Heal th Insurance (Purchased)						0	
9.00	Prescription Drug Plan						10, 732, 546	
10.00	Dental, Hearing and Vision Plan						803, 284	
11.00	Life Insurance (If employee is owner or benef						1, 773, 540	
12.00	Accident Insurance (If employee is owner or I						0	
13.00	Disability Insurance (If employee is owner or		`				802, 276	•
14.00	Long-Term Care Insurance (If employee is owned	er or beneficiary)				0	
15.00	'Workers' Compensation Insurance						0	
16.00	Retirement Health Care Cost (Only current yea Non cumulative portion)	ar, not the extra	ordinary	accrua	ai requir	ed by FASB 106.	0	16.00
	TAXES							-
17 00	FICA-Employers Portion Only						18,052,364	17.00
18.00	Medicare Taxes - Employers Portion Only						10, 052, 504	
19.00	Unemployment Insurance						168, 952	
	State or Federal Unemployment Taxes						00,732	
20.00	OTHER							20.00
21.00	Executive Deferred Compensation (Other Than I	Retirement Cost R	eported o	n line	es 1 thro	ugh 4 above (see	0	21.00
21.00	instructions))						0	21.00
22.00	Day Care Cost and Allowances						0	22.00
23.00	Tuition Reimbursement						725, 531	
24.00	Total Wage Related cost (Sum of lines 1 -23)						70, 273, 429	
	Part B - Other than Core Related Cost							1
25.00	OTHER WAGE RELATED COSTS (SPECIFY)							25.00

Heal th	Financial Systems	CENTRAL DUPAGE	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0242	Period: From 09/01/2021 To 08/31/2022	Worksheet S-3 Part V Date/Time Pre 1/28/2023 6:3	pared:
	Cost Center Description			Contract Labor		
				1.00	2.00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Identi					
1.00	Total facility's contract labor and benefit	cost		18, 516, 929		
2.00	Hospi tal			18, 516, 929	69, 704, 450	
3.00	SUBPROVIDER - IPF			0	511, 416	
4.00	SUBPROVIDER - IRF					4.00
5.00	Subprovi der - (Other)			0	0	
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	1.00
8.00	SKILLED NURSING FACILITY					8.00
9.00	NURSING FACILITY					9.00
10.00	OTHER LONG TERM CARE I					10.00
11.00	Hospital-Based HHA					11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I					12.00
13.00	Hospital -Based Hospice					13.00
14.00	Hospital -Based Health Clinic RHC					14.00 15.00
15.00 16.00	Hospital-Based Health Clinic FQHC					16.00
16.00	Hospital -Based-CMHC			0	0	
16.10	Hospital-Based-CMHC 10 Hospital-Based-CMHC 20			0	0	
	Hospital-Based-CMHC 30			0	0	
	Hospital -Based-CMHC 40			0	0	
	RENAL DIALYSIS I			0	0	
	Other			0	57, 563	
10.00				1 0	57,505	10.00

Heal th	Financial Systems CENTRAL DUPAGE HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
		Provider CCN:	14-0242	Peri od:	Worksheet S-1	0
				From 09/01/2021 To 08/31/2022	Date/Time Pre	narod
				10 00/31/2022	1/28/2023 6: 3	o pm
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	rided by line	202 col um	1.8)	0. 140521	1.00
1.00	Medicaid (see instructions for each line)		202 001 0	1 0)	0.110021	1.00
2.00	Net revenue from Medicaid				80, 987, 557	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement		From Medica	ai d?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicaid			19, 449, 000	
6.00 7.00	Medicaid charges Medicaid cost (line 1 times line 6)				702, 692, 754 98, 743, 088	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus	sum of li	nes 2 and 5: if	90, 743, 000	1
01.00	<pre>< zero then enter zero)</pre>				Ū	0.00
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line)				
9.00	Net revenue from stand-alone CHIP				0	
10.00	5				0	
11.00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (line 11 minur		f , zoro thon	0	
12.00	enter zero)	inne ni minus	s i ne 9;	i < zero then	0	12.00
	Other state or local government indigent care program (see inst	ructions for	each line)		
13.00	Net revenue from state or local indigent care program (Not incl				0	13.00
14.00	Charges for patients covered under state or local indigent care	e program (Not	t included	in lines 6 or	0	14.00
	10)				_	
15.00	State or local indigent care program cost (line 1 times line 14				0	
16.00	Difference between net revenue and costs for state or local ind 13; if < zero then enter zero)	ligent care pi	rogram (III	ne 15 minus line	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state/I	ocal indi	pent care progra	ms (see	
	instructions for each line)					
	Private grants, donations, or endowment income restricted to fu				0	
18.00	Government grants, appropriations or transfers for support of h				0	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	That gent car	e program	s (sum of times	0	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	
			1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fac	ility	148, 403, 88	20, 445, 462	168, 849, 344	20.00
20.00	(see instructions)	, i i i cy	140, 403, 00	20, 440, 402	100, 047, 344	20.00
21.00	Cost of patients approved for charity care and uninsured discou	ints (see	20, 853, 86	2 20, 445, 462	41, 299, 324	21.00
	instructions)					
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22.00
22.00	charity care		20, 853, 86	20, 445, 462	41, 299, 324	22 00
23.00	Cost of charity care (line 21 minus line 22)		20, 655, 60	20, 445, 402	41, 299, 324	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patien	it days beyond	d a length	of stay limit	Ν	24.00
	imposed on patients covered by Medicaid or other indigent care					
25.00	If line 24 is yes, enter the charges for patient days beyond th	e indigent ca	are program	m's length of	0	25.00
26.00	stay limit Total bad debt expense for the entire hospital complex (see ins	tructions)			16, 887, 404	26.00
	Medicare reimbursable bad debts for the entire hospital complex (see his		ctions)		1, 369, 889	
27.00	Medicare allowable bad debts for the entire hospital complex (s				2, 107, 522	
	Non-Medicare bad debt expense (see instructions)				14, 779, 882	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see ins	structions)	2, 814, 517	29.00
	Cost of uncompensated care (line 23 column 3 plus line 29)	1			44, 113, 841	
31 00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			44, 113, 841	31.00

	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE		Provider C		eriod: rom 09/01/2021 o 08/31/2022	Worksheet A Date/Time Pre	pare
						1/28/2023 6: 3	
	Cost Center Description	Sal ari es	Other	10tal (col. 1 + col. 2)	Reclassificati ons (See A-6)	Recl assi fi ed Tri al Bal ance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5. 00	
	GENERAL SERVICE COST CENTERS	T T					
00	00100 CAP REL COSTS-BLDG & FIXT		25, 137, 549	25, 137, 549 15, 175, 991			
00 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		15, 175, 991 0	15, 175, 991	0		3
0	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	-	0	4
0	00540 NON PATIENT TELEPHONES	0	0	0	0	0	5
0	00560 PURCHASING AND STORES	0	0	0	0	0	5
0	00570 ADMI TTI NG	0	0	0	0	0	5
0	00580 ACCOUNTS RECEIVABLE AND CASHIERS	0	0	0	0	0	Ę
0	00590 ADMI NI STRATI ON & GENERAL	17, 040, 541	292, 678, 016	309, 718, 557			5
0 0	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT		0		100, 204	-	
0	00800 LAUNDRY & LINEN SERVICE	2, 484, 654 298, 117	27, 354, 373 182, 156	29, 839, 027 480, 273			
0	00900 HOUSEKEEPING	5, 315, 585	4, 580, 561	9, 896, 146			
00	01000 DI ETARY	3, 540, 031	5, 844, 343				
00	01100 CAFETERI A	0	0	0			
00	01200 MAINTENANCE OF PERSONNEL	0	0	0	-	0	12
00	01300 NURSING ADMINISTRATION	1, 572, 832	572, 826				
00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	3, 303, 485	7, 600, 570				
00 00	01600 MEDICAL RECORDS & LIBRARY	7, 473, 536 1, 500	93, 106, 169 220			7, 873, 858 1, 720	
00	01700 SOCIAL SERVICE	4, 549, 699	1, 631, 524	6, 181, 223			
00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0, 101, 220	00,002	0,017,070	19
00	02000 NURSI NG PROGRAM	0	0	0	0	0	20
00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21
00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22
00	02300 PARAMED ED PRGM-PARAMED EDU	249, 613	403, 383	652, 996	9, 775	662, 771	23
00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	42, 679, 934	41, 740, 837	84, 420, 771	-3, 011, 729	81, 409, 042	30
00	03100 I NTENSI VE CARE UNI T	8, 329, 359	7, 073, 389				
00	03200 CORONARY CARE UNIT	2, 800, 785	2, 277, 381	5, 078, 166			
00	02060 NEONATAL INTENSIVE CARE UNIT	6, 552, 428	2, 349, 096	8, 901, 524			
00	04000 SUBPROVIDER - IPF	7, 102, 978	2, 901, 849	10, 004, 827	5, 670	10, 010, 497	40
00	04300 NURSERY	0	0	0	1, 931, 377	1, 931, 377	43
00	ANCI LLARY SERVI CE COST CENTERS	15 500 (41	E2 240 240	(7.077.000	20 140 215	20 720 774	
00 00	05100 RECOVERY ROOM	15, 528, 641 6, 337, 610	52, 349, 348 2, 857, 175				
00	05200 DELIVERY ROOM & LABOR ROOM	7, 288, 537	3, 650, 471	10, 939, 008			
00	05300 ANESTHESI OLOGY	624, 977	2, 903, 732				
00	05400 RADI OLOGY-DI AGNOSTI C	5, 936, 210	2, 604, 671	8, 540, 881	422, 230	8, 963, 111	54
00	05500 RADI OLOGY-THERAPEUTI C	8, 511, 465	5, 368, 875				
	05600 RADI OI SOTOPE	699, 759	1, 520, 262				
00	05700 CT SCAN	1, 794, 626	1, 198, 522	2, 993, 148			
00 00	05800 MRI 06000 LABORATORY	2, 623, 045 44, 313, 229	1, 798, 460 96, 104, 382				
00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 312, 874	3, 431, 445				
30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0, 101, 110	0		0	62
00	06400 I NTRAVENOUS THERAPY	801, 232	505, 699	1, 306, 931	-97, 440	1, 209, 491	64
00	06500 RESPI RATORY THERAPY	3, 686, 162	2, 548, 394	6, 234, 556			
00	06600 PHYSI CAL THERAPY	9, 786, 992	3, 164, 216	12, 951, 208			
00		1, 627, 087	527, 718	2, 154, 805			
00 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	996, 169 8, 150, 549	271, 274 25, 291, 474	1, 267, 443 33, 442, 023			
00	07000 ELECTROEARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	1, 476, 116	1, 043, 678				
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 043, 078	2, 319, 794			
00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0			
00	07300 DRUGS CHARGED TO PATIENTS	0	0	0			
00	07400 RENAL DI ALYSI S	0	0	0		3, 091, 201	74
01	07501 CARDI AC REHAB	491, 999	160, 228				75
02 03	07502 SLEEP LAB 07503 I NPATI ENT DI ALYSI S	0	0	0	0	0	75
03	07504 PAIN MANAGEMENT	418, 961	332, 509	751, 470	-420		
97	07697 CARDI AC REHABI LI TATI ON	0	002,009	0	-420		76
98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	-		
99	07699 LI THOTRI PSY	0	0	0	0	0	76
_	OUTPATIENT SERVICE COST CENTERS					_	
00	09000 CLINIC	3, 439, 728	-605, 648				
01	09001 PATIENT TREATMENT CENTER	1, 653, 901	766, 194	2, 420, 095			
02 03	09002 REHAB SERVI CES-BLOOMI NGDALE 09003 CANTERA	0	0	0	-	0	90 90
03	09003 CANTERA 09004 MENTAL HEALTH 0/P	1, 442, 160	399, 453	-	-		
	09005 WOMENS CLINIC	1, 1, 2, 100	0 377, 433				90

Health Financial Systems	CENTRAL DUPAGE	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		eriod: rom 09/01/2021	Worksheet A	
				o 08/31/2022	Date/Time Pre	pared:
					1/28/2023 6:3	
Cost Center Description	Sal ari es	Other		Reclassi fi cati		
			+ col. 2)	ons (See A-6)		
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
90. 06 09006 WOUND CARE	230, 790	115, 322				
91.00 09100 EMERGENCY	10, 058, 293	9, 633, 920	19, 692, 213	417, 054	20, 109, 267	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
OTHER REIMBURSABLE COST CENTERS		-	-	-	-	
99. 10 09910 CORF	0	0	0	0	0	99.10
99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY	0	0	0	0	0	99.20
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	C	0	0	99.30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	252, 526, 189	748, 552, 007	1, 001, 078, 196	23, 147	1,001,101,343	118.00
NONREI MBURSABLE COST CENTERS				-		
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	51, 796	353, 031	404, 827		404, 827	
190. 01 19001 KOFEE KORNER	0	0	C	•		190.01
191. 00 19100 RESEARCH	714,070	417, 466			1, 108, 389	
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	8, 908, 118	8, 908, 118	0	8, 908, 118	
192. 01 19201 WSKF	0	0	0	0		192.01
193. 01 19301 DEVELOPMENT	0	0	C	0		193.01
193. 02 19302 MARKETI NG	0	0	C	0		193.02
193. 04 19303 PHYSI CI AN ANSWERI NG SERVI CE	0	0	C	0		193.04
193.05 19304 CAR SEAT SAFETY PROGRAM	0	0	C	0		193.05
193. 07 19305 JOINT VENTURE	0	0	C	0		193.07
193. 08 19306 PARKI NSONS CENTER	0	0	0	0		193.08
200.00 TOTAL (SUM OF LINES 118 through 199)	253, 292, 055	758, 230, 622	1, 011, 522, 677	0	1, 011, 522, 677	200. 00

				To 08/31/2022 Date/Time 1/28/2023	
	Cost Center Description		Net Expenses For Allocation		0.00 p
		6.00	7.00		
. 00	GENERAL SERVICE COST CENTERS	92 609	27 120 411		1
00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	83, 608 0	27, 120, 411 15, 175, 991		2
. 00	00300 OTHER CAP REL COSTS	0	0		3
00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		4
10	00540 NON PATIENT TELEPHONES	0	0		5
30	00560 PURCHASI NG AND STORES	0	Ő		5
40	00570 ADMI TTI NG	0	0		5
50	00580 ACCOUNTS RECEIVABLE AND CASHIERS	0	0		5
60	00590 ADMINISTRATION & GENERAL	-89, 433, 854	224, 403, 424		5
00	00600 MAI NTENANCE & REPAI RS	0	0		6
00	00700 OPERATION OF PLANT	-45, 924	29, 901, 499		7
00	00800 LAUNDRY & LINEN SERVICE	-931	487, 942		8
00	00900 HOUSEKEEPI NG	-28, 630	10, 040, 525		9
	01000 DI ETARY	227, 095	5, 982, 989		10
1.00		-2, 369, 219	1, 363, 714		11
	01200 MAINTENANCE OF PERSONNEL	0	0		12
	01300 NURSI NG ADMI NI STRATI ON	-18, 054	2, 249, 035		13
	01400 CENTRAL SERVICES & SUPPLY	-504, 075	10, 510, 890		14
		-7, 811	7, 866, 047		15
	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0 -5, 108	1, 720 6, 341, 967		16
	01900 NONPHYSI CI AN ANESTHETI STS	-5, 108	0, 341, 907		19
	02000 NURSI NG PROGRAM	0	0		20
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		20
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		22
	02300 PARAMED ED PRGM-PARAMED EDU	-26, 894	635, 877		23
0.00	INPATIENT ROUTINE SERVICE COST CENTERS	20,071	000,011		20
0. 00	03000 ADULTS & PEDIATRICS	-16,000,098	65, 408, 944		30
	03100 I NTENSI VE CARE UNI T	-821	15, 118, 861		31
	03200 CORONARY CARE UNIT	-130, 034	4, 909, 576		32
	02060 NEONATAL INTENSIVE CARE UNIT	-6, 733	9,071,059		35
D. 00	04000 SUBPROVI DER – I PF	-713, 458	9, 297, 039		40
3.00	04300 NURSERY	0	1, 931, 377		43
	ANCILLARY SERVICE COST CENTERS	- i i			
	05000 OPERATI NG ROOM	-2, 973	28, 725, 801		50
	05100 RECOVERY ROOM	-503	9, 418, 334		51
	05200 DELIVERY ROOM & LABOR ROOM	-728, 708	10, 449, 578		52
	05300 ANESTHESI OLOGY	-115, 575	3, 101, 580		53
	05400 RADI OLOGY-DI AGNOSTI C	-227, 115	8, 735, 996		54
	05500 RADI OLOGY-THERAPEUTI C	-65, 475	13, 283, 752		55
	05600 RADI OI SOTOPE	-685	2, 247, 483		56
	05700 CT SCAN	0	3, 063, 060		57
		-1,650	4, 558, 599		58
	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	-660, 569	125, 183, 768		60
2.00	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	4, 783, 984		62
2.30 4.00		-969	1, 208, 522		64
	06500 RESPIRATORY THERAPY	-2, 942	6, 348, 638		65
5.00 6.00		-2, 942	13, 257, 240		66
	06700 OCCUPATI ONAL THERAPY	-7,437	2, 202, 886		67
	06800 SPEECH PATHOLOGY	- 104	1, 300, 902		68
	06900 ELECTROCARDI OLOGY	-2, 123, 691	9, 854, 350		69
	07000 ELECTROENCEPHALOGRAPHY	-41, 154	2, 589, 084		70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	30, 551, 149		71
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	32, 004, 922		72
	07300 DRUGS CHARGED TO PATIENTS	0	92, 999, 337		73
	07400 RENAL DI ALYSI S	0	3, 091, 201		74
	07501 CARDI AC REHAB	-1, 225	669, 096		75
5. 02	07502 SLEEP LAB	0	0		75
5. 03	07503 I NPATI ENT DI ALYSI S	0	0		75
	07504 PALN MANAGEMENT	0	751, 050		75
	07697 CARDI AC REHABI LI TATI ON	0	0		76
	07698 HYPERBARI C OXYGEN THERAPY	0	0		76
5. 99	07699 LI THOTRI PSY	0	0		76
	OUTPATIENT SERVICE COST CENTERS		4 510 15-		
	09000 CLINIC	-3, 643, 601	1, 518, 187		90
	09001 PATI ENT TREATMENT CENTER	-32, 972	2, 404, 931		90
	09002 REHAB SERVI CES-BLOOMI NGDALE	0	0		90
1 02	09003 CANTERA	0	0		90
		170 626	1, 710, 967		90
0. 04	09004 MENTAL HEALTH 0/P	-170, 626	1, 710, 907		
0.04	09005 WOMENS CLINIC	-124, 327	0 225, 287		90 90

CENTRAL DUPAGE HOSPITAL

Health Financial Systems

In Lieu of Form CMS-2552-10

Health Financial Systems	CENTRAL DUPAG	GE HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	CN: 14-0242	Period:	Worksheet A	
				From 09/01/2021 To 08/31/2022	Date/Time Pre	pared [.]
				10 00/01/2022	1/28/2023 6:3	<u>O pm</u>
Cost Center Description	Adjustments	Net Expenses				
	(For Allocation				
	6.00	7.00				00.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
OTHER REI MBURSABLE COST CENTERS	0	0				99, 10
99. 10 109910 CORF 99. 20 109920 OUTPATI ENT PHYSI CAL THERAPY	0	0				99.10
99. 20 109920 OUTPATIENT PHYSICAL THERAPT 99. 30 109930 OUTPATIENT OCCUPATIONAL THERAPY	0	0				99.20
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0				99.40
SPECIAL PURPOSE COST CENTERS	0	0				77.40
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-117, 285, 542	883, 815, 801				118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	404, 827				190.00
190. 01 19001 KOFEE KORNER	0	0				190. 01
191. 00 19100 RESEARCH	0	1, 108, 389				191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	8, 908, 118				192.00
192. 01 19201 WSKF	0	0				192.01
193. 01 19301 DEVELOPMENT	0	0				193.01
193. 02 19302 MARKETI NG	0	0				193. 02
193. 04 19303 PHYSI CI AN ANSWERI NG SERVI CE	0	0				193.04
193. 05 19304 CAR SEAT SAFETY PROGRAM	0	0				193.05
193. 07 19305 JOI NT VENTURE	0	0				193.07
193. 08 19306 PARKI NSONS CENTER	117 DOE E40	004 007 105				193.08
200.00 TOTAL (SUM OF LINES 118 through 199)	-117, 285, 542	894, 237, 135				200.00

SI FI CATI ONS			Provider CCN: 14		Worksheet A-6
				From 09/01/20 To 08/31/20	22 Date/Time Prepare
	Increases			I .	1/28/2023 6:30 pm
Cost Center	Line #	Salary	Other		
2.00 A - IMPLANTS	3.00	4.00	5.00		
IMPL. DEV. CHARGED TO	72.00	0	32, 004, 922		1.
PATIENTS					
	0.00	0	0		2.
	0. 00 0. 00	0	0		3.
TOTALS — — — —		— — — <u>o</u>	32,004,922		4.
B - CHARGEABLE MEDI CAL SUPPL					
MEDICAL SUPPLIES CHARGED TO	71.00	0	30, 498, 979		1.
PATI ENT	0.00	0	0		2.
	0.00	0	Ö		3.
	0.00	0	0		4.
	0.00	0	0		5.
	0. 00 0. 00	0	0		6. 7.
	0.00	0	0		8.
	0.00	0	0		9.
	0.00	0	0		10.
	0. 00 0. 00	0	0		11.
	0.00	0	0		12.
	0.00	0	0		14.
	0.00	0	0		15.
	0. 00 0. 00	0	0		16. 17.
	0.00	0	0		17.
	0.00	0	0		19.
	0.00	0	0		20.
	0.00	0	0		21.
	0. 00 0. 00	0	0		22. 23.
	0.00	0	0		23.
	0.00	0	0		25.
			0		26.
TOTALS C - CAFETERIA		0	30, 498, 979		
CAFETERI A	11.00	1, 293, 777	2, 439, 156		1.
TOTALS		1, 293, 777	2, 439, 156		
D - DRUGS	70.00		00,000,007		
DRUGS_CHARGED_TO_PATIENTS TOTALS		0	<u>92, 999, 337</u> 92, 999, 337		1.
E - INSURANCE		UU	72, 777, 337		
CAP_REL_COSTS_BLDG_&_FLXT	1.00	0	1, 899, 254		1.
TOTALS		0	1, 899, 254		
G - BILLING AND REGISTRATION ADMINISTRATION & GENERAL	E (O	6 074 000	2 127 704		1
ADMINI SIKATI UN & GENERAL	5. 60 0. 00	6, 074, 000 0	2, 137, 796 0		1.
	0.00	0	0		3.
	0.00	О	0		4.
-	0.00	0	0		5.
	0. 00 0. 00		0		6. 7.
	0.00	0	õ		8.
	0. 00	О	0		9.
	0.00	0	0		10.
TOTALS		6,074,000	2, 137, 796		11.
H - PEDIATRIC BUILDING RENT	· · · · · · · · · · · · · · · · · · ·				
CLINIC	90.00	0	2, 178, 184		1.
		0	2, 178, 184		
I - NURSERY NURSERY	43.00	1, 423, 755	507, 622		1.
TOTALS		1, 423, 755	507, 622		1.
J - RENAL DIALYSIS					
RENAL DI ALYSI S	74.00	0	3, 090, 956		1.
-	0. 00 0. 00	0	0		2.
	0.00	0			3.
	0.00	0	Ő		6.

Health Financial Systems	CENTRAL DUPAGE HOSPI TAL	In Lieu	u of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CC	CN: 14-0242 Period: From 09/01/2021	Worksheet A-6
			Date/Time Prepared: 1/28/2023 6:30 pm

					1/28/2023 6:	<u>30 pm</u>
		Increases				
	Cost Center	Line #	Sal ary	Other		
	2.00	3.00	4.00	5.00		
	L - PATIENT TRANSPORTATION					_
1.00	ADULTS & PEDIATRICS	30.00	783, 693	367, 079		1.00
2.00	INTENSIVE CARE UNIT	31.00	33, 921	15, 889		2.00
3.00	CORONARY CARE UNIT	32.00	12, 290	5, 756		3.00
4.00	NEONATAL INTENSIVE CARE UNIT	35.00	1, 613	755		4.00
5.00	OPERATING ROOM	50.00	52, 606	24, 640		5.00
6.00	RECOVERY ROOM	51.00	1, 335	625		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	8, 174	3, 829		7.00
8.00	ANESTHESI OLOGY	53.00	1, 279	599		8.00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	101, 375	47, 483		9.00
10.00	CT SCAN	57.00	6, 173	2, 891		10.00
11.00	MRI	58.00	30, 195	14, 143		11.00
12.00	LABORATORY	60.00	1, 057	495		12.00
13.00	PHYSICAL THERAPY	66.00	556	260		13.00
14.00	ELECTROCARDI OLOGY	69.00	35, 756	16, 748		14.00
15.00	ELECTROENCEPHALOGRAPHY	70.00	42, 485	19, 900		15.00
16.00	RENAL DI ALYSI S	74.00	167	78		16.00
17.00	CLINIC	90.00	9, 398	4, 402		17.00
18.00	WOUND CARE	90.06	56	26		18.00
19.00	EMERGENCY		8 <u>3, 8</u> 58	3 <u>9, 2</u> 79		19.00
	TOTALS		1, 205, 987	564, 877		
	M - INTERCOMPANY					_
1.00	ADMINISTRATION & GENERAL	5.60	0	100, 795		1.00
2.00	SUBPROVIDER - IPF	40.00	0	151		2.00
4.00		0.00	0	0		4.00
	TOTALS		0	100, 946		
	N - NON PATIENT TRANSPORTATIO					_
1.00	ADMINISTRATION & GENERAL	5.60	0	8, 511, 624		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	8, 511, 624		
	0 - ORGANIZATIONAL INCENTIVE					-
1.00	OPERATION OF PLANT	7.00	108, 396	0		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	8, 600	0		2.00
3.00	HOUSEKEEPING	9.00	172, 944	0		3.00
4.00	DI ETARY	10.00	104, 453	0		4.00
5.00	NURSING ADMINISTRATION	13.00	110, 723	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	107, 242	0		6.00
7.00	PHARMACY	15.00	294, 770	0		7.00
8.00	SOCI AL SERVI CE	17.00	165, 852	0		8.00
9.00	PARAMED ED PRGM-PARAMED EDU	23.00	9, 775	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	1, 209, 990	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	275, 422	0		11.00
12.00	CORONARY CARE UNIT	32.00	69, 587	0		12.00
13.00	NEONATAL INTENSIVE CARE UNIT	35.00	201, 959	0		13.00
14.00	SUBPROVIDER - IPF	40.00	313, 002	0		14.00
15.00	OPERATING ROOM	50.00	556, 239	0		15.00
16.00	RECOVERY ROOM	51.00	246, 457	0		16.00
17.00	DELIVERY ROOM & LABOR ROOM	52.00	262, 443	0		17.00
18.00	ANESTHESI OLOGY	53.00	19, 823	0		18.00
19.00	RADI OLOGY-DI AGNOSTI C	54.00	297, 168	0		19.00
20.00	RADI OLOGY-THERAPEUTI C	55.00	329, 928	0		20.00
21.00	RADI OI SOTOPE	56.00	28, 147	0		21.00
22.00	CT SCAN	57.00	60, 910	0		22.00
23.00	MRI	58.00	97, 043	0		23.00
24.00	LABORATORY	60.00	1, 407, 447	0		24.00
25.00	WHOLE BLOOD & PACKED RED	62.00	39, 665	0		25.00
	BLOOD CELL					
26.00	INTRAVENOUS THERAPY	64.00	25, 471	0		26.00
27.00	RESPI RATORY THERAPY	65.00	153, 252	0		27.00
28.00	PHYSI CAL THERAPY	66.00	355, 966	0		28.00
29.00	OCCUPATI ONAL THERAPY	67.00	55, 229	0		29.00
30.00	SPEECH PATHOLOGY	68.00	33, 563	0		30.00
31.00	ELECTROCARDI OLOGY	69.00	207, 097	0		31.00
32.00	ELECTROENCEPHALOGRAPHY	70.00	55, 167	0		32.00
33.00	CARDI AC REHAB	75.01	18, 094	0		33.00
34.00	PAIN MANAGEMENT	75.04	24, 410	0		34.00
35.00	CLINIC	90.00	139, 129	0		35.00
36.00	PATIENT TREATMENT CENTER	90.01	44, 084	0		36.00
37.00	MENTAL HEALTH O/P	90.04	39, 980	0		37.00
38.00	WOUND CARE	90.06	7, 911	0		38.00
39.00	EMERGENCY	91.00	340, 159	0		39.00
41.00	RESEARCH	1 <u>91.</u> 00	<u> </u>	<u>o</u>		41.00
	TOTALS		7, 999, 481	ō		

Heal th	Financial Systems		CENTRAL DUPA	AGE HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provi der (CCN: 14-0242	Period: From 09/01/2021	Worksheet A-	-6
						To 08/31/2022	Date/Time Pr 1/28/2023 6:	repared: 30 pm
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	P - EMERGENCY INCENTIVE							
1.00	HOUSEKEEPI NG	9.00	0	65				1.00
2.00	NURSING ADMINISTRATION	13.00	0	10, 708				2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	3, 668				3.00
4.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	52, 170				4.00
	PATI ENT							
	TOTALS		0	66, 611				
500.00	Grand Total: Increases		17, 997, 000	177, 000, 264				500.00

	Financial Systems SIFICATIONS		CENTRAL DUPAG		CCN: 14-0242	Peri od:	u of Form CMS-2552-1 Worksheet A-6
						From 09/01/2021 To 08/31/2022	Date/Time Prepared
		Decreases				L	1/28/2023 6:30 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	· .	
	6.00 A - IMPLANTS	7.00	8.00	9.00	10.00		
1.00	OPERATING ROOM	50.00	0	19, 748, 195	5	0	1.0
2.00	ELECTROCARDI OLOGY	69.00	0	12, 256, 696		0	2. C
3.00	INTENSIVE CARE UNIT	31.00	0	15		0	3.0
4.00	CORONARY CARE UNI T	<u>32.00</u>	<u></u>	16 32,004,922		Ō	4. C
	B - CHARGEABLE MEDICAL SUPPLI	ES	0	32,004,722	-		
1.00	PHARMACY	15.00	0	1, 280		0	1.0
2.00	CORONARY CARE UNIT	32.00	0	55, 026		0	2.0
3.00 4.00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	234, 552 142, 860		0	3. C 4. C
5.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	28, 059		0	5.0
6.00	SUBPROVI DER – I PF	40.00	0	16	5	0	6. C
7.00	OPERATING ROOM	50.00	0	19, 913, 744		0	7.0
8.00 9.00	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	51.00 52.00	0	24, 365 35, 168		0	8. C 9. C
10.00	ANESTHESI OLOGY	53.00	0	333, 255		0	10.0
11.00	RADI OLOGY-DI AGNOSTI C	54.00	0	23, 796	5	0	11. C
12.00	RADI OLOGY-THERAPEUTI C	55.00	0	20, 326		0	12.0
13.00 14.00	CT SCAN MRI	57.00 58.00	0	62 2, 637		0	13. C 14. C
14.00	LABORATORY	60.00	0	9, 331		0	14.0
16.00	INTRAVENOUS THERAPY	64.00	0	122, 911		0	16. C
17.00	RESPI RATORY THERAPY	65.00	0	36, 228		0	17. C
18.00 19.00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66. 00	0	2,060		0	18. C
20.00	ELECTROCARDI OLOGY	67.00 69.00	0	6, 885 9, 449, 833		0	20.0
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	7, 108		0	21.0
22.00	PAIN MANAGEMENT	75.04	0	24, 830		0	22. C
23.00		90.00	0	1, 907		0	23.0
24.00 25.00	PATIENT TREATMENT CENTER WOUND CARE	90. 01 90. 06	0	5, 484 4, 491		0	24. C 25. C
26.00	EMERGENCY	91.00	0	12, 765		0	26.0
	TOTALS			30, 498, 979	,	1	
1.00	C – CAFETERIA DI ETARY	10.00	1, 293, 777	2, 439, 156		0	1.0
1.00			1, 293, 777	2, 439, 156			1.0
	D – DRUGS						
1.00	PHARMACY		<u></u>	<u>92, 999, 337</u>		Ō	1. C
	TOTALS E - INSURANCE		0	92, 999, 337	1		
1.00	ADMI NI STRATI ON & GENERAL	5.60	0	1, 899, 254	1	2	1.0
	TOTALS		0	1, 899, 254		1	
	G - BILLING AND REGISTRATION		0.057				
1.00 2.00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	3, 257 693	746 130		0	1.0
2.00	CORONARY CARE UNIT	32.00	159	33		0	3.0
4.00	SUBPROVI DER – I PF	40.00	242, 145	65, 322	2	0	4. C
5.00	OPERATING ROOM	50.00	96, 729	24, 032		0	5. C
6.00 7.00	RADI OLOGY-THERAPEUTI C LABORATORY	55. 00 60. 00	170, 777 5, 479, 018	45, 096 1, 982, 300		0	6. C 7. C
7.00 8.00	PHYSICAL THERAPY	66.00	32, 064	1, 982, 300 9, 189		ō	8.0
9.00	CLINIC	90.00	1, 147	351		0	9.0
10.00	EMERGENCY	91.00	28, 132	5, 345		0	10.0
11.00	RESEARCH	1 <u>91.</u> 00	<u> </u>	<u>5, 2</u> 52 2, 137, 796		4	11.0
	H - PEDIATRIC BUILDING RENT		0, 074, 000	2, 137, 790	'I		
1.00	ADULTS & PEDI ATRI CS	30.00	0	<u>2, 178, 1</u> 84		0	1.0
			0	2, 178, 184	<u>ــــــــــــــــــــــــــــــــــــ</u>		
1.00	I - NURSERY ADULTS & PEDIATRICS	30.00	1, 423, 755	507, 622		0	1.0
1.00	TOTALS		1, 423, 755	<u>507, 622</u> 507, 622			1.0
	J - RENAL DIALYSIS	I	,,				
1.00	ADMINI STRATI ON & GENERAL	5.60	0	969, 284		0	1. C
2.00	ADULTS & PEDIATRICS	30.00	0	940, 483		0	2.0
3.00 4.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	31.00 32.00	0	464, 600 70, 955		0	3. C 4. C
4.00 6.00	RADI OLOGY-THERAPEUTI C	32.00 55.00	U	70, 955 624, 842		0	4.0
7.00	PATIENT TREATMENT CENTER	<u>90.</u> 01	0	2 <u>0, 7</u> 92	2	Q	7.0
			0	3, 090, 956			
	L - PATIENT TRANSPORTATION	5.60	1, 205, 987	564, 877	7	0	1.0
1 00	IADMENTS RATION & GENERAL						
1.00 2.00	ADMINI STRATION & GENERAL	0.00	1, 203, 707	0		0	2.0

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	S

 CENTRAL DUPAGE HOSPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 14-0242
 Period: From 09/01/2021
 Worksheet A-6

RECENS	STITCATIONS			Frovider con.		From 09/01/2021 To 08/31/2022	Date/Time Prepared: 1/28/2023 6:30 pm
		Decreases					
	Cost Center 6.00	Line # 7.00	Sal ary 8.00	Other Wks 9.00	t. A-7 Ref. 10.00		
4.00	0.00	0.00	0.00	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00 8.00		0. 00 0. 00	0	0	0		7.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0	0	0		11.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16. 00 17. 00		0. 00 0. 00	0	0	0		16.00 17.00
18.00		0.00	Ő	0	0		18.00
19.00		0.00	0	0	<u>0</u>	-	19.00
			1, 205, 987	564, 877			
1.00	M - INTERCOMPANY ADULTS & PEDIATRICS	30.00	0	83, 892	0		1.00
2.00		0.00	0	0	0		2.00
4.00	ELECTROCARDIOLOGY		0	17,054	0		4.00
	TOTALS N - NON PATIENT TRANSPORTATIO		0	100, 946			
1.00	N - NON FAITENT TRANSFORTATIO	0.00	0	0	0		1.00
2.00	LABORATORY		0	<u>8, 511, 6</u> 24	0		2.00
			0	8, 511, 624			
1.00	O - ORGANIZATIONAL INCENTIVE ADMINISTRATION & GENERAL	5.60	7, 999, 481	0	0		1.00
2.00		0.00	0	Ő	0		2.00
3.00		0.00	0	0	0		3.00
4.00 5.00		0. 00 0. 00	0	0	0		4.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9. 00 10. 00		0. 00 0. 00	0	0	0		9.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00 14.00		0. 00 0. 00	0	0	0		13.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18. 00 19. 00		0. 00 0. 00	0	0	0		18.00 19.00
20.00		0.00	Ő	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00 23.00		0. 00 0. 00	0	0	0		22.00 23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00 28.00		0. 00 0. 00	0	0	0		27.00 28.00
29.00		0.00	0	Ő	0		29.00
30.00		0.00	0	0	0		30.00
31.00 32.00		0. 00 0. 00	0	0	0		31.00 32.00
32.00 33.00		0.00	0	0	0		33.00
34.00		0.00	0	0	0		34.00
35.00		0.00	0	0	0		35.00
36.00 37.00		0. 00 0. 00	0	0	0		36.00 37.00
37.00 38.00		0.00	0	0	0		38.00
39.00		0.00	0	0	0		39.00
41.00		0.00	0	0	<u>0</u>	-	41.00
	TOTALS P - EMERGENCY INCENTIVE		7, 999, 481	0			
1.00	ADMINISTRATION & GENERAL	5.60	0	66, 611	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00	TOTALS	0.00	0	<u>66, 611</u>	0	{	4.00
			0	33, 011		1	

Heal th	Financial Systems		CENTRAL DUPA	GE HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLASS	SI FI CATI ONS			Provi der (CCN: 14-0242	Period: From 09/01/2021	Worksheet A-	6
							Date/Time Pr 1/28/2023 6:	
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
500.00	Grand Total: Decreases		17, 997, 000	177, 000, 264				500.00

Heal th	Financial Systems	CENTRAL DUPAG	E HOSPI TAL		In Lieu of Form CMS-2552-10			
RECONO	LIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 14-0242	Period: From 09/01/202 To 08/31/202		pared:	
				Acqui si ti on	S			
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements		
		1,00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	35, 273, 260	0		0	0 0	1.00	
2.00	Land Improvements	0	0		0	o o	2.00	
3.00	Buildings and Fixtures	610, 984, 310	44, 216, 400		0 44, 216, 40	o o	3.00	
4.00	Building Improvements	0	0		0	0 0	4.00	
5.00	Fixed Equipment	157, 950, 050	15, 243, 650		0 15, 243, 65	o o	5.00	
6.00	Movable Equipment	0	0		0	0 0	6.00	
7.00	HIT designated Assets	0	0		0	o o	7.00	
8.00	Subtotal (sum of lines 1-7)	804, 207, 620	59, 460, 050		0 59, 460, 05	o o	8.00	
9.00	Reconciling Items	0	0		0	o o	9.00	
10.00	Total (line 8 minus line 9)	804, 207, 620	59, 460, 050		0 59, 460, 05	o o	10.00	
		Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	35, 273, 260	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	655, 200, 710	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	173, 193, 700	0				5.00	
6.00	Movable Equipment	0	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	863, 667, 670	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	863, 667, 670	0				10.00	

Health Financial Systems		CENTRAL DUPAGE HOSPITAL		In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS			Provider C	CN: 14-0242	Period:	Worksheet A-7	
					From 09/01/2021 To 08/31/2022		pared:
						1/28/2023 6:3	
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	•	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	<u>//N 2, LINES 1 a</u>	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	25, 137, 549	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15, 175, 991	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	40, 313, 540	0		0 0	0	3.00
SUMMARY OF CAPITAL							
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	-				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	25, 137, 549				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	15, 175, 991				2.00
3.00	Total (sum of lines 1-2)	0	40, 313, 540				3.00

Health Financial Systems	CENTRAL DUPAGE HOSPITAL			In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 09/01/2021 To 08/31/2022	Worksheet A-7 Part III Date/Time Prep 1/28/2023 6:30	pared:	
	COMI	PUTATION OF RA	TI OS	ALLOCATION OF	OTHER CAPITAL	<u>o piii</u>	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance		
		Leases	for Ratio	instructions)			
			(col. 1 - col 2)				
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS C							
1.00 CAP REL COSTS-BLDG & FIXT	35, 273, 260	0			0	1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	828, 394, 410		828, 394, 41			2.00	
3.00 Total (sum of lines 1-2)	863, 667, 670		863, 667, 67			3.00	
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				IF CAPITAL		
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease		
		Capi tal -Rel ate					
		d Costs	through 7)				
DART LLL DECONCLULATION OF CARLEAL COSTS	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 CAP REL COSTS-BLDG & FIXT		0		0 25 221 157	0	1.00	
2.00 CAP REL COSTS-BEDG & FIXT				0 25, 221, 157 0 15, 175, 991		2.00	
3.00 Total (sum of lines 1-2)	0			0 40, 397, 148		2.00	
	0		JMMARY OF CAPI		0	3.00	
		50	MINIART OF CALL	TAL			
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum		
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9		
				d Costs (see	through 14)		
				instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1,00 CAP REL COSTS-BLDG & FIXT 0 1.899, 254 0 0 27, 120, 411						1.00	
1. 00 CAP REL COSTS-BLDG & FIXT 2. 00 CAP REL COSTS-MVBLE EQUIP	0				27, 120, 411 15, 175, 991	2.00	
3.00 Total (sum of lines 1-2)		-		0 0	42, 296, 402	2.00	
5.00 10tal (Sull 01 11165 1-2)	0	1,077,234	I	0	42, 270, 402	3.00	

	Financial Systems		CENTRAL DUPA	GE HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 14-0242	Period: From 09/01/2021	Worksheet A-8	
				To 08/31/20			
				Expense Classification on Worksheet A To/From Which the Amount is to be Adjuste			
					ŗ		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00 0	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	
	(chapter 2)		0				
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service	A	-34, 459	OPERATION OF PLANT	7.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	
10.00	Provider-based physician adjustment	A-8-2	-21, 181, 131			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-26, 477, 647			0	12.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	0 -2, 369, 219	CAFETERIA	0. 00 11. 00	0	13.00 14.00
15.00	Rental of quarters to employee and others		0		0.00	0	
16.00	Sale of medical and surgical supplies to other than	В	-1, 662	DELIVERY ROOM & LABOR ROOM	52.00	0	16.00
17.00	patients Sale of drugs to other than		0		0. 00	0	17.00
18.00	patients Sale of medical records and		0		0.00	0	18.00
19.00	abstracts Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees, books, etc.)					-	
20.00	Vending machines		0		0.00	0	
21.00	Income from imposition of interest, finance or penalty		0		0.00	0	21.00
22.00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 30.00	Physicians' assistant	A-8-3	0		0.00	0	
30.00	Adjustment for occupational therapy costs in excess of	A-0-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31.00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of limitation (chapter 14)						
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00		A	-16, 146, 083	ADMINISTRATION & GENERAL	5.60	0	33.00

Health Financial Systems ADJUSTMENTS TO EXPENSES	CENTRAL DUPA		In Lie Period:	u of Form CMS-2 Worksheet A-8		
ADJUSTIMENTO TO EXTENSES				From 09/01/2021 To 08/31/2022		pared:
			Expense Classification or To/From Which the Amount is		172072023 0. 3	
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
34.02 NON PT MED SUPP	1.00	2.00	3.00 PATIENT TREATMENT CENTER	4.00	5.00 0	24.02
34.02 NON PT MED SUPP 35.04 MEALS REVENUE	B B		DIETARY	90. 01 10. 00	0	
36.00 OTHER I NCOME	В		NEONATAL INTENSIVE CARE UNI		0	
36. 01 OTHER I NCOME 36. 02 OTHER I NCOME	B B		ADMINISTRATION & GENERAL	5.60 8.00	0	
36. 03 OTHER I NCOME	В		DI ETARY	10.00	0	
36.04 OTHER INCOME	B B		RECOVERY ROOM	51.00	0	36.04
36. 05 OTHER I NCOME 36. 06 OTHER I NCOME	В		RADI OLOGY-THERAPEUTI C	55.00 60.00	0	36.05 36.06
36.07 OTHER INCOME	В		SUBPROVIDER - IPF	40.00	0	
36.08 OTHER INCOME 36.09 OTHER INCOME	BB	0 2, 415, 644-	MENTAL HEALTH O/P	90.04 90.00	0	36.08 36.09
36. 10 OTHER I NCOME	B		OPERATING ROOM	50.00	0	
36.11 OTHER INCOME	B B		PATIENT TREATMENT CENTER	90.01	0	36. 11 36. 12
36. 12 OTHER I NCOME 36. 13 OTHER I NCOME	В		INTENSIVE CARE UNIT	13.00 31.00	0	36.12
36.14 OTHER INCOME	В	579	CENTRAL SERVICES & SUPPLY	14.00	0	
36. 15 OTHER I NCOME 36. 16 OTHER I NCOME	BB		PHYSICAL THERAPY	66.00 70.00	0	36. 15 36. 16
36. 17 OTHER I NCOME	B		ADULTS & PEDIATRICS	30.00	0	36.17
36. 18 OTHER I NCOME	В		DELIVERY ROOM & LABOR ROOM	52.00	0	36.18
38.00 TUITION INCOME 38.01 TUITION INCOME	BB		ELECTROCARDI OLOGY	69.00 60.00	0	38.00 38.01
38.02 TUITION INCOME	В	-81, 864	EMERGENCY	91.00	0	38. 02
38.03 TUITION INCOME 39.00 RENTAL INCOME	BB	0 1, 198, 083-	SUBPROVIDER – IPF	40.00 90.00	0	38.03 39.00
39.00 RENTAL INCOME	В		SUBPROVIDER - IPF	40.00	0	39.00
39.04 INTERCOMPANY RENTAL INCOME	В		OPERATION OF PLANT	7.00	0	
39.05 INTERCOMPANY RENTAL INCOME 40.00 OTHER SERVICE REVENUE	B B		ADMINISTRATION & GENERAL	5.60 90.01	0	39.05 40.00
40. 01 OTHER SERVICE REVENUE	B		SUBPROVI DER – I PF	40.00	0	
40. 02 OTHER SERVICE REVENUE	В		ADULTS & PEDIATRICS	30.00	0	
40. 03 OTHER SERVICE REVENUE 40. 06 OTHER SERVICE REVENUE	B B		MENTAL HEALTH 0/P	90.04 54.00	0	
40.07 OTHER SERVICE INCOME	В	-34, 643	EMERGENCY	91.00	0	40. 07
41.00 INSTYMED REV 41.01 INSTYMED REV	BB		CLINIC PHARMACY	90.00 15.00	0	41.00
41.03 RECOVERY LIVING REV	B		ADULTS & PEDIATRICS	30.00	0	
42.00 REAL ESTATE TAXES	A			90.00	0	
42.04 LOBBYING DUES 42.05 PHYSICIAN BILLING SVC	A A		ADMINISTRATION & GENERAL	5.60 60.00	0	
42.06 PHYSICIAN BILLING SVC	A	0	ELECTROCARDI OLOGY	69.00	0	42.06
42.07 REAL ESTATE TAXES 44.00 CHARI TABLE CONTRI BUTI ONS	A A		ADMINISTRATION & GENERAL	5.60 5.60	0	
44. 01 CHARI TABLE CONTRI BUTI ONS	Â		HOUSEKEEPING	9.00	0	44.00
44. 02 CHARI TABLE CONTRI BUTI ONS	A		NURSING ADMINISTRATION	13.00	0	
44. 03 CHARI TABLE CONTRI BUTI ONS 44. 04 CHARI TABLE CONTRI BUTI ONS	A A		ADULTS & PEDIATRICS	30.00 31.00	0	
44.05 CHARI TABLE CONTRI BUTI ONS	A	0	SUBPROVI DER – I PF	40.00	0	44.05
44. 06 CHARI TABLE CONTRI BUTI ONS 44. 07 CHARI TABLE CONTRI BUTI ONS	A A		OPERATING ROOM DELIVERY ROOM & LABOR ROOM	50.00 52.00	0	44.06 44.07
44. 07 CHARTTABLE CONTRIBUTIONS	A		CLINIC	90.00	0	44.07
44. 09 CHARI TABLE CONTRI BUTI ONS	A		PATIENT TREATMENT CENTER	90.01	0	
44.10 CHARI TABLE CONTRI BUTI ONS 44.11 CHARI TABLE CONTRI BUTI ONS	A A		EMERGENCY MRI	91.00 58.00	0	
45.00 EQPT DI SPOSALS	A		ADMINISTRATION & GENERAL	5.60	0	
45.01 EQPT DI SPOSALS	A		HOUSEKEEPING	9.00	0	
45. 02 EQPT DI SPOSALS 45. 03 EQPT DI SPOSALS	A A		PHARMACY CENTRAL SERVICES & SUPPLY	15.00 14.00	0	45.02 45.03
45.04 EQPT DI SPOSALS	A	0	MEDICAL RECORDS & LIBRARY	16.00	0	45.04
45. 05 EQPT DI SPOSALS 45. 06 EQPT DI SPOSALS	A A		ADULTS & PEDIATRICS	30.00 31.00	0	45.05 45.06
45. 07 EQPT DI SPOSALS	A		NEONATAL INTENSIVE CARE UNIT		0	45.08
45. 08 EQPT DI SPOSALS	A		SUBPROVIDER - IPF	40.00	0	
45. 09 EQPT DI SPOSALS 45. 10 EQPT DI SPOSALS	A A		OPERATING ROOM DELIVERY ROOM & LABOR ROOM	50.00 52.00	0	
45. 11 EQPT DI SPOSALS	А	-197, 234	RADI OLOGY-DI AGNOSTI C	54.00	0	45.11
45. 12 EQPT DI SPOSALS 45. 13 EQPT DI SPOSALS	A A		RADI OLOGY-THERAPEUTI C	55.00 57.00	0	
10. 10 LEGI DI DI DI ODALD		0	101 JOHN	1 37.00	U U	1 70. 10

AD HISTMENT	ancial Systems S TO EXPENSES			GE HOSPITAL Provider CCN: 14-0242	Period:	Worksheet A-8	2552-10
ADJUJ IMLINI.	5 TO EXPENSES				rom 09/01/2021		
					Го 08/31/2022	Date/Time Pre 1/28/2023 6:3	
				Expense Classification or			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
	F DI SPOSALS	A		LABORATORY	60.00	0	
45.15 EQPT	F DI SPOSALS	A	0	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	45.15
45.16 EQPT	DI SPOSALS	А	-825	ELECTROCARDI OLOGY	69.00	0	45.16
45.17 EQPT	F DI SPOSALS	A	0	CLINIC	90.00	0	45.17
	F DI SPOSALS	A	-1, 650		58.00	0	45.18
	F DI SPOSALS F DI SPOSALS	A A		PHYSI CAL THERAPY EMERGENCY	66.00 91.00	0	45.19 45.20
	T DI SPOSALS	A		CAP REL COSTS-MVBLE EQUIP	2.00	9	45.20
	F DI SPOSALS	A	-383	OPERATION OF PLANT	7.00	0	45.22
	F DI SPOSALS	A		RECOVERY ROOM	51.00	0	45.23
	F DI SPOSALS F DI SPOSALS	A A		INTRAVENOUS THERAPY CAP REL COSTS-BLDG & FIXT	64.00 1.00	0	45.24 45.25
	T DI SPOSALS	A		CORONARY CARE UNIT	32.00	0	45.26
45.27 EQPT	F DI SPOSALS	А	-2, 166	PATIENT TREATMENT CENTER	90.01	0	45. 27
	F DI SPOSALS	A		NURSING ADMINISTRATION	13.00	0	45.28
	F DI SPOSALS TALI ZED I NTEREST	A A		ELECTROENCEPHALOGRAPHY CAP REL COSTS-BLDG & FIXT	70.00 1.00	0	45.29 48.00
	CALD TAX OFFSET	A		ADMINI STRATI ON & GENERAL	5.60	0	49.00
	PART B	A		WOUND CARE	90.06	0	49.01
	PART B PART B	A A		ADULTS & PEDIATRICS	30.00	0	
	PART B	A		ELECTROCARDI OLOGY I NTENSI VE CARE UNI T	69.00 31.00	0	49.03 49.04
	PART B	А		CORONARY CARE UNIT	32.00	0	49.05
	COST	A		PATIENT TREATMENT CENTER	90.01	9	49.06
	C COST C COST	A A		ADMINISTRATION & GENERAL OPERATION OF PLANT	5. 60 7. 00	0	49.07 49.08
	COST	A		LAUNDRY & LINEN SERVICE	8.00	0	
	COST	A		HOUSEKEEPI NG	9.00	0	49.10
	COST	A			10.00	0	49.11
	C COST C COST	A A		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13.00 14.00	0	49.12 49.13
	COST	A		PHARMACY	15.00	0	
	COST	A		SOCIAL SERVICE	17.00	0	
	C COST C COST	A A		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30.00 31.00	0	49.16 49.17
	COST	A		CORONARY CARE UNIT	31.00	0	49.18
49.19 MISC	COST	A		NEONATAL INTENSIVE CARE UNI	Г 35.00	0	
	COST	A		SUBPROVIDER - IPF	40.00	0	
49.21 MISC 49.22 MISC	C COST	A A		OPERATING ROOM RECOVERY ROOM	50.00 51.00	0	
	COST	A		DELIVERY ROOM & LABOR ROOM	52.00	0	
49.24 MISC		А		RADI OLOGY-DI AGNOSTI C	54.00	0	
	C COST C COST	A A		RADI OLOGY-THERAPEUTI C CT SCAN	55.00 57.00	0	49.25 49.26
	COST	A		MRI	58.00	0	
49.28 MI SC	COST	A		LABORATORY	60.00	0	49.28
49.29 MISC	COST	A	0	WHOLE BLOOD & PACKED RED	62.00	0	49.29
49.30 MISC	C COST	А	_2 0/2	BLOOD CELL RESPI RATORY THERAPY	65.00	0	49.30
	COST	A		PHYSICAL THERAPY	66.00	0	
49.32 MI SC	C COST	A	-263	OCCUPATI ONAL THERAPY	67.00	0	49.32
	C COST	A			68.00	0	
	C COST C COST	A A		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69.00 70.00	0	49.34 49.35
	C COST	A		CARDI AC REHAB	75. 01	0	
	COST	A		PALN MANAGEMENT	75.04	0	
	C COST	A		CLINIC PATIENT TREATMENT CENTER	90.00 90.01	0	49.38 49.39
	C COST C COST	A A		MENTAL HEALTH O/P	90.01	0	
	COST	A		WOUND CARE	90.06	0	
	COST	A		EMERGENCY	91.00	0	
	C COST C COST	A A		PARAMED ED PRGM-PARAMED EDU ANESTHESI OLOGY	23.00 53.00	0	49.43 49.44
	COST	A		RADI OI SOTOPE	53.00	0	49.44
	AL (sum of lines 1 thru 49)		-117, 285, 542			0	50.00
(T	ansfer to Worksheet A,			1	1		1

Health Financial Systems		CENTRAL DUPA	GE HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 14-0242	Period: From 09/01/2021	Worksheet A-8	
					Date/Time Pre 1/28/2023 6:3	pared: 0 pm
			Expense Classification of	on Worksheet A		
			To/From Which the Amount i	s to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(2) Additional determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	CENTRAL DUPA	AGE HOSPI TAL	In Lie	u of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 14-0242	Period: From 09/01/2021	Worksheet A-8	-1
OFFI CE				To 08/31/2022	Date/Time Pre 1/28/2023 6:3	pared: 0 pm
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5.60	ADMINISTRATION & GENERAL	HOME OFFICE COST	217, 574, 827	244, 052, 474	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			217, 574, 827	244, 052, 474	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which h_{1} been nosted to Worksheet A columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part

nas no	t been posted to worksneet A,	corumns r and/or 2, the amou	nt arrowable sr	iourd be rhdrcated rh corullin	4 of this part.				
				Related Organization(s) and/	or Home Office				
	Symbol (1)	Name	Percentage of	Name	Percentage of				
			Ownershi p		Ownershi p				
	1.00	2.00	3.00	4.00	5.00				
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

i ci indui sch					
6.00	В	NMHC	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100. 00 G.	Other (financial or				100.00
Inor	-financial) specify:				

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Health Financial Systems	CENTRAL DUPAGE	HOSPI TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELAT	ED ORGANIZATIONS AND HOME	Provider CCN: 14-0242		Worksheet A-8-1
OFFICE COSTS			From 09/01/2021 To 08/31/2022	Date/Time Prepared

			1/28/2023 6:3	30 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	-26, 477, 647	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-26, 477, 647			5.00

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

 as not	Deen posted to worksheet A,	COLUMNS		Ζ,	the amount	. allowable	Shourd L	TH COLUMN 4 OF	this part.	
	Related Organization(s)									
	and/or Home Office									
	Type of Business	1								
	51									
	6, 00									
	B. INTERRELATIONSHIP TO RELA	IED ÜRGAN	IZATION(S)	AND/OR HOM	E OFFICE:				

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

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

6.00 7.00 8.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
9. 00 10. 00	10.00
100.00	100.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th	Financial Syste	ems	CENTRAL DUPA	AGE HOSPITAL		In Lie	eu of Form CMS-	2552-10
PROVI D	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (Period: From 09/01/2021 To 08/31/2022		epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	1/28/2023 6: 3 Physi ci an/Prov	
	intst. A Erne #	I denti fi er	Remuneration	Component	Component		ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		AGGREGATE-ADMINISTRATION & GENERAL	2, 179, 720	2, 179, 720	(211, 500	0	1.00
2.00		AGGREGATE-NURSI NG ADMI NI STRATI ON	4, 813	4, 813	(0 0	0	2.00
3.00	15.00	AGGREGATE-PHARMACY	5, 900	5, 900	(0 0	0	3.00
4.00	17.00	AGGREGATE-SOCIAL SERVICE	15, 785	0	15, 78	5 211, 500	105	4.00
5.00		AGGREGATE-PARAMED ED PRGM-PARAMED ED	39, 902	5, 247	34, 65	5 211, 500	239	5.00
6.00		AGGREGATE-ADULTS & PEDI ATRI CS	15, 154, 117	15, 154, 117	(211, 500	0	6.00
7.00	40.00	AGGREGATE-SUBPROVI DER – I PF	421, 277	421, 277	(0 181, 300	0	7.00
8.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	676, 238	676, 238	(0 0	0	8.00
9.00	53.00	AGGREGATE-ANESTHESI OLOGY	115, 500	115, 500	(0 0	0	9.00
10.00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST I C	0	0	(0 0	0	10.00
11.00	55.00	AGGREGATE-RADI OLOGY-THERAPEU TI C	100, 000	0	100, 00	271, 900	400	11.00
12.00	56.00	AGGREGATE-RADI OI SOTOPE	680	680	(0 0	0	12.00
13.00	60.00	AGGREGATE-LABORATORY	177, 876	177, 876	(0 0	0	13.00
14.00	66.00	AGGREGATE-PHYSI CAL THERAPY	0	0	(0 0	0	14.00
15.00	67.00	AGGREGATE-OCCUPATI ONAL THERAPY	0	0	(0 0	0	15.00
16.00	69.00	AGGREGATE-ELECTROCARDI OLOGY	2, 090, 216	2, 090, 216	(0 0	0	16.00
17.00		AGGREGATE-ELECTROENCEPHALOGR APHY	44, 825	21, 025	23, 80	271, 900	136	17.00
18.00	90.00	AGGREGATE-CLI NI C	29, 403	29, 403	(211, 500	0	18.00
19.00	90.01	AGGREGATE-PATIENT TREATMENT CENTER	0	0	(0 179,000	0	19.00
20.00	90.04	AGGREGATE-MENTAL HEALTH O/P	0	0	(o o	0	20.00
21.00	91.00	AGGREGATE-EMERGENCY	229, 925	229, 925	(o o	0	21.00
200.00			21, 286, 177	21, 111, 937	174, 24	D	880	200.00

Heal th	Financial System	ms	CENTRAL DUP	AGE HOSPITAL		In Lieu of Form CMS-2552-10			
PROVI DE	ER BASED PHYSICI	AN ADJUSTMENT		Provider (CCN: 14-0242	Period: From 09/01/2021	Worksheet A-8	3-2	
						To 08/31/2022			
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physi ci an Cost		
		I denti fi er	Limit	Unadjusted RCE			of Mal practi ce		
				Limit	Conti nui ng	Share of col.	Insurance		
	1.00	0.00	0.00	0.00	Education	12	14.00		
1.00	1.00	2.00 AGGREGATE-ADMINISTRATION &	8.00	9.00	12.00	13.00 0 0	14.00	1.00	
1.00		GENERAL	0	0		0 0	0	1.00	
2.00		AGGREGATE-NURSI NG	0	0		0 0	0	2.00	
2.00		ADMI NI STRATI ON					0	2.00	
3.00		AGGREGATE-PHARMACY	0	0		0 0	0	3.00	
4.00		AGGREGATE-SOCIAL SERVICE	10, 677	534		0 0	0	4.00	
5.00		AGGREGATE-PARAMED ED	24, 302			0 0	0	5.00	
	F	PRGM-PARAMED ED							
6.00		AGGREGATE-ADULTS &	0	0		0 0	0	6.00	
		PEDI ATRI CS							
7.00		AGGREGATE-SUBPROVIDER - IPF	0	0		0 0	0		
8.00		AGGREGATE-DELIVERY ROOM &	0	0		0 0	0	8.00	
		_ABOR ROOM		_			_		
9.00		AGGREGATE - ANESTHESI OLOGY	0	0		0 0	0		
10.00		AGGREGATE-RADI OLOGY-DI AGNOST	0	0		0 0	0	10.00	
11.00		AGGREGATE-RADI OLOGY-THERAPEU	52, 289	2, 614		o o	0	11.00	
	1	TIC							
12.00		AGGREGATE-RADI OI SOTOPE	0	0		0 0	0		
13.00		AGGREGATE-LABORATORY	0	0		0 0	0	13.00	
14.00		AGGREGATE-PHYSI CAL THERAPY	0	0		0 0	0	14.00	
15.00		AGGREGATE-OCCUPATI ONAL THERAPY	0	0		0 0	0	15.00	
16.00	69. 00 <i>4</i>	AGGREGATE-ELECTROCARDI OLOGY	0	0		o o	0	16.00	
17.00		AGGREGATE-ELECTROENCEPHALOGR	17, 778	889		0 0	. O	17.00	
18.00		APHY AGGREGATE-CLINIC					0	18,00	
18.00		AGGREGATE-CLINIC							
17.00		CENTER				۵ ۱	0	17.00	
20.00		AGGREGATE-MENTAL HEALTH 0/P	n –	n –		0 0	0	20.00	
21.00		AGGREGATE-EMERGENCY	0	0		0 0	0	21.00	
200.00			105, 046	5, 252		0 0	0	200.00	
			•		,	•			

Heal th	Financial Syste	ems	CENTRAL DUP	AGE HOSPI TAL		In Lie	u of Form CMS-2552-1	10
PROVI D	ER BASED PHYSIC		-		CCN: 14-0242	Period: From 09/01/2021 To 08/31/2022	Worksheet A-8-2 Date/Time Prepared: 1/28/2023 6:30 pm	:
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Di sal I owance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		AGGREGATE-ADMINISTRATION & GENERAL	0	0	(2, 179, 720	1.00	0
2.00		AGGREGATE-NURSI NG ADMI NI STRATI ON	0	0	(4, 813	2.00	0
3.00	15.00	AGGREGATE-PHARMACY	0	0	(5, 900	3.00	0
4.00	17.00	AGGREGATE-SOCIAL SERVICE	0	10, 677	5, 10	5, 108	4.00	0
5.00		AGGREGATE-PARAMED ED PRGM-PARAMED ED	0	24, 302	10, 35	3 15,600	5.00	0
6.00		AGGREGATE-ADULTS & PEDI ATRI CS	0	0		0 15, 154, 117	6.00	0
7.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	(0 421, 277	7.00	
8.00		AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0		676, 238	8.00	
9.00		AGGREGATE-ANESTHESI OLOGY	0	0	(0 115, 500	9.00	
10.00		AGGREGATE-RADI OLOGY-DI AGNOST I C	0	0		0 0	10.00	0
11.00		AGGREGATE-RADI OLOGY-THERAPEU TI C	0	52, 289	47, 71	1 47, 711	11.00	0
12.00		AGGREGATE-RADI OI SOTOPE	0	0	(086 0	12.00	
13.00		AGGREGATE-LABORATORY	0	0	(0 177, 876	13.00	
14.00		AGGREGATE-PHYSI CAL THERAPY	0	0	(0 0	14.00	
15.00		AGGREGATE-OCCUPATI ONAL THERAPY	0	0		0 0	15.00	
16.00		AGGREGATE-ELECTROCARDI OLOGY	0	0		2, 090, 216	16.00	
17.00		AGGREGATE-ELECTROENCEPHALOGR APHY	0	17, 778	6, 02	2 27,047	17.00	0
18.00		AGGREGATE-CLI NI C	0	0	(29, 403	18.00	
19.00		AGGREGATE-PATIENT TREATMENT CENTER	0	0		0 0	19.00	
20.00		AGGREGATE-MENTAL HEALTH O/P	0	0	(0 0	20.00	
21.00		AGGREGATE-EMERGENCY	0	0	(229, 925	21.00	
200.00			0	105, 046	69, 19	4 21, 181, 131	200.00	0

	Financial Systems	CENTRAL DUPAGE HOSPIT				u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C	F	eriod: rom 09/01/2021 o 08/31/2022	Worksheet B Part I Date/Time Pre	nared
				_ATED COSTS	0 00/31/2022	1/28/2023 6: 3	
	Cost Center Description	Net Expenses for Cost Allocation	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	NON PATIENT TELEPHONES	
		(from Wkst A col. 7)					
		0	1.00	2.00	4.00	5. 10	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	27, 120, 411	27, 120, 411	[1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	15, 175, 991	27, 120, 411	15, 175, 991			2.00
4.00 5.10	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NON PATIENT TELEPHONES	0	0 421, 390	0 235, 705	0	657, 095	4.00 5.10
5. 10 5. 30	00560 PURCHASING AND STORES	0	421, 390	235,705	0	057,095	5.10
5.40	00570 ADMI TTI NG	0	0	0	-	0	5.40
5.50 5.60	00580 ACCOUNTS RECEIVABLE AND CASHIERS 00590 ADMINISTRATION & GENERAL	0 224, 403, 424	0 849, 950	0 475, 420	-	0 32, 629	5.50 5.60
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	29, 901, 499 487, 942	14, 293, 513 73, 041	7, 995, 083 40, 856		21, 868 521	7.00 8.00
9.00	00900 HOUSEKEEPI NG	10, 040, 525	240, 439	134, 490	-	6, 422	1
10.00	01000 DI ETARY	5, 982, 989	257, 725	144, 159		5, 033	
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	1, 363, 714	200, 223	111, 995 0		2, 603 0	1
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 249, 035	103, 215	57, 733	-	12, 843	1
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	10, 510, 890	150, 556	84, 213		8, 852	
15.00 16.00	01600 MEDICAL RECORDS & LIBRARY	7, 866, 047	89, 572 0	50, 102 0	0	10, 066 0	15.00 16.00
17.00	01700 SOCI AL SERVI CE	6, 341, 967	22, 249	12, 445		0	17.00
19.00 20.00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM	0	0	0	0	0	19.00 20.00
20.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	20.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM-PARAMED EDU	635, 877	15, 005	8, 393	0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	65, 408, 944	2, 887, 149	1, 614, 928		100, 838	30.00
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	15, 118, 861 4, 909, 576	510, 222 124, 382	285, 393 69, 573		26, 207 0	31.00 32.00
32.00	02060 NEONATAL INTENSIVE CARE UNIT	9, 071, 059	163, 443	91, 422		5, 727	
40.00	04000 SUBPROVIDER - IPF	9, 297, 039		340, 914		14, 579	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 931, 377	139, 017	77, 759	0	6, 942	43.00
50.00	05000 OPERATI NG ROOM	28, 725, 801	1, 388, 449	776, 630		77, 928	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	9, 418, 334 10, 449, 578	177, 189 361, 606	99, 111 202, 265	0	1, 909 30, 373	
53.00	05300 ANESTHESI OLOGY	3, 101, 580	25, 448	14, 234		8, 331	
	05400 RADI OLOGY-DI AGNOSTI C	8, 735, 996					54.00
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	13, 283, 752 2, 247, 483	582, 389 48, 615	325, 760 27, 193		38, 009 174	
57.00	05700 CT SCAN	3, 063, 060	75, 722	42, 355		694	57.00
58.00 60.00	05800 MRI 06000 LABORATORY	4, 558, 599 125, 183, 768		34, 451 408, 681	0	1, 215 26, 555	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	4, 783, 984	25, 611	14, 326	0	1, 215	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	1, 208, 522 6, 348, 638	9, 169 73, 426	5, 129 41, 071	0	521 3, 992	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	13, 257, 240		85, 249	-	13, 190	1
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	2, 202, 886	4, 681 6, 799	2, 618		868 521	1
68.00 69.00	06900 ELECTROCARDI OLOGY	9, 854, 350	486, 122	3, 803 271, 912		23, 430	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 589, 084	65, 116	36, 423	0	2, 951	70.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	30, 551, 149 32, 004, 922		0		0	71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	92, 999, 337	0	0	0	0	73.00
74.00 75.01	07400 RENAL DI ALYSI S	3, 091, 201	0	0	0	0	
75.01 75.02	07501 CARDI AC REHAB 07502 SLEEP LAB	669, 096 0	0	0	0	0	75.01 75.02
75.03	07503 INPATIENT DIALYSIS	0	0	0	0	0	75.03
75.04 76.97	07504 PAIN MANAGEMENT 07697 CARDIAC REHABILITATION	751,050	44, 571	24, 931	0	0	75.04 76.97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.97
76.99		0	0	0	0	0	76.99
90.00	OUTPATI ENT SERVI CE COST CENTERS	1, 518, 187	310, 266	173, 547	0	79, 143	90.00
90.01	09001 PATIENT TREATMENT CENTER	2, 404, 931	125, 108	69, 979	0	12, 670	90.01
90.02 90.03	09002 REHAB SERVI CES-BLOOMI NGDALE 09003 CANTERA	0	0	0		0	
70.03		0	0	0	0	0	70.03

Health Financial Systems	CENTRAL DUPAG	E HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	Period: From 09/01/2021 To 08/31/2022	Worksheet B Part I Date/Time Pre 1/28/2023 6:3	pared:
		CAPI TAL REL	ATED COSTS		172072023 0. 3	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	NON PATIENT TELEPHONES	
	0	1.00	2.00	4.00	5. 10	
90.04 09004 MENTAL HEALTH 0/P	1, 710, 967	80, 522	45, 040	0 0	2, 777	90.04
90.05 09005 WOMENS CLINIC	0	0		0 0	0	90.05
90.06 09006 WOUND CARE	225, 287	3, 244	1, 815	5 0	1, 736	90.06
91.00 09100 EMERGENCY	19, 757, 230	604, 327	338, 030	0 0	29, 852	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
99. 10 09910 CORF	0	0	(0 0	0	99.10
99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY	0	0	(0 0	0	99.20
99. 30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY	0	0	(0 0	0	99.30
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	(0 0	0	99.40
SPECIAL PURPOSE COST CENTERS				1		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	883, 815, 801	27,087,349	15, 151, 324	1 0	655, 880	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	404, 827	30, 233				190.00
190. 01 19001 KOFEE KORNER	0	0	(190. 01
191. 00 19100 RESEARCH	1, 108, 389	2, 829	1, 583			191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	8, 908, 118	0	6, 173			192.00
192. 01 19201 WSKF	0	0	(0		192.01
193. 01 19301 DEVELOPMENT	0	0	(0		193.01
193. 02 19302 MARKETI NG	0	0	(0		193.02
193. 04 19303 PHYSI CI AN ANSWERI NG SERVI CE	0	0	(0		193.04
193.05 19304 CAR SEAT SAFETY PROGRAM	0	0	(0		193.05
193. 07 19305 JOINT VENTURE	0	0	(0 0		193.07
193. 08 19306 PARKI NSONS CENTER	0	0	(0	0	193.08
200.00 Cross Foot Adjustments		_			-	200.00
201.00 Negative Cost Centers	004 007 105	0	(0		201.00
202.00 TOTAL (sum lines 118 through 201)	894, 237, 135	27, 120, 411	15, 175, 991	0	657, 095	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	CENTRAL DUPAG			<u>In Lie</u> eriod: om 09/01/2021	u of Form CMS-2 Worksheet B Part I	2552-10
				To			pared:
	Cost Center Description	PURCHASI NG AND STORES	ADMI TTI NG	ACCOUNTS RECEI VABLE AND CASHI ERS	Subtotal	ADMI NI STRATI ON & GENERAL	
		5.30	5.40	5.50	5A. 50	5.60	
1.00 2.00 4.00 5.10 5.30 5.40	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MUBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NON PATIENT TELEPHONES 00560 PURCHASING AND STORES 00570 ADMITTING	0	(1.00 2.00 4.00 5.10 5.30 5.40
5.50 5.60	00580 ACCOUNTS RECEIVABLE AND CASHIERS 00590 ADMINISTRATION & GENERAL	0	(225, 761, 423	225, 761, 423	5.50 5.60
15.00 16.00 17.00 19.00 20.00 21.00 22.00	00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV				0 52, 211, 963 602, 360 10, 421, 876 6, 389, 906 1, 678, 535 0 2, 422, 826 10, 754, 511 8, 015, 787 1, 720 6, 376, 661 0 0 0	$\begin{array}{c} 0\\ 17, 633, 337\\ 203, 433\\ 3, 519, 738\\ 2, 158, 037\\ 566, 885\\ 0\\ 818, 251\\ 3, 632, 078\\ 2, 707, 140\\ 581\\ 2, 153, 564\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	$\begin{array}{c} 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$
23.00	02300 PARAMED ED PRGM-PARAMED EDU I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	(0 0	659, 275	222, 654	23.00
30.00 31.00 32.00 35.00 40.00 43.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04300 NURSERY ANCILLARY SERVICE COST CENTERS			0 0 0 0 0 0	70, 011, 859 15, 940, 683 5, 103, 531 9, 331, 651 10, 262, 013 2, 155, 095	23, 644, 825 5, 383, 583 1, 723, 595 3, 151, 541 3, 465, 749 727, 832	31.00 32.00 35.00 40.00
$\begin{array}{c} 60.\ 00\\ 62.\ 00\\ 62.\ 30\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 70.\ 00\\ 70.\ 00\\ 71.\ 00\\ 71.\ 00\\ 73.\ 00\\ 73.\ 00\\ 74.\ 00\\ 75.\ 01\\ 75.\ 01\\ 75.\ 02\\ 75.\ 03\\ 75.\ 04\\ 76.\ 97\\ 76.\ 98\\ 76.\ 99\\ \end{array}$	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-THERAPEUTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 06900 ELECTROCARDI OLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07501 CARDI AC REHAB 07503 I NPATI ENT DI ALYSI S 07504 PAI N MANAGEMENT 07697 CARDI AC REHAB LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY 00TPATI ENT SERVICE COST CENTERS 00200 (LIMIC				30, 968, 808 9, 696, 543 11, 043, 822 3, 149, 593 9, 548, 645 14, 229, 910 2, 323, 465 3, 181, 831 4, 655, 856 126, 349, 638 4, 825, 136 0 1, 223, 341 6, 467, 127 13, 508, 086 2, 211, 053 1, 312, 025 10, 635, 814 2, 693, 574 30, 551, 149 32, 004, 922 92, 999, 337 3, 091, 201 669, 096 0 820, 552 0 0 0	10, 458, 972 3, 274, 775 3, 729, 786 1, 063, 699 3, 224, 826 4, 805, 811 784, 695 1, 074, 587 1, 572, 404 42, 671, 352 1, 629, 574 0 413, 154 2, 184, 117 4, 562, 032 746, 730 443, 105 3, 591, 991 909, 690 10, 317, 917 10, 808, 894 31, 408, 294 1, 043, 979 225, 971 0 0 277, 122 0 0 0	51.00 52.00 53.00 54.00 55.00 56.00 57.00 58.00 62.00 62.00 62.00 62.00 65.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 75.01 75.02 75.03 75.04 76.98 76.99
90. 03 90. 04 90. 05 90. 06	09000 CLINIC 09001 PATIENT TREATMENT CENTER 09002 REHAB SERVICES-BLOOMINGDALE 09003 CANTERA 09004 MENTAL HEALTH 0/P 09005 WOMENS CLINIC 09006 WOUND CARE 09100 EMERGENCY				2, 081, 143 2, 612, 688 0 0 1, 839, 306 0 232, 082 20, 729, 439	702, 856 882, 373 0 621, 181 78, 380 7, 000, 871	90. 01 90. 02 90. 03 90. 04 90. 05 90. 06

Health Financial Systems	CENTRAL DUPAG	E HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	F	eriod: rom 09/01/2021	Worksheet B Part I	
			T	0 08/31/2022	Date/Time Pre 1/28/2023 6:3	
Cost Center Description	PURCHASI NG AND	ADMI TTI NG	ACCOUNTS	Subtotal	ADMI NI STRATI ON	
	STORES		RECEI VABLE AND		& GENERAL	
	5.00	F 40	CASHI ERS	54 50	F (0	
02.00 00200 ODCEDVATION DEDC (NON DICTINCT DADT	5.30	5.40	5.50	5A. 50	5.60	00.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REI MBURSABLE COST CENTERS				0		92.00
99. 10 09910 CORF				0	0	99.10
99. 10 109910 CORP 99. 20 109920 OUTPATI ENT PHYSI CAL THERAPY	0	(0	0	99.10
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0			0	0	99.30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	(0	0	99.40
SPECIAL PURPOSE COST CENTERS	0	(0	0	77.40
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	(0 0	883, 756, 857	222, 221, 961	118.00
NONREI MBURSABLE COST CENTERS	1 -1					
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	(0 0	451, 971	152, 642	190.00
190. 01 19001 KOFEE KORNER	0	(0 0	0	0	190.01
191. 00 19100 RESEARCH	0	(0 0	1, 114, 016	376, 232	191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	(0 0	8, 914, 291	3, 010, 588	192.00
192. 01 19201 WSKF	0	(0 0	0	0	192.01
193. 01 19301 DEVELOPMENT	0	C	0 0	0		193.01
193. 02 19302 MARKETI NG	0	(0 0	0		193.02
193. 04 19303 PHYSI CI AN ANSWERI NG SERVI CE	0	(0 0	0		193.04
193.05 19304 CAR SEAT SAFETY PROGRAM	0	(0 0	0		193.05
193. 07 19305 JOINT VENTURE	0	C	0 0	0		193.07
193. 08 19306 PARKI NSONS CENTER	0	(0 0	0		193.08
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers	0	(0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	(0 0	894, 237, 135	225, 761, 423	202.00

COST	n Financial Systems ALLOCATION - GENERAL SERVICE COSTS		Provider C	F	Period: From 09/01/2021	Worksheet B Part I	
					To 08/31/2022	1/28/2023 6:3	
	Cost Center Description	MAINTENANCE & REPAIRS	PLANT	LAUNDRY & LINEN SERVICE		DI ETARY	
	GENERAL SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.10	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NON PATIENT TELEPHONES						4.00
5.30	00560 PURCHASING AND STORES						5.30
5.40	00570 ADMI TTI NG						5.40
5.50	00580 ACCOUNTS RECEIVABLE AND CASHIERS						5.50
5.60	00590 ADMINI STRATI ON & GENERAL						5.6
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT		69, 845, 300				6.00
8.00	00800 LAUNDRY & LINEN SERVICE				5		8.00
9.00	00900 HOUSEKEEPI NG	C					9.00
10.00		C	1, 556, 284			10, 458, 165	
11.00		0	1, 209, 052			0	
12.00 13.00			623, 265		0 0 0 141, 746	0	
14.00			909, 137			0	
15.00		C	540, 884			0	
16.00		C	0 0			0	
17.00		C	134, 349		30, 554	0	
19.00 20.00						0	
21.00					-	0	
22.00		C	-			0	
23.00		C	90, 610) (20, 607	0	23.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS		17 101 150				
30.00 31.00						8, 578, 908 962, 052	
32.00						902,052	
35.00		C				0	
40.00		C				917, 205	
43.00		C	839, 458	3 16, 023	3 190, 914	0	43.00
50.00	ANCILLARY SERVICE COST CENTERS	C	8, 384, 202	134, 432	2 1, 906, 779	0	50.00
51.00						0	
52.00		C				0	
53.00		C	153, 670			0	53.00
54.00		C	2, 981, 618			0	
55.00 56.00		0) 3, 516, 778 293, 564			0	
57.00			457, 252	1		0	
58.00		C				0	58.00
	06000 LABORATORY	C	4, 411, 961			0	
62.00 62.30		0	154,653		35, 172	0	
64.00			55, 368		12, 592	0	
65.00		C	443, 388			0	
66.00		C	920, 318			0	
67.00		C	28, 265			0	
68.00 69.00			41, 056 2, 935, 463		0 9, 337 9 667, 598	0	
70.00		0	393, 208		89, 425	0	
71.00		C	C		0 0	0	
72.00		C	C		0 0	0	
73.00		C C				0	
74.00 75.01	07400 RENAL DI ALYSI S 07501 CARDI AC REHAB					0	
75.02						0	
75.03		C				0	
75.04		C	269, 145	5 C	61, 210	0	
76. 97 76. 98						0	
	07699 LI THOTRI PSY					0	
, ,	OUTPATIENT SERVICE COST CENTERS]
90.00	09000 CLI NI C	C				0	
90.01		C	755, 467			0	
90.02						0	
90. 03 90. 04			486, 233		110, 582	0	90.03 90.04
90.04 90.05			400, 233		0 0	0	90.02
90.06		0	19, 589		4, 455	0	90.06
91.00	09100 EMERGENCY	C	3, 649, 249			0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1	1	1	1		92.0

Health Financial Systems	CENTRAL DUPA	GE HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 09/01/2021 To 08/31/2022	Worksheet B Part I Date/Time Pre 1/28/2023 6:3	
Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	6.00	7.00	8.00	9.00	10.00	
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	0		0 0	0	99.10
99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY	0	0		0 0	0	99.20
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0		0 0	0	99.30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0		0 0	0	99.40
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	69, 579, 017	1, 246, 85	5 15, 393, 514	10, 458, 165	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	182, 561		0 0	0	190.00
190. 01 19001 KOFEE KORNER	0	0		0 0	0	190.01
191. 00 19100 RESEARCH	0	17, 084		0 0	0	191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	66, 638		0 0	0	192.00
192. 01 19201 WSKF	0	0		0 0	0	192.01
193. 01 19301 DEVELOPMENT	0	0		0 0	0	193.01
193. 02 19302 MARKETI NG	0	0		0 0	0	193.02
193. 04 19303 PHYSICIAN ANSWERING SERVICE	0	0		0 0	0	193.04
193.05 19304 CAR SEAT SAFETY PROGRAM	0	0		0 0	0	193.05
193. 07 19305 JOINT VENTURE	0	0		0 0	0	193.07
193. 08 19306 PARKI NSONS CENTER	0	0		0 0	0	193.08
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	69, 845, 300	1, 246, 85	5 15, 393, 514	10, 458, 165	202.00

Health Financial Systems	CENTRAL DUPAG	E HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C		Period: From 09/01/2021	Worksheet B Part I	
				08/31/2022	Date/Time Pre 1/28/2023 6:3	pared:
Cost Center Description	CAFETERIA	MAINTENANCE OF		CENTRAL	PHARMACY	
		PERSONNEL	ADMI NI STRATI ON			
	11.00	12.00	13.00	SUPPLY 14.00	15.00	
GENERAL SERVICE COST CENTERS			i i	- -		
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 10 00540 NON PATIENT TELEPHONES						5.10
5. 30 00560 PURCHASI NG AND STORES 5. 40 00570 ADMI TTI NG						5.30 5.40
5. 50 00580 ACCOUNTS RECEIVABLE AND CASHI ERS						5.50
5. 60 00590 ADMI NI STRATI ON & GENERAL						5.60
6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT						6.00 7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	2 720 441					10.00
11. 00 01100 CAFETERIA 12. 00 01200 MAI NTENANCE OF PERSONNEL	3, 729, 441	0				11.00 12.00
13.00 01300 NURSING ADMINISTRATION	21, 032	0				13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	92, 807 83, 949	0			11 514 107	14.00
16.00 01600 MEDICAL RECORDS & LIBRARY	83, 949	0			11, 514, 107 12	15.00 16.00
17.00 01700 SOCI AL SERVI CE	63, 771	0			0	17.00
19.00 01900 NONPHYSI CLAN ANESTHETI STS	0	0	(0	19.00
20.00 02000 NURSING PROGRAM 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	-	-	0	20.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	-	-	0	22.00
23.00 O2300 PARAMED ED PRGM-PARAMED EDU	4, 080	0	580	33, 617	461	23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	657, 627	0	1, 318, 562	618, 666	3, 255	30.00
31. 00 03100 I NTENSI VE CARE UNI T	117, 880	0			382	31.00
32.00 03200 CORONARY CARE UNIT	41, 469	0			143	
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF	79, 364 115, 018	0 0			247 34	35.00 40.00
43. 00 04300 NURSERY	20, 061	0			0	43.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	232, 069 93, 908	0 0			16, 599 1, 494	50.00 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	100, 863	0			1, 868	
53.00 05300 ANESTHESI OLOGY	14, 402	0			29, 374	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	87, 083 131, 699	0			8, 510 28, 932	54.00 55.00
56. 00 05500 RADI 010001-1112RAPE0110	8,004	0			76, 002	1
57.00 05700 CT SCAN	28, 816	0	3, 252		0	
58.00 05800 MRI 60.00 06000 LABORATORY	34, 981 1, 001, 295	0	21 4, 729		833 10, 988	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	20, 683	0	4,725		10, 988	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(-	0	62.30
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	9, 441 51, 713	0	30, 935 99		7 75	64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	163, 494	0			50	
67.00 06700 OCCUPATI ONAL THERAPY	25, 863	0	C	-,	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	14, 583 84, 363	0	95, 689	210	0 12, 469	68.00 69.00
70. 00 07000 ELECTROCARDI OLOGY	24, 257	0	95,089	57, 823	12, 469	70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	5, 173, 023	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		5, 428, 418 0 0	0 11, 309, 974	72.00
74.00 07400 RENAL DIALYSIS	0	0			11, 309, 974	73.00
75. 01 07501 CARDI AC REHAB	8, 392	0	11, 298	3 1, 113	31	75.01
75. 02 07502 SLEEP LAB 75. 03 07503 I NPATI ENT DI ALYSI S	0	0			0	75.02 75.03
75.04 07504 PAIN MANAGEMENT	6, 463	0	12, 936	, i	2, 272	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	(0	0	76.97
76.98 07698 HYPERBARI C OXYGEN THERAPY	0	0		-	0	76.98
76. 99 07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0	(0	0	76.99
90. 00 09000 CLINIC	63, 343	0	73, 055	5 17, 884	155	90.00
90. 01 09001 PATI ENT TREATMENT CENTER	26, 757	0	47, 048		703	
90. 02 09002 REHAB SERVI CES-BLOOMI NGDALE 90. 03 09003 CANTERA	0	0		-	0	90.02 90.03
90. 03 09003 CANTERA 90. 04 09004 MENTAL HEALTH 0/P	25, 254	0	3, 271	, o	0	90.03
90. 05 09005 WOMENS CLINIC	0	0	(0 0	0	90.05
90. 06 09006 WOUND CARE 91. 00 09100 EMERGENCY	2, 551 158, 287	0	8, 615 310, 104		656 8, 581	
	130, 207	0	1 510, 102	JZJ, Z74	0, 301	1 /1.00

Health Financial Systems	CENTRAL DUPA	GE HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C		eriod: rom 09/01/2021 o 08/31/2022	Worksheet B Part I Date/Time Pre 1/28/2023 6:3	
Cost Center Description	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
	11.00	12.00	13.00	14.00	15.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS		•				1
99.10 09910 CORF	0	C	0 0	0	0	99.10
99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY	0	C	0 0	0	0	99.20
99. 30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY	0	C	0 0	0	0	99.30
99. 40 09940 OUTPATI ENT SPEECH PATHOLOGY	0	C	0 0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 715, 622	C	4, 020, 041	15, 595, 346	11, 514, 107	118.00
NONREI MBURSABLE COST CENTERS	r					
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	1, 256	C	0 0	0		190.00
190. 01 19001 KOFEE KORNER	0	C	0 0	0		190. 01
191. 00 19100 RESEARCH	12, 472	C	7, 079	24		191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	91	C	0 0	0		192.00
192. 01 19201 WSKF	0	C	0 0	0		192.01
193. 01 19301 DEVELOPMENT	0	C	0 0	0		193.01
193. 02 19302 MARKETI NG	0	C	0 0	0		193. 02
193. 04 19303 PHYSI CI AN ANSWERI NG SERVI CE	0	C	0 0	0		193.04
193.05 19304 CAR SEAT SAFETY PROGRAM	0	C	0 0	0		193.05
193. 07 19305 JOINT VENTURE	0	C	0 0	0		193.07
193. 08 19306 PARKI NSONS CENTER	0	C	0 0	0	0	193. 08
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	C	0 0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	3, 729, 441	C	4, 027, 120	15, 595, 370	11, 514, 107	202.00

Health Financial Systems	CENTRAL DUPA	GE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	CN: 14-0242	Period: From 09/01/2021 To 08/31/2022	Worksheet B Part I Date/Time Pre	pared:
					1/28/2023 6:3 I NTERNS &	0 pm
					RESI DENTS	
Cost Center Description	MEDI CAL RECORDS &	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS		SERVI CES-SALAR Y & FRI NGES	
	LI BRARY	17.00			APPRV	
GENERAL SERVICE COST CENTERS	16.00	17.00	19.00	20.00	21.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 10 00540 NON PATIENT TELEPHONES						5.10
5. 30 00560 PURCHASI NG AND STORES						5.30
5. 40 00570 ADMI TTI NG 5. 50 00580 ACCOUNTS RECEI VABLE AND CASHI ERS						5.40 5.50
5. 60 00590 ADMI NI STRATI ON & GENERAL						5.60
6.00 00600 MAINTENANCE & REPAIRS						6.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10.00 01000 DI ETARY						10.00
11.00 01100 CAFETERIA 12.00 01200 MAINTENANCE OF PERSONNEL						11.00 12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	2, 313					15.00 16.00
17.00 01700 SOCIAL SERVICE	2, 313					17.00
19.00 01900 NONPHYSI CLAN ANESTHETI STS	C	-		0		19.00
20.00 02000 NURSING PROGRAM 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV		-		0	0	20.00 21.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	C				_	22.00
23. 00 02300 PARAMED ED PRGM-PARAMED EDU I NPATI ENT ROUTI NE SERVI CE COST CENTERS	C	0				23.00
30. 00 03000 ADULTS & PEDIATRICS	C	6, 256, 862		0 0	0	30.00
31.00 03100 I NTENSI VE CARE UNI T	C			0 0	0	31.00
32.00 03200 CORONARY CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT				0 0 0 0	0	32.00 35.00
40. 00 04000 SUBPROVI DER - I PF	0			0 0	0	40.00
43.00 04300 NURSERY	C	398, 282		0 0	0	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	C	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	C			0 0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY		0		0 0	0	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT_SCAN		0		0 0	0	56.00 57.00
58. 00 05800 MRI	C	0		0 0	0	58.00
60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0		0 0	0	60.00 62.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0		0 0	0	62.30
64.00 06400 I NTRAVENOUS THERAPY	C	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY					0	65.00 66.00
67.00 06700 OCCUPATI ONAL THERAPY	C	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY		0		0 0	0	69.00 70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	C	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS		0		0 0	0	72.00 73.00
74. 00 07400 RENAL DI ALYSI S		0		0 0	0	74.00
75. 01 07501 CARDI AC REHAB	0	0		0 0	0	75.01
75. 02 07502 SLEEP LAB 75. 03 07503 I NPATI ENT DI ALYSI S					0	75.02 75.03
75.04 07504 PAIN MANAGEMENT	C	0		0 0	0	75.04
76. 97 07697 CARDIAC REHABILITATION	0	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 99 07699 LI THOTRI PSY		0		0 0 0 0	0	76. 98 76. 99
OUTPATIENT SERVICE COST CENTERS		-		-		
90.00 09000 CLINIC 90.01 09001 PATIENT TREATMENT CENTER		0		0 0	0	90.00 90.01
90. 02 09002 REHAB SERVI CES-BLOOMI NGDALE		0		ŏ o	0	90.01 90.02
90. 03 09003 CANTERA	C	0		0 0	0	90.03
90. 04 09004 MENTAL HEALTH 0/P 90. 05 09005 WOMENS CLINIC					0	90. 04 90. 05
		. 0	1	0	. 0	

Health Financial Systems	CENTRAL DUPAG	E HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 14-0242	Period: From 09/01/2021 To 08/31/2022		
					I NTERNS & RESI DENTS	
Cost Center Description	RECORDS & LI BRARY	SOCI AL SERVI CE	ANESTHETI STS		SERVI CES-SALAR Y & FRI NGES APPRV	
	16.00	17.00	19.00	20.00	21.00	
90.06 09006 WOUND CARE	0	0		0 0	0	90.06
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
99. 10 09910 CORF	0	0		0 0	0	99.10
99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY	0	0		0 0	0	99.20
99. 30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY	0	0		0 0	0	99.30
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0		0 0	0 0	99.40
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 313	8, 893, 268		0 0	0	118.00
NONREI MBURSABLE COST CENTERS				1		
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0 0		190.00
190. 01 19001 KOFEE KORNER	0	0		0 0		190. 01
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0		0 0		192.00
192. 01 19201 WSKF	0	0		0 0		192.01
193. 01 19301 DEVELOPMENT	0	0		0 0		193.01
193. 02 19302 MARKETI NG	0	0		0 0		193. 02
193. 04 19303 PHYSI CI AN ANSWERI NG SERVI CE	0	0		0 0		193.04
193.05 19304 CAR SEAT SAFETY PROGRAM	0	0		0 0		193.05
193. 07 19305 JOINT VENTURE	0	0		0 0		193.07
193. 08 19306 PARKI NSONS CENTER	0	0		0 0		193.08
200.00 Cross Foot Adjustments				0 0		200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	2, 313	8, 893, 268		0 0	0	202.00

IST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 14-0242	Period: From 09/01/2021 To 08/31/2022	Worksheet B Part I Date/Time Pre 1/28/2023 6:3	
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM-PARAMED EDU	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		22.00	23.00	24.00	25.00	26.00	
2.00 3.00 4.00 5.00 5.00 7.00 7.00 9.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NON PATIENT TELEPHONES 00560 PURCHASING AND STORES 00570 ADMITTING 00580 ACCOUNTS RECEIVABLE AND CASHIERS 00590 ADMINISTRATION & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02100 NURSING PHOREM						$\begin{array}{c} 1.00\\ 2.00\\ 4.00\\ 5.10\\ 5.30\\ 5.50\\ 5.50\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 12.00\\ 13.00\\ 15.00\\ 15.00\\ 16.00\\ 17.00\\ 19.00\\ 20.00\\ 21.00\\ 20.00\\ 21.00\\ 20.00\\ 20.00\\ 21.00\\ 20.00\\$
	02100 I & R SERVI CES-SALARY & FRI NGES APPRV 02200 I & R SERVI CES-OTHER PRGM COSTS APPRV	0					21.00
	02300 PARAMED ED PRGM-PARAMED EDU		1, 031, 884				23.00
2.00 5.00 0.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04300 NURSERY		52, 247 0 0 0	133, 024, 1 27, 495, 6 8, 223, 8 14, 717, 2 20, 063, 3 4, 401, 5	94 0 02 0 40 0 52 0	133, 024, 110 27, 495, 694 8, 223, 802 14, 717, 240 20, 063, 352 4, 401, 553	31.00 32.00 35.00 40.00
). 00	ANCILLARY SERVICE COST CENTERS	0	65, 309	53, 654, 3	80 0	53, 654, 380	50.00
1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 3. 00 5. 000	05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07501 CARDI AC REHAB 07502 SLEEP LAB 07503 I NPATI ENT DI ALYSI S 07504 PAI N MANAGEMENT 07699 LI THOTRI PSY		26, 124 52, 247 39, 185 0 0 0 0 0 26, 124 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14, 754, 2 18, 008, 0 4, 761, 6 16, 709, 7 23, 930, 1 3, 589, 4 4, 966, 0 6, 886, 4 176, 042, 0 7, 178, 1 1, 778, 7 9, 385, 7 19, 397, 2 3, 026, 5 1, 820, 3 18, 222, 6 4, 167, 9 46, 042, 0 48, 242, 2 135, 717, 6 4, 135, 1 915, 9 1, 475, 7	71 0 35 0 72 0 98 0 45 0 64 0 52 0 0 0 24 0 39 0 86 0 34 0 34 0 35 0 00 0 01 0 0 0 0 0 0 0 0 0	14, 754, 271 18, 008, 035 4, 761, 672 16, 709, 772 23, 930, 198 3, 589, 445 4, 966, 064 6, 886, 458 176, 042, 003 7, 178, 152 0 1, 778, 724 9, 385, 739 19, 397, 286 3, 026, 512 1, 820, 354 18, 222, 634 4, 167, 977 46, 042, 089 48, 242, 234 135, 717, 605 4, 135, 180 915, 901 0 1, 475, 727 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 53.\ 00\\ 54.\ 00\\ 55.\ 00\\ 56.\ 00\\ 65.\ 00\\ 62.\ 00\\ 62.\ 00\\ 62.\ 00\\ 62.\ 00\\ 62.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 65.\ 00\\ 65.\ 00\\ 65.\ 00\\ 65.\ 00\\ 65.\ 00\\ 65.\ 00\\ 65.\ 00\\ 75.\ 00\\ 71.\ 00\\ 71.\ 00\\ 71.\ 00\\ 71.\ 00\\ 71.\ 00\\ 71.\ 00\\ 75.\ 00\ 00\\ 75.\ 00\ 00\\ 75.\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ 0$
	OUTPATIENT SERVICE COST CENTERS	0		5, 353, 8		5, 353, 853	
01	09001 PATIENT TREATMENT CENTER	0	0	4, 531, 3	11 0	4, 531, 311	90.0

Health Financial Systems	CENTRAL DUPA	GE HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 14-0242	Period: From 09/01/2021 To 08/31/2022	Worksheet B Part I Date/Time Pre 1/28/2023 6:3	pared: <u>0 pm</u>
Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PRGM-PARAMED EDU	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		
	22.00	23.00	24.00	25.00	26.00	00.01
90. 04 09004 MENTAL HEALTH 0/P	0	0	3, 085, 94		3, 085, 940	
90. 05 09005 WOMENS CLINIC	0	0		0 0	0	90.05
90.06 09006 WOUND CARE	0	0	351, 82		351, 821	90.06
91.00 09100 EMERGENCY	0	679, 215	33, 873, 10	2 0	33, 873, 102	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS						
99. 10 09910 CORF	0	0		0 0	0	99.10
99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY	0	0		0 0	0	99.20
99. 30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY	0	0		0 0	0	99.30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0		0 0	0	99.40
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 031, 884	879, 930, 19	0 0	879, 930, 190	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	788, 43	0 0	788, 430	190.00
190. 01 19001 KOFEE KORNER	0	0		0 0		190. 01
191. 00 19100 RESEARCH	0	0	1, 526, 90	7 0	1, 526, 907	191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0	11, 991, 60	8 0	11, 991, 608	192.00
192. 01 19201 WSKF	0	0		0 0	0	192.01
193. 01 19301 DEVELOPMENT	0	0		0 0	0	193.01
193. 02 19302 MARKETI NG	0	0		0 0	0	193.02
193. 04 19303 PHYSI CLAN ANSWERING SERVI CE	0	0		0 0	0	193.04
193.05 19304 CAR SEAT SAFETY PROGRAM	0	0		0 0	0	193.05
193. 07 19305 JOI NT VENTURE	0	0		0 0	0	193.07
193. 08 19306 PARKI NSONS CENTER	0	0		0 0	0	193.08
200.00 Cross Foot Adjustments	0	0		0 0		200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	1, 031, 884	894, 237, 13	5 0		
				-		

	Financial Systems	CENTRAL DUPAC	E HOSPITAL In Lie Provi der CCN: 14-0242 Period: From 09/01/2021 To 08/31/2022			u of Form CMS-: Worksheet B Part II Date/Time Pre 1/28/2023 6:3	epared:
			CAPI TAL REI	ATED COSTS		172072023 0.3	
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
			1.00	2.00	2A	4.00	
	ENERAL SERVICE COST CENTERS	1		Γ			
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0	0	1
	00540 NON PATIENT TELEPHONES	0	421, 390	235, 70	5 657, 095	0	1
	00560 PURCHASING AND STORES	0	0		0 0	0	
	00570 ADMITTING 00580 ACCOUNTS RECEIVABLE AND CASHIERS	0	0		0 0	0	
	00590 ADMI NI STRATI ON & GENERAL	23, 724, 065	849, 950	475, 42	0 25, 049, 435	0	
	00600 MAINTENANCE & REPAIRS	0	0	110,12	0 0	0	
	00700 OPERATION OF PLANT	0	14, 293, 513			0	
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	73, 041 240, 439	40, 85	-	0	1
	1000 DI ETARY	48, 418	240, 439			0	
	01100 CAFETERI A	37, 613	200, 223			0	11.00
	1200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	
	1300 NURSI NG ADMI NI STRATI ON	0	103, 215			0	
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	150, 556 89, 572			0	
	1600 MEDI CAL RECORDS & LI BRARY	0	0,0,2		0 0	0	
	1700 SOCIAL SERVICE	0	22, 249	12, 44	5 34, 694	0	17.00
	1900 NONPHYSI CI AN ANESTHETI STS	0	0		0 0	0	19.00
	02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	20.00
	2200 I & R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	
23.00 0	2300 PARAMED ED PRGM-PARAMED EDU	0	15, 005	8, 39	3 23, 398	0	
	NPATIENT ROUTINE SERVICE COST CENTERS	4 (0, 070	0.007.440				
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	162, 870 62, 117	2, 887, 149 510, 222			0	1
	3200 CORONARY CARE UNIT	19, 913				0	
	2060 NEONATAL INTENSIVE CARE UNIT	814	163, 443			0	35.00
	4000 SUBPROVI DER – I PF	0	609, 481			0	1
	04300 NURSERY NCI LLARY SERVI CE COST CENTERS	0	139, 017	77, 75	9 216, 776	0	43.00
	05000 OPERATI NG ROOM	3, 600	1, 388, 449	776, 63	0 2, 168, 679	0	50.00
	5100 RECOVERY ROOM	0	177, 189			0	
	D5200 DELIVERY ROOM & LABOR ROOM	20, 247	361, 606			0	1
	15300 ANESTHESI OLOGY 15400 RADI OLOGY-DI AGNOSTI C	0 28	25, 448 493, 765			0	53.00 54.00
	05500 RADI OLOGY-THERAPEUTI C	695	582, 389				
56.00 0	5600 RADI OI SOTOPE	0	48, 615	27, 19	3 75, 808	0	56.00
	05700 CT SCAN	0	75, 722			0	
	15800 MRI 16000 LABORATORY	0	61, 591 730, 634			0	
	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	25, 611	14, 32		0	1
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	
		0	9, 169			0	64.00 65.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	25, 801 193	73, 426 152, 407			0	66.00
	6700 OCCUPATI ONAL THERAPY	0	4, 681	2, 61		0	
	06800 SPEECH PATHOLOGY	0	6, 799			0	1
		0	486, 122			0	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	65, 116		3 101, 539 0 0	0	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	1
	7300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
	07400 RENAL DI ALYSI S	0	0		0 0	0	1
)7501 CARDI AC REHAB)7502 SLEEP LAB	0	0			0	1
	07503 I NPATI ENT DI ALYSI S	0	0		0 0	0	1
75.04 0	7504 PAIN MANAGEMENT	0	44, 571	24, 93	1 69, 502	0	75.04
		0	0		0 0	0	1
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	0		0 0 0 0	0	1
	UTPATIENT SERVICE COST CENTERS	0	0		0	0	10.77
	09000 CLINIC	312, 377	310, 266	173, 54	7 796, 190	0	90.00
	99001 PATIENT TREATMENT CENTER	2, 186	125, 108			0	
	19002 REHAB SERVI CES-BLOOMI NGDALE 19003 CANTERA	0	0			0	
	19003 CANTERA 19004 MENTAL HEALTH 0/P	0	80, 522				90.03
			00, 022	1 +0,04	-1 120,002	0	1 . 0. 07

Health Financial Systems	CENTRAL DUPAG	GE HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	 - 	Period: From 09/01/2021 Fo 08/31/2022	Worksheet B Part II Date/Time Pre 1/28/2023 6:3	
		CAPITAL REL	ATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
90.05 09005 WOMENS CLINIC	0	0	(0 0	0	90.05
90.06 09006 WOUND CARE	0	3, 244	1, 81	5 5, 059	0	90.06
91.00 09100 EMERGENCY	0	604, 327	338, 030	942, 357	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS						1
99. 10 09910 CORF	0	0	(0 0	0	99.10
99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY	0	0	(0 0	0	99.20
99. 30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY	0	0	(0 0	0	99.30
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	(0 0	0	99.40
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	24, 420, 937	27, 087, 349	15, 151, 324	4 66, 659, 610	0	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	30, 233	16, 91	47, 144		190.00
190. 01 19001 KOFEE KORNER	0	0	(0 0		190. 01
191. 00 19100 RESEARCH	0	2, 829	1, 583			191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0	6, 173	6, 173		192.00
192. 01 19201 WSKF	0	0	(0 0		192.01
193. 01 19301 DEVELOPMENT	0	0	(0 0		193.01
193. 02 19302 MARKETI NG	0	0	(0 0		193. 02
193. 04 19303 PHYSI CI AN ANSWERI NG SERVI CE	0	0	(0 0		193.04
193.05 19304 CAR SEAT SAFETY PROGRAM	0	0	(0 0		193.05
193. 07 19305 JOINT VENTURE	0	0	(0 0		193.07
193. 08 19306 PARKI NSONS CENTER	0	0	(0 0	0	193. 08
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	(0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	24, 420, 937	27, 120, 411	15, 175, 99 ⁻	66, 717, 339	0	202.00

Health Financial Systems	CENTRAL DUPAG	GE HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		eriod: rom 09/01/2021	Worksheet B Part II	
				08/31/2022		
Cost Center Description		PURCHASI NG AND	ADMI TTI NG		ADMI NI STRATI ON	
	TELEPHONES	STORES		RECEI VABLE AND CASHI ERS	& GENERAL	
	5.10	5.30	5.40	5. 50	5.60	
GENERAL SERVI CE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT	1					1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	(57.005					4.00
5. 10 00540 NON PATIENT TELEPHONES 5. 30 00560 PURCHASING AND STORES	657, 095 0	0				5.10 5.30
5. 40 00570 ADMI TTI NG	0	0	0			5.40
5. 50 00580 ACCOUNTS RECEIVABLE AND CASHI ERS	0	0	0	0	//	5.50
5. 60 00590 ADMI NI STRATI ON & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS	32, 629	0	0		25, 082, 064 0	5.60 6.00
7. 00 00700 OPERATI ON OF PLANT	21, 868	0	0	-	1, 959, 045	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	521	0	0		22, 601	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	6, 422 5, 033	0	0		391, 039 239, 756	
11. 00 01100 CAFETERI A	2,603	0	0		62, 980	
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0		0	12.00
13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY	12, 843 8, 852	0	0		90, 907 403, 520	13.00 14.00
15. 00 01500 PHARMACY	10, 066	0	0		300, 760	
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0		65	16.00
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0		239, 259 0	17.00 19.00
20. 00 02000 NURSI NG PROGRAM	0	0	0		0	20.00
21.00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0	0		0	21.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMED ED PRGM-PARAMED EDU	0	0	0		0 24, 737	22.00 23.00
INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0	24, 737	23.00
30. 00 03000 ADULTS & PEDI ATRI CS	100, 838	0	0		2, 626, 915	
31. 00 03100 I NTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	26, 207	0	0		598, 110 191, 490	
35.00 02060 NEONATAL INTENSIVE CARE UNIT	5, 727	0	0		350, 133	
40. 00 04000 SUBPROVI DER – I PF	14, 579	0	0		385, 041	40.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	6, 942	0	0	0	80, 861	43.00
50. 00 05000 OPERATING ROOM	77, 928	0	0	0	1, 161, 981	50.00
51.00 05100 RECOVERY ROOM	1, 909	0	0		363, 824	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	30, 373 8, 331	0	0	0	414, 375 118, 176	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	42, 696	0	0	-	358, 275	
55. 00 05500 RADI OLOGY-THERAPEUTI C	38, 009	0	0	0	533, 920	55.00
56. 00 05600 RADI OI SOTOPE 57. 00 05700 CT SCAN	174	0	0	0	87, 179	
58. 00 05800 MRI	1, 215	0	0	0	119, 385 174, 692	
60. 00 06000 LABORATORY	26, 555	0	0	0	4, 740, 951	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	1, 215	0	0	0	181, 044 0	62.00 62.30
64. 00 06400 I NTRAVENOUS THERAPY	521	0	0	0	45, 901	64.00
65. 00 06500 RESPI RATORY THERAPY	3, 992	0	0	0	242, 653	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	13, 190 868	0	0	0	506, 837 82, 961	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	521	0	0	0	49, 228	
69.00 06900 ELECTROCARDI OLOGY	23, 430	0	0	0	399, 066	
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	2, 951	0	0	0	101, 066 1, 146, 310	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1, 200, 857	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	3, 489, 428	73.00
74. 00 07400 RENAL DI ALYSI S 75. 01 07501 CARDI AC REHAB	0	0	0	0	115, 985	
75.02 07502 SLEEP LAB	0	0	0	0	25, 105 0	
75. 03 07503 INPATIENT DIALYSIS	0	0	0	0	0	75.03
75.04 07504 PAIN MANAGEMENT	0	0	0	0	30, 788	
76. 97 07697 CARDI AC REHABI LI TATI ON 76. 98 07698 HYPERBARI C 0XYGEN THERAPY	0	0		0	0	76. 97 76. 98
76. 99 07699 LI THOTRI PSY	0	0	0		0	76.99
	70 140	0	~		70.007	00.00
90. 00 09000 CLINIC 90. 01 09001 PATIENT TREATMENT CENTER	79, 143 12, 670	0	0		78, 087 98, 031	90.00 90.01
90. 02 09002 REHAB SERVI CES-BLOOMI NGDALE	0	0	0	o o	0	90. 02
90. 03 09003 CANTERA	0	0	0	0	0	90.03
90. 04 09004 MENTAL HEALTH 0/P 90. 05 09005 WOMENS CLINIC	2, 777	0		0	69, 013 0	90. 04 90. 05
90. 06 09006 WOUND CARE	1, 736	0	0	0	8, 708	90.06
91. 00 09100 EMERGENCY	29, 852	0	0	0	777, 789	91.00

Health Financial Systems	CENTRAL DUPA	GE HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		eriod:	Worksheet B	
				rom 09/01/2021 o 08/31/2022	Part II Date/Time Pre	narod
			'	0 00/31/2022	1/28/2023 6: 3	0 pm
Cost Center Description	NON PATIENT	PURCHASI NG AND	ADMI TTI NG	ACCOUNTS	ADMI NI STRATI ON	
	TELEPHONES	STORES		RECEI VABLE AND	& GENERAL	
				CASHI ERS		
	5.10	5.30	5.40	5.50	5.60	
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						0.0.40
99.10 09910 CORF	0	0	0	0	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	99.40
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	655, 880	0	0	0	24, 688, 834	110 00
NONREIMBURSABLE COST CENTERS	055,880	0	0	0	24,000,034	1110.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	16 958	190.00
190. 01 19001 KOFEE KORNER	0	0	0	0		190.01
191. 00 19100 RESEARCH	1, 215	0	0	0		191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	334, 473	
192. 01 19201 WSKF	0	0	0	0		192.01
193. 01 19301 DEVELOPMENT	0	0	0	0	0	193.01
193. 02 19302 MARKETI NG	0	0	0	0	0	193.02
193. 04 19303 PHYSI CI AN ANSWERI NG SERVI CE	0	0	0	0	0	193.04
193.05 19304 CAR SEAT SAFETY PROGRAM	0	0	0	0	0	193.05
193. 07 19305 JOINT VENTURE	0	0	0	0	0	193.07
193. 08 19306 PARKI NSONS CENTER	0	0	0	0	0	193.08
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	657, 095	0	0	0	25, 082, 064	202.00

Cost Center Description MAINTENANCE & OPERATION OF PLANT LAUNDRY & LAUNDRY & DATESTICON DateSTIT 0.00 00100 CAP REL COSTS-BLDG & FIXT 6.00 7.00 8.00 9.00 10.00 1.00 00100 CAP REL COSTS-BLDG & FIXT 6.00 7.00 8.00 9.00 10.00 1.00 00100 CAP REL COSTS-BLDG & FIXT 0.00 0.00 8.00 9.00 10.00 1.00 005100 CAP REL COSTS-MVBLE EQUIP 4.00 <t< th=""><th></th><th>Financial Systems TION OF CAPITAL RELATED COSTS</th><th>CENTRAL DUPAG</th><th></th><th></th><th>In Lie eriod: rom 09/01/2021</th><th>u of Form CMS- Worksheet B Part II</th><th>2552-10</th></t<>		Financial Systems TION OF CAPITAL RELATED COSTS	CENTRAL DUPAG			In Lie eriod: rom 09/01/2021	u of Form CMS- Worksheet B Part II	2552-10
Cost Conter: Doorn pluion Min TENANCE & DEBATION OF HIMPS STRUCK Cluster Struct (Min Structure) MOSEREEP NO DETA O 0 00000 CAP REL COSTS - MARE SUP IP 4.000 A.00 7.00 B.00 0 0.00 0 00000 CAP REL COSTS - MARE SUP IP 4.000 A.00 Image Struct Cost Carteries Sup International Structure Superior Sup IP 4.00 A.00 Image Structure Superior Sup IP 4.00 A.00 Image Structure Superior Sup IP 4.00 A.00 Image Sup IP 4.00 Image Sup I								
BENERAL SERVICE COST CENTERS 0.00 7.00 8.00 9.00 10.00 1.00 DOTOR CAP REL COST CENTERS		Cost Center Description				HOUSEKEEPI NG	DI ETARY	
1.00 001000 CAP REL COSTS-BLIDG & FIXT 2.00 002000 EXPLORTS-MERGLE ESUIP 2.00 00200 EXPLORTS-MERGLE ESUIP 2.00 00200 EXPLORTS-MERGLE ESUIP 2.00 00200 EXPLORTS-MERGLE AND CASHLERS 5.00 00500 CAUMINISTRATION & GENERAL 0.00 00200 EXPLORTS-MERGLE AND CASHLERS 5.00 00500 CAUMINISTRATION & GENERAL 0.00 00200 EXPLORTS-MERGLE 0 0.00 00200 EXPLORTS-MERGLE 0 0.00 00200 EXPLORTERATION & GENERAL 0 1.00 010000 ETARM FRESONEL 0 1.00 010000 ETARM 0 1.256.89 1.10 010000 ETARM 0 1.256.80 1.00 01000 ETARM 0 1.250.81 1.00 01000 ETARM 0 1.250.81 1.00 01000 ETARM 0 1.25						9.00	10.00	
2 00 00000 CAP REL COSTS-AWRLE EXUP 4 00 00000 CAPP REL COSTS-AWRLE EXUP 4 00 0000 CAPPACINA CASH ERS 0 00000 CARGENAL AND AND THE TELEPROPES 5.0 00000 CARGENAL AND AND THE AND CASH ERS 5.0 00000 CARGENAL AND AND THE AND CASH ERS 5.0 00000 CARGENAL AND AND THE AND CASH ERS 5.0 00000 CARGENAL AND CASH ERS 5.0 000000 CARGENAL AND CASH ERS 5.0 000000 CARGENAL AND CASH ERS 5.0 000000 CARGENAL AND CASH ERS 5.0 0000000 CARGENAL AND CASH ERS 5.0 00000000000000000000000000000000000	1 00							1.00
5.10 00560 (ANN PATIENT TELEPHONES STORES 4.00 4.00 4.00 4.01 4.01								2.00
5.30 00560 PURCHASH 00 AND STORES	4.00							4.00
5.40 00570 AMI IT ING								5.10
5.00 00580 ACCOUNTS RECTIVABLE AND CASHLERS 0 6.00 00560 AUMINISTRATION & GENERAL 0 6.00 01000 CAPETATION OF PLANT 0 24, 269, 509 7.100 01100 CAPETATION OF PLANT 0 440, 1710 22, 859 1, 26 7.100 011300 MURSING AUMINISTRATION 0 215, 669 0 11, 756 7.100 01500 GENERAL SCHART STR 0000 11, 758 140 0 100, 01400 11, 756 11, 758 11, 750 11								5.30
5.00 0005000 00050000 0005000 00050								5.40 5.50
7.00 00/200 DEPENTION OF PLANIT 0 24, 269, 509 9.00 00000 (AUDER & ETING 0 153, 256 70, 77 1, 276, 889 9.00 00100 (AUDER & ETING 0 420, 113 0 22, 809 1, 276, 889 9.01 01100 (AFETER) 0 420, 113 0 22, 809 1, 276, 889 9.01 01000 (DURES MA AURIN'S ETATION 0 420, 113 0 120, 926 1, 755 14.00 01400 (ENTRAL SERVICES & SUPPLY 0 315, 502 1, 755 0 15.00 01500 (MERI CAL RECORDS & LIBRARY 0 0 0 0 0 10.00 01700 SOLAL SERVICES SALINE RECEARPRY 0 0 0 0 0 0 10.00 01700 SOLAL SERVICES SALINE RECEARPRY 0								5.60
8.00 00600 LANINGY & LINEN SERVICE 0 153, 258 290, 277 990 10.00 01000 DISKEP IN MORESKEP IN MORESKEP IN CONSTRUCT 0 504, 499 0 1, 276, 889 10.00 01000 DISKEP AND INSTRA ADM INSTRATION 0 22, 599 1, 226 12.00 01000 DISKEP ADM INSTRATION 0 210, 550 0 117, 781 13.00 01000 DISKEP ADM INSTRATION 0 210, 550 0 117, 781 15.00 DISKEP ADM INSTRATION 0 0 0 0 0 15.00 DISKEP ADM INSTRATION 0 0 0 0 0 10.00 DISKEP ADM ANSTRATISTS 0 0 0 0 0 20.00 DISKEP ADMARES DE MARCHAR SERVICES-SALREY & SERVICE ADMARES DE MARCHAR SERVICES ADMARES DE MARCHARES ADMARES DE MARCHARES DE MARCHARES ADMARES DE MARCHARES DE	6.00	00600 MAINTENANCE & REPAIRS	0					6.00
9.00 00900 HOUSELEEPING 0 504, 499 1, 276, 899 1, 276, 899 11.00 01100 CAFTERIA 0 420, 115 0 226, 599 12.00 01200 MIRESING AMINITEMATION 0 276, 559 0 17, 758 13.00 01300 MIRESING AMINITEMATION 0 216, 569 0 17, 758 14.00 01400 MENICAL RECORDS & LIBRARY 0 187, 940 0 0 0 15.00 01500 MEDICAL RECORDS & LIBRARY 0 187, 940 0 0 0 0 17.00 1700 1700 MIRSING PROCORDM 0			-					7.00
10.00 010000 010000 010000 010000 010000 010000 010000 010000 010000 010000 0100000 0100000 01000000 0100000000 0100000000000000000000000000000000000			-					8.00
11 00 01100 CAPETRIA 0 420, 115 0 22, 809 12.00 01300 NURSING ADMINISTARTION 0 216, 569 0 11, 758 13.00 01300 NURSING ADMINISTARTION 0 216, 569 0 11, 758 14.00 01400 CHRIAL SERVICES & SUPPLY 0 187, 944 0 0, 204 10.00 01500 PHARMACY 0			-				1, 265, 220	
12.00 01200 (MAINTERANCE OF PERSONNEL 0 0 0 0 14.00 01400 (ENTRAL SERVICES & SUPPLY 0 315, 902 0 17, 151 14.00 01400 (ENTRAL SERVICES & SUPPLY 0 315, 902 0 17, 151 15.00 01500 (NEB) (CAL SERVICES & SUPPLY 0 316, 904 0 0 0 0 10.00 01700 (NURSING ANNURSING FANDARSETISTS 0 46, 68 0 2, 554 10.00 01700 (NURSING SIGNARY & FRINKES APPRY 0 0 0 0 0 21.00 0200 (NURSING FANDAR PROM PCDIST APPRY 0 0 0 0 0 21.00 0200 (ORNARY CARE PROM PCDID 0 31, 462 0 1, 709 NAMATI ENT ROUTINE SERVICE COST CENTERS 0 0, 60, 798 100, 133 328, 890 1, 02 21.00 03200 (ORNARY CARE UNIT 0 1, 708, 56, 738 11 14, 169 31.00 03100 (NTENSIS CARE UNIT 0 1, 738, 302 3, 730 15, 836 <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td>1, 200, 220</td> <td>1</td>			-				1, 200, 220	1
14.00 01400 CENTRAL SERVICES & SUPPLY 0 315,902 0 10,7,151 16.00 01600 MEDICAL, RECORDS & LIBRARY 0 0 0 0 10.00 01900 NORHARACCY 0 46,63 0 2,553 17.00 01700 NURSING FROGRAM 0 0 0 0 0.00 02000 IAR SERVICES-SALARY & FRINCES APPRV 0 0 0 0 0 0.00 02300 PARAMED ED PROM-PARAMED EDU 0 31,485 0 1,709 11.00 03000 ADULTS KERVICES ENSTAPRV 0 <t< td=""><td>12.00</td><td></td><td>0</td><td></td><td></td><td></td><td>0</td><td>12.00</td></t<>	12.00		0				0	12.00
15.00 01500 [PHARBARCY 0 187,944 0 107,04 17.00 01700 [SOI AL SERVICE 0 46,683 0 2,534 17.00 01700 [SOI AL SERVICES 0 0 0 0 17.00 01700 [SOI AL SERVICES CAN ARSTHETISTS 0 0 0 0 17.00 01700 [SOI AL SERVICES-SALARY & FINICES APPRV 0 0 0 0 18.00 02200 [HIR SERVICES-SALARY & FINICES APPRV 0 0 0 0 0 18.00 02200 [HIR SERVICES-SALARY & FINICES APPRV 0 0 0 0 0 0 18.00 02200 [HIR SERVICE COST CENTERS 0 6.057,938 103,131 328,890 1,03 31.00 03100 [NERMATIL INTRIVE CARE UNIT 0 374,933 0 96,9430 1 40.00 0300 [SUBPROV DER - IPF 0 2.91,691 3.730 158,861 71.00 DECOMPERT IN ROM & LABOR ROM 0 371,785 6.674 20,185 51.0			-				0	
16. 00 01600 MEDI CAL RECORDS & LIBRARY 0 0 0 0 17. 00 01700 NONPHYSI CIAN ANESTHETI STS 0 46, 663 0 2, 554 19. 00 01900 NONPHYSI CIAN ANESTHETI STS 0 0 0 0 21. 00 02300 IAR SERVI CES-SALARY & FRI NOES APPRV 0 0 0 0 10. 00 03000 ADULTS A PEDIATRICS 0 0 0 0 0 10. 00 03000 ADULTS A PEDIATRICS 0 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0 14, 169 30. 00 03200 COROMARY CARE UNIT 0 1, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0,			-				0	
17.00 01700 SOCIAL SERVICE 0 46,683 0 2,534 00 01700 SOCIAL SERVICE AMESTHETISTS 0 0 0 0 20.00 02000 NURSING PROGRAM 0 0 0 0 21.00 02100 [LAR SERVICES-SOLARY & FRINCES APPRV 0 0 0 0 20.00 02300 [LAR SERVICES-OTHER PROJ COSTS APPRV 0 0 1,070 0 0 0 0 0.00 03000 [ANUTS & PENGM-PARAME DE PU 0 3,485 0 1,070 56,057,938 103,131 328,890 1,020 0.00 03000 [ANUTS & PENGM-PARAME DE PU 0 242,043 0 18,619 31.00 03000 [ANUTS & PENGME CARE UNIT 0 242,043 0 18,619 43.00 04300 [ANUTS & PENGME 0 2,918,839 0 69,430 11 43.00 05000 [ANUTS & PENGME 0 2,918,93 31,297 15,836 15,836 50.00 05000 [ANUTS & PENGME 0 2,918,93 30,020 2,994 14,33,93 0 2,949 11,33,339			-				0	
19:00 01900/NONPHYSIC LAW AMESTHET ISTS 0 0 0 0 20:00 02:00 (BRS) RG PROGRAM 0 0 0 0 0 20:00 02:00 (BR SERVI CES-SALARY & FRINCES APPRV 0 <			-	-		-	0	
21.00 2010 IAR SERVICES-SALARY & FRINCES APPRV 0 0 0 0 23.00 02200 PARAMED ED PROM-PARAMED EDU 0 31.485 0 1.709 10.00 3100 IAR SERVICES-COTTER PROM-DEDU 0 31.485 0 1.709 10.00 3100 IAR SERVICE CASE CENTERS 0 6.057,938 103.131 328.890 1.03 30.00 000 INTENSI VE CARE UNIT 0 1.070.569 14.692 58.123 11 32.00 02600 NEWARTAL INTENSI VE CARE UNIT 0 3.200 15.836 11 30.00 04000 SUBPROVIDER - IPF 0 1.278.839 0 69,430 11 30.00 04000 DEPEATINE ROM 0 2.913.302 31.297 158.167 51.00 0500 OPERATINE ROM 0 7.878 17.718 41.193 53.00 05500 RADI OLOCY-IN ACMOM 0 7.878 17.138 41.193 53.00 05500 RADI OLOCY-INACOM 0 1.221.993 0 6.548 55.00 0			0				0	
22.00 02200 PARMED ED INFORM-PRARMED EDU 0 0 0 100 0200 PARAMED ED PROM-PRARMED EDU 0 31.485 0 1.709 100 03000 OLLTS & PEROM-PRARMED EDU 0 1.00 31.485 0 1.03 21.00 03100 INTENSIVE CARE UNI T 0 1.00,75.69 14.692 58.123 11 20.00 03000 CREMARY CARE UNI T 0 342.943 0 18.619 14.169 35.00 02060 NEOMATAL INTENSIVE CARE UNI T 0 342.943 0 18.619 14.169 43.00 04300 NURSTERY 0 1.278.839 0 69.430 11 43.00 05000 OPEATING ROOM 0 731.785 6.674 20.185 50.00 05000 NECOVERY ROM 0 731.785 6.674 20.185 51.00 05100 OPEATING ROOM 0 731.785 6.674 20.185 52.00 05000 PADIOLOCY-THERAPEUTIC 0 1.021.993 0 6.344 50.00 05000 PADI	20.00	02000 NURSI NG PROGRAM	0	C	0	0	0	20.00
23.00 02300 PARAMED ED PRGM-PARAMED EDU 0 31.485 0 1.709 INPART LENT ROUTINE SERVICE COST CENTERS 0 6.057,938 103.131 328.890 1.03 30.00 03000 ADULTS & PEDIATRICS 0 1.00 31.462 58.123 1.01 32.00 03200 COROMARY CARE UNIT 0 1.00 240.983 0 14.692 40.00 04000 SUBPROVIDER - IPF 0 1.278.839 0 69.430 11 43.00 04000 NURSERY 0 2.91.691 3.730 15.836 11 43.00 05000 OPENATI INC ROOM 0 2.91.332 31.297 158.167 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.02 15.836 0 2.999 14.193 35.21 0.00 15.336 0 2.999 14.193 35.231 10.00 10.00 1.032 1.993 0 6.344 10.00 <td< td=""><td></td><td></td><td>-</td><td>C</td><td></td><td></td><td>0</td><td></td></td<>			-	C			0	
INPATI ENT NOUTI NE SERVICE COST CENTERS 0.00 03000 ADULTS & PEDIATRICS 0 6, 657, 938 103, 131 328, 890 1, 070, 569 31.00 03100 INTENSI VE CARE UNI T 0 260, 983 0 14, 1692 35.00 02600 NEONATAL INTENSI VE CARE UNI T 0 342, 943 0 18, 619 43.00 04300 NUBSERV 0 271, 691 3, 730 15, 836 43.00 04300 NUBSERV 0 291, 691 3, 730 15, 836 51.00 05500 PECOVERY ROOM 0 371, 785 6, 674 20, 185 52.00 05200 PELVERY ROOM 0 737, 788 17, 138 41, 193 52.00 05500 PECOVERY ROOM 0 7, 333 56, 248 7, 229 53.00 05400 RADI LOGY-DH ENDATIC 0 1, 036, 038 19, 733 56, 248 54.00 05600 RADI OSOTPE 0 1, 221, 993 0 6, 5, 34 55.00 05500 IABIC ROOM PACKED RED BLOOD CELL 0 158, 884 7, 429 8, 265 </td <td></td> <td></td> <td>-</td> <td>-</td> <td></td> <td></td> <td>0</td> <td></td>			-	-			0	
30. 00 300.00 ADULTS & PEDIATRICS 0 6. 687, 98 102, 131 328, 890 1, 02 32. 00 03200 (DREDANLY CARE UNIT 0 260, 98 0 14, 699 14, 699 32. 00 03200 (DREDANLY CARE UNIT 0 342, 943 0 18, 619 40. 00 04000 SUBPROVI DER - 1 PF 0 1, 278, 839 0 69, 430 11 43. 00 04300 OPERATING ROM 0 2, 913, 302 31, 297 158, 167 50. 00 05000 OPERATING ROM 0 738 71, 718 41, 193 51. 00 05200 OPERATING ROM 0 733, 376 0 2, 999 54. 00 05400 RADI LOGY-INERAPEUTIC 0 1, 036, 038 19, 733 56, 248 55. 00 05600 RADI OLOGY-INERAPEUTIC 0 1, 237, 993 0 66, 344 56. 00 05600 RADI OLOGY-INERAPEUTIC 0 1, 233, 047 493 83, 231 62. 00 05600 NRI 0 122, 233 0 7, 016	23.00		0	31, 485	0 0	1,709	0	23.00
32.00 03200 CORONARY CARE UNIT 0 260.983 0 14,169 35.00 C2600 NEMATAL INTENSIVE CARE UNIT 0 342,943 0 18,619 40.00 Odd000 SUBPROVIDER - IPF 0 1,278,839 0 69,430 11 43.00 Odd00 SERVICE COST CENTERS 0 2,913,302 31,297 158,167 50.00 OSCOO DELIVERY ROOM 0 371,785 6,674 20,185 52.00 DESCOUPER YROOM 0 758,396 0 2,899 54.00 OSA00 ANESTHESI DLOGY 0 1,036,038 19,733 56,248 55.00 OSA00 RADI DLOCY-DI KONOSTIC 0 1,022,993 0 66,344 56.00 OSA00 RADI DLOCY-THERAPEUTIC 0 1,221,993 0 7,016 60.00 OSA00 ANDI NERCENTRY 0 129,233 0 7,016 60.00 OSA00 ANDI NERCENTRY 0 19,239 1,045 66,344 61.00 OKA00 ANDI ANDEYNEY 0 19,239 0 1,045 62.00	30.00		0	6, 057, 938	103, 131	328, 890	1, 037, 869	30.00
35. 00 02060 NEOMATAL INTERSIVE CARE UNIT 0 34.29 34.20 18, 619 43.00 04300 NUBSERV 0 291, 691 3, 730 19, 836 43.00 OBSOOD SUPROVIDER - 1PF 0 291, 691 3, 730 15, 836 50.00 OSCOOD OPERATING ROM 0 371, 785 6, 674 20, 185 51.00 OSCOOD DELIVERY ROOM 4.ABOR ROOM 0 371, 785 6, 674 20, 185 52.00 OSCOO RADIO LOCY-THERNOM & LABOR ROOM 0 758, 738 17, 738 41, 193 53.00 OSCOO RADIO LOCY-THERNPUTIC 0 1, 221, 993 0 66, 344 56.00 OSCOO RADIO LOCY-THERNPUTIC 0 1, 223, 00 7, 016 60.00 DSCOO RADIO LOCY-THERNPUTIC 0 1, 233, 047 493 83, 231 62.00 DSCOO RADIO RATORY 0 158, 864 7, 429 8, 626 60.00 DSGOO MIND 129, 233 0 7, 016 0 0			0	1, 070, 569	14, 692	58, 123	116, 388	31.00
40.00 00 0000 SUBPROVIDER - IPF 0 1.278,839 0 69,430 11 43.00 04300 NURSERY 0 291,691 3,730 15,836 11 50.00 05000 OPERATING ROOM 0 2,913,302 31,297 158,167 51.00 05100 RECOVERY ROOM 0 758,738 17,138 41,193 52.00 05400 RADIOLOGY-DI AGNOSTIC 0 1,036,038 19,733 56,248 55.00 05500 RADI LOGY-THERAPEUTIC 0 1,221,993 0 66,344 56.00 05600 RADI LOGY-THERAPEUTIC 0 129,233 0 7,016 57.00 05700 LESDON VERI 0 129,233 0 7,016 66.00 06600 LEDON CELL 0 31,738 0 2,918 66.00 06500 INTRAVENDUS THERAPY 0 19,239 0 1,045 66.00 06500 RESDON S			-				0	
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52.00 OS2000 DELI VERY ROOM & LABOR ROOM 0 758, 738 17, 138 41, 193 53.00 05300 ANESTHESI OLGGY 0 53, 396 0 2, 899 54.00 05400 RADI OLGGY-DI AGNOSTI C 0 1, 036, 038 19, 733 56, 248 55.00 05500 RADI OLGGY-THERAPEUTI C 0 122, 1993 0 66, 344 56.00 05600 RADI OLGGY-THERAPEUTI C 0 122, 1993 0 7, 016 60.00 06000 LABORATORY 0 129, 233 0 7, 016 60.00 06000 LABORATORY 0 19, 233 0 2, 918 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 53, 738 0 2, 918 62.00 06400 INTRAVENUS THERAPY 0 19, 239 0 1, 045 65.00 06500 RESPI RATORY THERAPY 0 319, 788 2, 067 17, 362 67.00 06700 OCLUPATI ONAL THERAPY 0 34, 266 0 775	50.00		0	2, 913, 302	31, 297	158, 167	0	50.00
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55.00 RSD0 RADI 0LOGV-THERAPEUTI C 0 1,221,993 0 66,344 56.00 05000 RADI 0LOGV-THERAPEUTI C 0 102,006 0 5,538 57.00 05700 CT SCAN 0 158,884 7,429 8,626 58.00 0000 LABORATORY 0 1,533,047 493 83,231 62.00 06200 WHOLE BLOOD CLOTTI NG FOR HEMOPHI LLACS 0 0 0 0 64.00 06400 INTRAVENUS THERAPY 0 19,239 0 1,045 65.00 06500 RESPI RATORY THERAPY 0 19,239 0 1,045 64.00 06400 INTRAVENUS THERAPY 0 9,821 0 533 65.00 06500 RESPI RATORY THERAPY 0 14,266 0 775 69.00 6900 10000 ELECTROCARDI 0LOGY 1,020,001 14,539 55,377 70.00 07000 ELECTROCARDI 0LOGY 1,020,001 14,539 <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td>0</td> <td></td>			-				0	
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76.99 07699 LI THOTRI PSY 0 0 0 OUTPATI ENT SERVI CE COST CENTERS 0 651,013 26,953 35,344 90.00 09001 PATI ENT TREATMENT CENTER 0 651,013 26,953 35,344 90.01 09002 REHAB SERVI CES-BLOOMI NGDALE 0 0 0 0 90.02 09003 CANTERA 0 0 0 0 90.04 09004 MENTAL HEALTH 0/P 0 168,954 0 9,173 90.05 09005 WOMENS CLINIC 0 0 0 0			0			0	0	
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90. 03 09003 CANTERA 0 0 0 0 90. 04 09004 MENTAL HEALTH 0/P 0 168, 954 0 9, 173 90. 05 09005 WOMENS CLINIC 0 0 0 0			0				0	
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90. 05 09005 WOMENS CLINIC 0 0 0			0	168, 954	0	9, 173	0	90.03
90. 06 09006 WOUND CARE 0 6. 807 0 370			0	C	0	0	0	90.05
			0				0	90.06
91. 00 09100 EMERGENCY 0 1, 268, 023 42, 401 68, 843 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART			0	1, 268, 023	42, 401	68, 843	0	91.00 92.00

Health Financial Systems	CENTRAL DUPA	GE HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	F	Period: From 09/01/2021 Fo 08/31/2022	Worksheet B Part II Date/Time Pre 1/28/2023 6:3	
Cost Center Description	MAI NTENANCE & REPAI RS		LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	6.00	7.00	8.00	9.00	10.00	
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	0	(0 0	0	99.10
99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY	0	0	(0 0	0	99.20
99. 30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY	0	0	(0 0	0	99.30
99. 40 09940 OUTPATI ENT SPEECH PATHOLOGY	0	0	(0 0	0	99.40
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	24, 176, 983	290, 277	1, 276, 889	1, 265, 220	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	63, 435	(0 0	0	190.00
190. 01 19001 KOFEE KORNER	0	0	(0 0	0	190.01
191. 00 19100 RESEARCH	0	5, 936	(0 0	0	191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	23, 155	(0 0	0	192.00
192. 01 19201 WSKF	0	0	(0 0	0	192.01
193. 01 19301 DEVELOPMENT	0	0	(0 0	0	193.01
193. 02 19302 MARKETI NG	0	0	(0 0	0	193.02
193. 04 19303 PHYSICIAN ANSWERING SERVICE	0	0	(0 0	0	193.04
193.05 19304 CAR SEAT SAFETY PROGRAM	0	0	(0 0	0	193.05
193. 07 19305 JOI NT VENTURE	0	0	(0 0	0	193.07
193. 08 19306 PARKI NSONS CENTER	0	0	(0 0	0	193.08
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	(0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	24, 269, 509	290, 27	1, 276, 889	1, 265, 220	202.00

Heal th	Financial Systems	CENTRAL DUPAG	E HOSPITAL		In Lieu	」of Form CMS-2	2552-10
	ATION OF CAPITAL RELATED COSTS		Provider C	CN: 14-0242 P	eriod: rom 09/01/2021 o 08/31/2022	Worksheet B Part II Date/Time Pre	pared.
	Cost Center Description	CAFETERIA	MAI NTENANCE OF PERSONNEL		CENTRAL SERVICES &	1/28/2023 6: 3 PHARMACY	
			TERSONNEL		SUPPLY		
	GENERAL SERVICE COST CENTERS	11.00	12.00	13.00	14.00	15.00	
1.00 2.00	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00 5.10	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NON PATIENT TELEPHONES						4.00 5.10
5.30 5.40	00560 PURCHASING AND STORES 00570 ADMITTING						5.30 5.40
5.50 5.60 6.00	00580 ACCOUNTS RECEIVABLE AND CASHIERS 00590 ADMINISTRATION & GENERAL 00600 MAINTENANCE & REPAIRS						5.50 5.60 6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9.00 10.00	00900 HOUSEKEEPING 001000 DI ETARY						9.00 10.00
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	858, 338 0	0				11.00 12.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVICES & SUPPLY	4, 841 21, 360	0	497, 866 9	1,001,563		13.00 14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	19, 321	0	0	2, 783	670, 752 1	15.00 16.00
17.00 19.00	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	14, 677 0	0	-	0	0	17.00 19.00
20.00 21.00	02000 NURSING PROGRAM 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	20.00 21.00
22. 00 23. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-PARAMED EDU	0 939	0		0 2, 159	0 27	22.00 23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	151, 354	0	163, 012	39, 732	190	30.00
31.00	03100 I NTENSI VE CARE UNI T	27, 130	0	38, 732	11, 504	22	31.00
32.00 35.00	03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	9, 544 18, 266	0 0		4, 653 5, 782	8 14	32.00 35.00
40.00 43.00	04000 SUBPROVI DER - I PF 04300 NURSERY	26, 472 4, 617	0		271 0	2 0	40.00 43.00
	ANCI LLARY SERVICE COST CENTERS				1 -		
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	53, 411 21, 613	0 0		66, 601 6, 708	967 87	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	23, 214	0	29, 469	5, 606	109	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	3, 315 20, 042	0 0		17, 575 4, 297	1, 711 496	53.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	30, 311	0	25, 404	13, 601	1, 685	55.00
56.00 57.00	05600 RADI 0I SOTOPE 05700 CT SCAN	1, 842 6, 632	0 0	-	2, 369 5, 422	4, 427 0	56.00 57.00
58.00	05800 MRI	8, 051	0	3	10, 652	49	
60.00 62.00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	230, 452 4, 760	0	585 0	35, 991 32, 942	640 0	60.00 62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	2, 173 11, 902	0	3, 824 12	2, 176 8, 887	0	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	37, 628	0	0	1, 614	3	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	5, 952 3, 356	0	0	525 16	0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	19, 416	0	11, 830	8, 786	726	69.00
70.00		5, 583	0	0	3, 714	0	70.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	332, 225 348, 614	0	71.00
		0	0	0	0	658, 862	73.00
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75. 01 75. 02	07501 CARDI AC REHAB 07502 SLEEP LAB	1, 931	0	1, 397 0	71 0	2	75.01 75.02
75.03		0	0	0	0	0	75.03
75.04	07504 PAIN MANAGEMENT	1, 487	0	1, 599	1, 672	132	
76. 97 76. 98	07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.97 76.98
76.99	07699 LI THOTRI PSY	0	0		0	0	76.99
90.00	OUTPATIENT SERVICE COST CENTERS	14, 579	0	9, 032	1, 149	9	90.00
90.00 90.01	09000 CLINIC 09001 PATIENT TREATMENT CENTER	6, 158	0	9, 032 5, 816	2, 213	9 41	90.00
90.02	09002 REHAB SERVI CES-BLOOMI NGDALE	0	0	0	0	0	90.02
90. 03 90. 04	09003 CANTERA 09004 MENTAL HEALTH 0/P	0 5, 812	0	0 404	0	0 0	90. 03 90. 04
90.04 90.05	09004 MENTAL HEALTH 07P	0,012	0	404	0	0	90.04 90.05
90.06	09006 WOUND CARE	587	0		353	38	90.06
91.00	09100 EMERGENCY	36, 430	0	38, 338	20, 891	500	91.00

Health Financial Systems	CENTRAL DUPA	GE HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		eriod:	Worksheet B	
				rom 09/01/2021 0 08/31/2022	Part II Date/Time Pre	narod
				00/31/2022	1/28/2023 6: 3	
Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	
		PERSONNEL	ADMI NI STRATI ON	SERVICES &		
				SUPPLY		
	11.00	12.00	13.00	14.00	15.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	C	0 0	0	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY	0	C	0 0	0	0	99.20
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	C	0 0	0	0	1 1 1 0 0
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	C	0 0	0	0	99.40
SPECIAL PURPOSE COST CENTERS			1			
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	855, 158		496, 991	1, 001, 561	670, 752	118.00
NONREI MBURSABLE COST CENTERS						1.00.00
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	289	(0	0		190.00
190. 01 19001 KOFEE KORNER	0	(0 0	0	-	190.01
	2, 870		875	2		191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	21			0		192.00
192. 01 19201 WSKF	0	(0	0		192.01
193. 01 19301 DEVELOPMENT	0		0	0		193.01
193. 02 19302 MARKETI NG	0			0		193.02
193. 04 19303 PHYSI CI AN ANSWERI NG SERVI CE	0			0		193.04
193. 05 19304 CAR SEAT SAFETY PROGRAM	0			0		193.05 193.07
193. 07 19305 JOI NT VENTURE	0			0		
193.08 19306 PARKINSONS CENTER 200.00 Cross Foot Adjustments	0	L C		0	0	193.08 200.00
200.00Cross Foot Adjustments201.00Negative Cost Centers	0			0	0	200.00
201.00 Negative cost centers 202.00 TOTAL (sum lines 118 through 201)	858, 338		497,866	1,001,563	670, 752	
202.00 TOTAL (Sum TIMES TTO THEODYN 201)	000, 330		기 477,000	1, 001, 003	070, 752	1202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	CENTRAL DUPA	GE HOSPITAL Provider CO	CN: 14-0242 P	In Lie Period:	u of Form CMS-2 Worksheet B	2552-10
				F	rom 09/01/2021 o 08/31/2022	Part II Date/Time Pre	pared:
						1/28/2023 6:3 I NTERNS &	0 pm
	Cost Center Description	MEDI CAL	SOCI AL SERVI CE	NONPHYSI CI AN	NURSI NG	RESI DENTS SERVI CES-SALAR	
		RECORDS & LI BRARY		ANESTHETI STS	PROGRAM	Y & FRI NGES APPRV	
		16. 00	17.00	19.00	20.00	21.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 10 5. 30	00540 NON PATIENT TELEPHONES 00560 PURCHASING AND STORES						5.10 5.30
5.40	00570 ADMI TTI NG						5.40
5.50	00580 ACCOUNTS RECEIVABLE AND CASHIERS						5.50
5.60 6.00	00590 ADMI NI STRATI ON & GENERAL 00600 MAI NTENANCE & REPAI RS						5.60 6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11.00	01100 CAFETERI A						11.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY						13.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	66					16.00
17.00 19.00	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	66		0			17.00
20.00	02000 NURSI NG PROGRAM				0		20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	C				0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23.00	02300 PARAMED ED PRGM-PARAMED EDU I NPATI ENT ROUTI NE SERVI CE COST CENTERS	C	0				23.00
30.00	03000 ADULTS & PEDIATRICS	C	249, 225				30.00
	03100 I NTENSI VE CARE UNI T	0					31.00
32.00 35.00	03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT						32.00 35.00
40.00	04000 SUBPROVI DER – I PF	C					40.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	C	15, 864				43.00
50.00	05000 OPERATING ROOM	C	0				50.00
51.00	05100 RECOVERY ROOM	C	0				51.00
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0				52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0				53.00
55.00	05500 RADI OLOGY-THERAPEUTI C	C	0				55.00
56.00	05600 RADI OI SOTOPE		0				56.00 57.00
	05700 CT SCAN 05800 MRI		0				57.00
60.00	06000 LABORATORY	C	0				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
62.30 64.00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06400 INTRAVENOUS THERAPY		0				62.30 64.00
	06500 RESPI RATORY THERAPY	C	0				65.00
66.00	06600 PHYSI CAL THERAPY		0				66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY						67.00 68.00
69.00	06900 ELECTROCARDI OLOGY		0				69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS						71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	c	0				73.00
	07400 RENAL DI ALYSI S	0	0				74.00
75.01 75.02	07501 CARDI AC REHAB 07502 SLEEP LAB						75.01
75.03	07503 I NPATI ENT DI ALYSI S		0				75.03
	07504 PAIN MANAGEMENT		0				75.04
	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY		0				76.97
	07699 LI THOTRI PSY						76.99
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
90.00 90.01	09000 CLINIC 09001 PATIENT TREATMENT CENTER						90.00 90.01
70.01	09002 REHAB SERVICES-BLOOMINGDALE						90.01
90.02	107002 REIND SERVICES DECOMINODALE		'l 0				70. UZ
90.02 90.03 90.04	09003 CANTERA 09004 MENTAL HEALTH 0/P	0	0				90.02 90.03 90.04

Health Financial Systems	CENTRAL DUPA	GE HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	1	Period: From 09/01/2021 Fo 08/31/2022		
					I NTERNS & RESI DENTS	
Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSI NG	SERVI CES-SALAR	
	RECORDS &		ANESTHETI STS	PROGRAM	Y & FRINGES	
	LI BRARY 16. 00	17.00	19.00	20.00	APPRV 21.00	
90.06 09006 WOUND CARE	10.00	17.00	19.00	20.00	21.00	90.06
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	-					92.00
OTHER REIMBURSABLE COST CENTERS			I			
99.10 09910 CORF	0	0				99.10
99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY	0	0				99.20
99. 30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY	0	0				99.30
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0				99.40
SPECIAL PURPOSE COST CENTERS				1		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	66	354, 238	(0 0	0	118.00
NONREI MBURSABLE COST CENTERS	-					
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0				190.00
190. 01 19001 KOFEE KORNER	0	0				190.01
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0				191. 00 192. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	0	0				192.00 192.01
193. 01 19301 DEVELOPMENT	0	0				192.01
193. 02 19302 MARKETI NG	0	0				193.01
193. 04 19303 PHYSI CLAN ANSWERING SERVICE	0	0				193.02
193. 05 19304 CAR SEAT SAFETY PROGRAM	0	0				193.05
193. 07 19305 JOINT VENTURE	0	0				193.07
193. 08 19306 PARKI NSONS CENTER	0	0				193.08
200.00 Cross Foot Adjustments	0			0 0		200.00
201.00 Negative Cost Centers	0	0	(0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	66	354, 238	(0 0	0	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	CENTRAL DUPA	GE HOSPITAL Provider CC		In Lie Period: From 09/01/2021 To 08/31/2022	u of Form CMS-: Worksheet B Part II Date/Time Pre 1/28/2023 6:3	pared:
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM-PARAMED EDU	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	GENERAL SERVICE COST CENTERS	22.00	23.00	24.00	25.00	26.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 10\\ 5.\ 30\\ 5.\ 50\\ 5.\ 50\\ 5.\ 60\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00 \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NON PATI ENT TELEPHONES 00560 PURCHASI NG AND STORES 00570 ADMITTI NG 00580 ACCOUNTS RECEI VABLE AND CASHI ERS 00590 ADMINI STRATI ON & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A						$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 10\\ 5.\ 30\\ 5.\ 50\\ 5.\ 60\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00 \end{array}$
$\begin{array}{c} 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ \end{array}$	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM 02100 I & SERVI CES-SALARY & FRI NGES APPRV 02200 I & SERVI CES-SALARY & FRI NGES APPRV 02200 I & SERVI CES-CHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-PARAMED EDU I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	84, 526				12.00 13.00 14.00 15.00 16.00 17.00 19.00 20.00 21.00 22.00 23.00
30.00 31.00 32.00 35.00 40.00 43.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04300 NURSERY			15, 524, 04 2, 847, 15 718, 26 1, 050, 96 2, 876, 58 642, 97	57 0 55 0 55 0 30 0	15, 524, 041 2, 847, 157 718, 265 1, 050, 965 2, 876, 580 642, 979	35.00 40.00
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 62.\ 00\\ 62.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 67.\ 00\\ 71.\ 00\\ 71.\ 00\\ 71.\ 00\\ 71.\ 00\\ 71.\ 00\\ 71.\ 00\\ 71.\ 00\\ 75.\ 01\\ 75.\ 01\\ 75.\ 02\\ 75.\ 03\\ 75.\ 04\\ 76.\ 98\\ 76.\ 99\end{array}$	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 CT SCAN 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 CLECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 CUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 CLA SUPPLI ES CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07501 CARDI AC REHAB 07503 INPATI ENT DI ALYSI S 07504 PAI N MANAGEMENT 07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY 0UTPATI ENT SERVI CE COST CENTERS 09000 CLI NI C			6, 687, 98 1, 095, 66 1, 904, 33 245, 47 2, 311, 43 2, 840, 11 279, 35 425, 55 426, 95 7, 791, 26 316, 55 89, 17 570, 17 1, 136, 33 107, 95 78, 76 2, 311, 20 358, 90 1, 478, 53 1, 549, 47 4, 148, 29 115, 98 28, 50	37 0 37 0 33 0 34 0 35 0 36 0 37 0 33 0 34 0 35 0 36 0 37 0 38 0 39 0 38 0 39 0 36 0 37 0 38 0 39 0 39 0 30 0 31 0 32 0 33 0 34 0 35 0 36 0 37 0 38 0 39 0 30 0 31 0 32 0 33 0 34 0 35 0 36 <td< td=""><td>$\begin{array}{c} 6, 687, 987\\ 1, 095, 667\\ 1, 904, 333\\ 245, 475\\ 2, 311, 432\\ 2, 840, 111\\ 279, 351\\ 425, 551\\ 426, 953\\ 7, 791, 260\\ 316, 554\\ 0\\ 89, 177\\ 570, 178\\ 1, 136, 338\\ 107, 959\\ 78, 764\\ 2, 311, 205\\ 358, 901\\ 1, 478, 535\\ 1, 549, 471\\ 4, 148, 290\\ 115, 985\\ 28, 506\\ 0\\ 0\\ 203, 778\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$</td><td>$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 55.\ 00\\ 55.\ 00\\ 55.\ 00\\ 55.\ 00\\ 56.\ 00\\ 60.\ 00\\ 62.\ 00\\ 62.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 67.\ 00\\ 71.\ 00\\ 72.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 75.\ 01\\ 75.\ 02\\ 75.\ 03\\ 75.\ 04\\ 76.\ 97\\ 76.\ 98\\ 76.\ 99\\ \end{array}$</td></td<>	$\begin{array}{c} 6, 687, 987\\ 1, 095, 667\\ 1, 904, 333\\ 245, 475\\ 2, 311, 432\\ 2, 840, 111\\ 279, 351\\ 425, 551\\ 426, 953\\ 7, 791, 260\\ 316, 554\\ 0\\ 89, 177\\ 570, 178\\ 1, 136, 338\\ 107, 959\\ 78, 764\\ 2, 311, 205\\ 358, 901\\ 1, 478, 535\\ 1, 549, 471\\ 4, 148, 290\\ 115, 985\\ 28, 506\\ 0\\ 0\\ 203, 778\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 55.\ 00\\ 55.\ 00\\ 55.\ 00\\ 55.\ 00\\ 56.\ 00\\ 60.\ 00\\ 62.\ 00\\ 62.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 67.\ 00\\ 71.\ 00\\ 72.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 75.\ 01\\ 75.\ 02\\ 75.\ 03\\ 75.\ 04\\ 76.\ 97\\ 76.\ 98\\ 76.\ 99\\ \end{array}$
90. 01 90. 02	09000 CLINIC 09001 PATIENT TREATMENT CENTER 09002 REHAB SERVICES-BLOOMINGDALE 09003 CANTERA			1, 691, 49 598, 96		1, 691, 499 598, 960 0 0	90. 01 90. 02

Health Financial Systems	CENTRAL DUPA	GE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Peri od:	Worksheet B	
				From 09/01/2021 To 08/31/2022		narod
				10 00/31/2022	1/28/2023 6: 3	
	INTERNS &					
	RESI DENTS					
Cost Center Description	SERVI CES-OTHER PRGM COSTS	PARAMED ED PRGM-PARAMED	Subtotal	Intern & Residents Cost	Total	
	APPRV	EDU		& Post		
		LDO		Stepdown		
				Adjustments		
	22.00	23.00	24.00	25.00	26.00	
90.04 09004 MENTAL HEALTH 0/P			381, 70	02 0	381, 702	90.04
90.05 09005 WOMENS CLINIC				0 0	0	90.05
90. 06 09006 WOUND CARE			24, 72		24, 723	90.06
91.00 09100 EMERGENCY			3, 225, 42		3, 225, 424	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART				0		92.00
99.10 09910 CORF			1	0 0	0	99, 10
99. 10 09910 CORP 99. 20 09920 OUTPATIENT PHYSICAL THERAPY				0 0	0	99.10
99. 30 09930 OUTPATIENT PHYSICAL THERAPT						99.30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY				0 0	0	99.40
SPECIAL PURPOSE COST CENTERS	1		1			
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	66, 084, 05	6 0	66, 084, 056	118.00
NONREI MBURSABLE COST CENTERS	F					
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN			127, 82			
190. 01 19001 KOFEE KORNER				0 0		190. 01
191. 00 19100 RESEARCH			57, 10		57, 109	
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES			363, 82	0	363, 822	
192. 01 19201 WSKF 193. 01 19301 DEVELOPMENT				0 0		192. 01 193. 01
193. 02 19302 MARKETI NG				0 0		193.01
193. 04 19303 PHYSI CLAN ANSWERING SERVICE				0 0		193.02
193. 05 19304 CAR SEAT SAFETY PROGRAM				0 0		193.05
193. 07 19305 JOINT VENTURE				0 0		193.07
193. 08 19306 PARKI NSONS CENTER				0 0	0	193.08
200.00 Cross Foot Adjustments	0	84, 526	84, 52	26 0	84, 526	200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	84, 526	66, 717, 33	39 0	66, 717, 339	202.00

CAPITAL PRIATE DOOTS PARTON NULL 2002 (S. 20.00) NULL 2002 (S. 20.00) Exact Conture Description FILO AS FIXT (SQUARE FEE) MORE FOUR NULL 2002 (SCUARE (SQUARE FEE) NULL 2002 (SCUARE (SQUARE FEE) NULL 2003 (SQUARE (SQUARE FEE) NULL 2003 (SQUARE (SQUARE FEE) NULL 2003 (SQUARE (SQUARE FEE) NULL 2003 (SQUARE (SQUARE FEE) NULL 2003 (SQUARE FEE) <th></th> <th>Financial Systems LLOCATION - STATISTICAL BASIS</th> <th>CENTRAL DUPA</th> <th>GE HOSPITAL Provider CO</th> <th>F</th> <th>In Lie Period: From 09/01/2021 To 08/31/2022</th> <th>w of Form CMS-2 Worksheet B-1 Date/Time Pre</th> <th>pared:</th>		Financial Systems LLOCATION - STATISTICAL BASIS	CENTRAL DUPA	GE HOSPITAL Provider CO	F	In Lie Period: From 09/01/2021 To 08/31/2022	w of Form CMS-2 Worksheet B-1 Date/Time Pre	pared:
Lost Genter Description Rule A TAT (SUMPE Text) UPL CEUP (SUMPE Text) UPL DESCRIPTION (SUMPE Text) OUT MUTHING (SUMPE Text) OUT MUTHING (SUMPE Text) 1:00 2:00 2:00 5:00 5:00 5:00 1:00 0:00 2:00 5:00 5:00 5:00 1:00 0:00 0:00 5:00 5:00 5:00 1:00 0:00 0:00 5:00 5:00 5:00 1:00 0:00 0:00 0:00 5:00 5:00 1:00 0:00 0:00 0:00 5:00 5:00 1:00 0:00 0:00 0:00 0:00 5:00 1:00 0:00 0:00 0:00 0:00 0:00 0:00 1:00 0:00			CAPITAL RE	LATED COSTS			1/28/2023 6:3	0 pm
Description 100 2.00 4.00 5.10 5.30 2.00 DOUTO CP BL. DEST-PRISE LEDIT 1, B30, B90 1, B31, 640 1, C31, 640 1, C31, 640 2.00 DOUTO CP BL. DOUTS LESENT E LEDIT 1, B30, B90 252, 292, 65 3, 76 5, 10 5.00 DOUTO CP BL. DOUTS LESENT E LEDIATION 28, 448 22, 448 22, 448 22, 448 22, 448 25, 292, 65 1, 00 5, 10 5.00 DOUTO CPUCKE EDENET TO STORES 0 0 0 0 5, 10 5.00 DOUTO CPUCKE EDENET TO STORES 0 0 0 0 5, 20 5.00 DOUTO CPUCKE EDENET TO STORES 0 <td></td> <td>Cost Center Description</td> <td>BLDG & FIXT (SQUARE FEE</td> <td>MVBLE EQUI P</td> <td>BENEFI TS DEPARTMENT (GROSS</td> <td>TELEPHONES (NUMBER OF</td> <td>STORES (SUPPLIES E</td> <td></td>		Cost Center Description	BLDG & FIXT (SQUARE FEE	MVBLE EQUI P	BENEFI TS DEPARTMENT (GROSS	TELEPHONES (NUMBER OF	STORES (SUPPLIES E	
1.00 DOUDD (CAP REL COSIS*-RELE ON PARTY 1, B30, 89% 1, B31, 660 223, 392, B3 1, C0 0.00 DOUDD (SPE) FUTE INFERT IS DEPARIMENT 26, 441 211, 44 233, 726, B5 3, 726 4, C0 0.00 DOUDD (SPE) FUTE INFERT IS DEPARIMENT 26, 441 211, 44 233, 727, B5 3, 726 4, C0 0.00 DOUDD (SPE) FUTE INFERT IS 0			1.00	2.00		5. 10	5. 30	
2.00 DOOD CAP FLICTSIS=VUILE FOULP 1,131,460 25,292,085 3,786 4,00 5.10 DODARAM KON PART FTT TT FRANCES 20,448 20,448 0,72,292,085 3,786 5,10 5.10 DODARAM KON PART FTT TT FRANCES 0 0 0 0 0 0 5,60 5.00 DODARAM KON PART FTT TT FRANCES 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>1</td><td></td><td></td></td<>						1		
5.30 DOSEQU PURCHASH CAND STORES 0 0 0 0 0 0 5.40 5.00 DOSEM ACCOUNTS RECEIVARLE AND CASH ERS 0	2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 831, 640 0				2.00 4.00
5.60 00599 QAMIN ISTRATION & CENERAL 57.380 73.99 73.90 0 </td <td>5.30 5.40</td> <td>00560 PURCHASI NG AND STORES 00570 ADMI TTI NG</td> <td>0</td> <td>0</td> <td>-</td> <td></td> <td>0</td> <td>5.30 5.40</td>	5.30 5.40	00560 PURCHASI NG AND STORES 00570 ADMI TTI NG	0	0	-		0	5.30 5.40
B. 00 00800 LANDRY & LINEN SERVICE 4,931 4,921 306,717 3 0 8.00 0.00 0000 DIETARY 17,399 17,399 17,293 777 3 0 0.00 10.00 01000 DIETARY 17,399 17,399 17,293 777 15 0 10.00 11.00 01000 DIETARY PERSONEL 0 <td< td=""><td>5.60 6.00</td><td>00590 ADMI NI STRATI ON & GENERAL 00600 MAI NTENANCE & REPAI RS</td><td>57, 380 0</td><td>57, 380 0</td><td>(</td><td>3 188 D 0</td><td>0</td><td>5.60 6.00</td></td<>	5.60 6.00	00590 ADMI NI STRATI ON & GENERAL 00600 MAI NTENANCE & REPAI RS	57, 380 0	57, 380 0	(3 188 D 0	0	5.60 6.00
10.00 01000 DICLARY 17,399 2,390,707 29 0 0 0 12.00 01200 LARTTRANCE OF PERSONEL 0								
11.00 01100 CAEFERIA 13.517 13.917 1.293,777 15 0 11.00 12.00 01200 MURES IN ADMIN TENACE OF PERSONNEL 0		00900 HOUSEKEEPI NG	16, 232	16, 232	5, 488, 529	37		
12.00 01200 0200 0 0 0 0 0 0 12.00 01200 01400 0100 0100 0100 0100								
13.00 01300 NURSING ADMINISTRATION 6.968 1,6.0555 74 0 13.00 14.00 01400 KIND 6.047 6.047 7.768.306 55 0 14.00 15.00 01500 PHARMACY 6.047 7.768.306 55 0 0 15.00 17.00 01700 SOLAL SERVICE 1.502 1.502 4.715.551 0 0 17.00 00 01700 SOLAL SERVICE 1.502 1.502 4.715.551 0 0 19.00 00 00000 NURSIN PROGRAM FEINESS APPRY 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
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20. 00 202000 NURSING PROGRAM 0 <td></td> <td>01700 SOCI AL SERVI CE</td> <td>1, 502</td> <td>1, 502</td> <td></td> <td></td> <td>0</td> <td></td>		01700 SOCI AL SERVI CE	1, 502	1, 502			0	
11.00 02100 LAR SERVICES-SALARY & FRINCES APPRV 0 0 0 0 0 0 21.00 23.00 DER SERVICES-OTHER PRGN-COSTS APPRV 1,013 1,013 259,388 0 0 23.00 INPART ENT ROUTINE SERVICE COST CENTERS 194,911 194,911 194,245 86,8009 151 0 30.00 32.00 03200 ADULTS & PEDIATRICS 194,911 194,445 86,38.009 151 0 30.00 32.00 03200 COROMARY CARE UNIT 36,397 8,397 86,375 240 0 43.00 04000 SUBPROVIDER - IPF 9,310 93,295 1,423,755 40 0 43.00 01.00 05100 OPERATING ROM 11,962 1,423,755 40 0 53.00 53.00 54.000 4.100 54.00 53.00 53.00 54.00 54.00 54.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 56.00 56.00 56.00 56.00			5		(-	
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INPATIENT ROUTINE SERVICE COST CENTERS 000 03000 ADULTS & PEDIATRICS 194, 911 194, 911 43, 246, 605 581 0 30.00 31.00 03100 INTENSIVE CARE UNIT 34, 445 34, 441 74, 73, 355 40 0 30 00 30.00 05000 PERIATING ROOM 24, 412 24, 412 24, 412 24, 412 24, 412 24, 412 24, 412 24, 412 24, 412 24, 412 24, 412 24, 412 24, 412 24, 412 24, 412 24, 412 24, 412 24, 412 24, 412			0	0	(-	
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60.00 06000 LABORATORY 49, 325 49, 325 40, 242, 715 153 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 1, 729 1, 729 1, 352, 539 7 0 62.00 64.00 06400 INTRAVENOUS THERAPY 619 619 826, 703 3 0 64.00 65.00 06500 RESPI RATORY THERAPY 4, 957 4, 957 3, 839, 414 23 0 65.00 66.00 06500 RESPI RATORY THERAPY 10, 289 10, 111, 450 76 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 316 316 1, 682, 316 5 0 67.00 68.00 06800 SPEECH PATHOLOGY 459 459 1, 029, 732 3 0 68.00 70.00 07100 REDCALABUPCLES CHARGED TO PATI ENT 0 0 0 0 0 0 0 71.00 70.00 71.00 70.00 71.00 07100 0 0 0 0 0 72.00 72.00 72.00 72							-	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 1,729 1,729 1,352,539 7 0 62.00 62.30 06250 BLODD CLOTTING FOR HEMOPHI LIACS 0 0 0 0 62.30 64.00 06400 INTRAVENOUS THERAPY 619 619 826,703 3 0 64.00 65.00 06500 RESPI RATORY THERAPY 4,957 4,957 3,839,414 23 0 65.00 66.00 06600 PHYSI CAL THERAPY 10,289 10,111,450 76 0 66.00 67.00 0500 RESPI RATORY THERAPY 316 316 1,682,316 5 0 67.00 6800 SPEECH PATHOLOGY 32,818 32,818 8,393,402 135 0 69.00 71.00 OTOO ELECTROENCEPHALOGRAPHY 4,396 4,396 1,573,768 17 0 70.00 73.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 73.00 73.00 0 0 73.00 73.00 0 74.00 75.01 75.								
64.00 06400 INTRAVENOUS THERAPY 619 619 619 826,703 3 0 64.00 65.00 06500 RESPI RATORY THERAPY 4,957 4,957 3,839,414 23 0 65.00 66.00 06500 RESPI RATORY THERAPY 10,289 10,111,450 76 0 66.00 67.00 06700 0CUPATI ONAL THERAPY 316 316 1,682,316 5 0 67.00 68.00 06800 SPEECH PATHOLOGY 459 459 1,029,732 3 0 68.00 69.00 ELECTROCACEPHALOGRAPHY 4,396 4,396 1,573,768 17 0 70.00 71.00 OT100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 71.00 72.00 07200 IMEL DEV. CHARGED TO PATI ENTS 0 0 0 0 73.00 73.00 73.00 DRUGS CHARGED TO PATI ENTS 0 0 0 0 74.00 75.01 75.01 75.01 75.02 75.03 75.04 75.02 75.04	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL					0	62.00
65.00 06500 RESPI RATORY THERAPY 4,957 4,957 3,839,414 23 0 65.00 66.00 06600 PHYSI CAL THERAPY 10,289 10,289 10,111,450 76 0 66.00 67.00 0C000/DENTI ONAL THERAPY 316 316 1,682,316 5 0 67.00 68.00 06800 SPECH PATHOLOGY 459 459 1,029,732 3 0 68.00 69.00 ELECTROCARDI OLOGY 32,818 32,818 8,393,402 135 0 69.00 70.00 ELECTROCARDI OLOGY 32,818 32,818 8,393,402 135 0 69.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 71.00 72.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 73.00 73.00 75.01 07501 CARDI AC REHAB 0 0 0 0 75.01 75.02 07502 SLEP LAB 0 0 0 0 75.03 75.03					(926-703			
66.00 06600 PHYSI CAL THERAPY 10, 289 10, 289 10, 111, 450 76 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 316 316 1, 682, 316 5 0 67.00 68.00 06800 SPEECH PATHOLOGY 459 459 1, 029, 732 3 0 68.00 69.00 06900 ELECTROCARDI OLOGY 32, 818 32, 818 8, 393, 402 135 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 4, 396 4, 396 1, 573, 768 17 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 75.01 75.01 07502 SLEECT RABL 0 0 0 0 75.02 75.02 SLECT P LAB 0 0 0 0 0								
68.00 06800 SPEECH PATHOLOGY 459 459 1,029,732 3 0 68.00 69.00 06900 ELECTROCARDI OLOGY 32,818 32,818 8,393,402 135 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 4,396 4,396 1,573,768 17 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.00 73.00 0 0 0 72.00 0 0 0 72.00 0 0 0 0 72.00 0 0 0 0 72.00 0 0 0 0 72.00 73.00 73.00 0 0 0 72.00 73.00 73.00 73.00 73.00 74.00 74.00 75.01 75.01 75.01 75.01 75.02 SLEEP LAB 0 0 0 0 75.02 75.02 75.03 07503 INPATIENT DI ALYSIS 0 0 0 75.03 75.04 76.97 76.97 CARDI AC REHABI LI TATI ON 0		06600 PHYSI CAL THERAPY						
69.00 06900 ELECTROCARDI OLOGY 32,818 32,818 32,818 8,393,402 135 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 4,396 4,396 1,573,768 17 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 RENAL DI ALYSI S 0 0 0 0 73.00 73.00 74.00 76.01 75.01 75.01 07501 CARDI AC REHAB 0 0 0 74.00 75.01 07502 SLEEP LAB 0 0 0 75.01 75.02 07503 INPATI ENT DI ALYSI S 0 0 0 75.02 75.03 07504 PATI N MANAGEMENT 3,009 3,009 443,371 0 0 75.03 76.97 76.97 76.98 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 76.97 76.98 76.98 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td><td></td></td<>						-		
70.00 07000 ELECTROENCEPHALOGRAPHY 4, 396 4, 396 1, 573, 768 17 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 RENAL DI ALYSI S 0 0 0 0 73.00 75.01 07501 CARDI AC REHAB 0 0 0 74.00 74.00 75.01 07501 CARDI AC REHAB 0 0 0 0 75.01 75.02 S12,62 S12,02 S12,02 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 167 0 0 74.00 75.01 07501 CARDI AC REHAB 0 0 510,093 0 75.01 75.02 07502 SLEEP LAB 0 0 0 0 75.02 75.03 07503 INPATIENT DI ALYSI S 0 0 0 0 75.03 75.04 07504 PAIN MANAGEMENT 3,009 3,009 443,371 0 0 75.04 76.97 07697 CARDI AC REHABILI TATI ON 0 0 0 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 76.99 0000 07609 LI THOTRI PSY 0 0 0 0 0 0 76.99 010001 09000 CLINI C								
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 167 0 0 74.00 75.01 07501 CARDI AC REHAB 0 0 510,093 0 75.01 75.02 07502 SLEEP LAB 0 0 0 0 75.02 75.03 07503 INPATIENT DI ALYSI S 0 0 0 0 75.02 75.04 07504 PAIN MANAGEMENT 3,009 3,009 443,371 0 0 75.04 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.97 76.99 07699 LI THOTRI PSY 0 0 0 0 76.98 09000 CLINI C 09000 CLINI C 00 0 0 90.00 90.01 09000 PATI ENT TREATMENT CENTER 8,446 8,446 1,697,985 <td></td> <td></td> <td>0</td> <td>0</td> <td>(</td> <td></td> <td></td> <td></td>			0	0	(
74.00 07400 RENAL DI ALYSI S 0 167 0 74.00 75.01 07501 CARDI AC REHAB 0 0 510,093 0 75.01 75.02 07502 SLEEP LAB 0 0 0 0 75.02 75.03 07503 INPATI ENT DI ALYSI S 0 0 0 0 75.03 75.04 07504 PAI N MANAGEMENT 3,009 3,009 443,371 0 0 75.04 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.98 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 76.98 70.00 09000 CLINI C 20,946 3,587,108 456 0 90.00				0				
75.02 07502 SLEEP LAB 0 0 0 0 75.02 75.03 07503 INPATI ENT DI ALYSI S 0 0 0 0 0 75.03 75.04 07504 PAI N MANAGEMENT 3,009 3,009 443,371 0 0 75.04 76.97 CARDI AC REHABI LI TATI ON 0 0 0 0 76.97 76.98 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 0 76.98 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 90.00 90.01 09001 PATI ENT TREATMENT CENTER 20,946 3,587,108 456 0 90.01 90.02 09002 REHAB SERVI CES-BLOOMI NGDALE 0 <td></td> <td></td> <td>0</td> <td>0</td> <td>167</td> <td></td> <td></td> <td></td>			0	0	167			
75.03 07503 INPATI ENT DI ALYSI S 0 0 0 0 75.03 75.04 07504 PAI N MANAGEMENT 3,009 3,009 443,371 0 0 75.04 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.98 76.98 07699 LI THOTRI PSY 0 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 0 76.98 00TPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 76.99 90.00 09000 CLI NI C 20,946 3,587,108 456 0 90.00 90.01 09001 PATI ENT TREATMENT CENTER 8,446 8,446 1,697,985 73 0 90.01 90.02 09002 REHAB SERVI CES-BLOOMI NGDAL			0	0			-	
75.04 07504 PAIN MANAGEMENT 3,009 3,009 443,371 0 0 75.04 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 76.98 76.99 LI THOTRI PSY 0 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 0 0 0 0 76.98 00TPATI ENT SERVICE COST CENTERS 0 <td< td=""><td></td><td></td><td></td><td>0</td><td></td><td></td><td>-</td><td></td></td<>				0			-	
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 76. 98 90. 00 09000 CLI NI C 20, 946 20, 946 3, 587, 108 456 0 90. 00 90. 01 09001 PATI ENT TREATMENT CENTER 8, 446 8, 446 1, 697, 985 73 0 90. 01 90. 02 09002 REHAB SERVI CES-BLOOMI NGDALE 0 0 0 0 0 90. 02			3,009	3, 009	443, 371		-	
76. 99 07699 LI THOTRI PSY 0 0 0 0 76. 99 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 76. 99 90. 00 09000 CLI NI C 20, 946 20, 946 3, 587, 108 456 0 90. 00 90. 01 09001 PATI ENT TREATMENT CENTER 8, 446 8, 446 1, 697, 985 73 0 90. 01 90. 02 09002 REHAB SERVI CES-BLOOMI NGDALE 0 0 0 0 0 0 90. 02			0	0	C		-	
OUTPATI ENT_SERVICE_COST_CENTERS 90.00 09000 CLINIC 20,946 3,587,108 456 0 90.00 90.01 09001 PATI ENT_TREATMENT_CENTER 8,446 8,446 1,697,985 73 0 90.01 90.02 09002 REHAB_SERVICES-BLOOMI NGDALE 0 0 0 0 0 90.02				0		-		
90. 01 09001 PATI ENT TREATMENT CENTER 8, 446 8, 446 1, 697, 985 73 0 90. 01 90. 02 09002 REHAB SERVI CES-BLOOMI NGDALE 0 0 0 0 0 0 90. 02	, 0. , ,							, , ,
90. 02 09002 REHAB SERVI CES-BLOOMI NGDALE 0 0 0 0 0 0 90. 02								
					1, 697, 985 r			
			-	-		-		

Health Financial Systems	CENTRAL DUPA	GE HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
				From 09/01/2021 To 08/31/2022	Data (Tima Dra	norod.
				To 08/31/2022	Date/Time Pre 1/28/2023 6:30	
	CAPITAL REI	ATED COSTS			172072023 0. 3	
		2.1120 00010				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	NON PATIENT	PURCHASING AND	
	(SQUARE FEE	(SQUARE FEET)	BENEFITS	TELEPHONES	STORES	
	T))		DEPARTMENT	(NUMBER OF	(SUPPLIES E	
			(GROSS	PHONES)	XPENSE)	
			SALARI ES)			
	1.00	2.00	4.00	5.10	5.30	
90.04 09004 MENTAL HEALTH 0/P	5, 436		1, 482, 14			90.04
90. 05 09005 WOMENS CLINIC	0	-		0 0		90.05
90. 06 09006 WOUND CARE	219		238, 75	-		90.06
91.00 09100 EMERGENCY	40, 798	40, 798	10, 454, 17	8 172	0	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
OTHER REI MBURSABLE COST CENTERS						00.40
99. 10 09910 CORF 99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY	0				0	99.10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY 99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	-			-	99.20 99.30
99. 40 09940 OUTPATIENT OCCUPATIONAL THERAPY	0	-			0	99.30 99.40
SPECIAL PURPOSE COST CENTERS	0	0		<u> </u>	0	99.40
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 828, 663	1, 828, 663	252, 544, 08	4 3, 779	0	118.00
NONREI MBURSABLE COST CENTERS	1, 020, 003	1, 020, 003	232, 344, 00	+ 3,777	0	110.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	2,041	2, 041	51, 79	6 0	0	190.00
190. 01 19001 KOFEE KORNER	0			0 0		190.01
191. 00 19100 RESEARCH	191	191	696, 17	5 7	0	191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	745		o o	0	192.00
192. 01 19201 WSKF	0	0		0 0	0	192.01
193. 01 19301 DEVELOPMENT	0	0		0 0	0	193.01
193. 02 19302 MARKETI NG	0	0		0 0	0	193.02
193.04 19303 PHYSICIAN ANSWERING SERVICE	0	0		0 0	0	193.04
193.05 19304 CAR SEAT SAFETY PROGRAM	0	0		0 0	0	193.05
193. 07 19305 JOINT VENTURE	0	0		0 0	0	193.07
193. 08 19306 PARKI NSONS CENTER	0	0		0 0	0	193.08
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	27, 120, 411	15, 175, 991	-	0 657, 095	0	202.00
Part I)	44.040/50	0.005444		170 5501/5		
203.00 Unit cost multiplier (Wkst. B, Part I)	14. 812652	8. 285466	0.00000			
204.00 Cost to be allocated (per Wkst. B,				0 657, 095	0	204.00
Part II) 205.00 Unit cost multiplier (Wkst. B, Part			0. 00000	173. 559165	0,000000	205 00
205.00 Unit cost multiplier (wkst. B, Part			0.00000	1/3. 559165	0. 000000	205.00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						200.00
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						
	1			1		•

	Financial Systems LLOCATION - STATISTICAL BASIS	CENTRAL DUPA	<u>GE HOSPITAL</u> Provider CC	N: 14 0242	In Lie Period:	u of Form CMS-: Worksheet B-1	
0001 6	LECONTON - STATISTICAL DASIS			F	rom 09/01/2021 o 08/31/2022		pared:
	Cost Center Description	ADMI TTI NG (I NPATI ENT REVENUE)	ACCOUNTS RECEI VABLE AND CASHI ERS (DOLLAR VALUE)	Reconciliation	ADMI NI STRATI ON & GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	
		5.40	5.50	5A. 60	5.60	6.00	
4 00	GENERAL SERVICE COST CENTERS						1 1 00
16.00 17.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NON PATIENT TELEPHONES 00560 PURCHASING AND STORES 00570 ADMITTING 00580 ACCOUNTS RECEIVABLE AND CASHIERS 00590 ADMINISTRATION & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I& SERVICES-SALARY & FRINGES APPRV 02200 I& SERVICES-OTHER PRGM COSTS APPRV			-225, 761, 423 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 52, 211, 963 602, 360 10, 421, 876 6, 389, 906 1, 678, 535 0 2, 422, 826 10, 754, 511 8, 015, 787 1, 720 6, 376, 661 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00
22.00	02300 PARAMED ED PRGM-PARAMED EDU		-	0		0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	-	I			-	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT			C C		0	30.00 31.00
32.00	03200 CORONARY CARE UNIT			0		0	32.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	C	0 0	C	9, 331, 651	0	35.00
40.00	04000 SUBPROVIDER - IPF	0		0		0	40.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS		0	0	2, 155, 095	0	43.00
50.00	05000 OPERATING ROOM	0	0	C	30, 968, 808	0	50.00
51.00	05100 RECOVERY ROOM	C		0		0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	C	0 0	C		0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0		0	53.00
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C			C C		0	54.00 55.00
56.00	05600 RADI OLOGI - THERAPEOTIC			0		0	56.00
	05700 CT SCAN	0	o o	0	3, 181, 831	0	•
	05800 MRI	C	0 0	C		0	
	06000 LABORATORY	0	0	0			
62.00 62.30	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS			0		0	62.00 62.30
	06400 I NTRAVENOUS THERAPY			0		0	64.00
	06500 RESPI RATORY THERAPY		0	Ő		0	65.00
	06600 PHYSI CAL THERAPY	C	0 0	C		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	_, ,	0	67.00
			0	0	1, 312, 025	0	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY			0	10, 635, 814 2, 693, 574	0	69.00 70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT		o o	C			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	C	32, 004, 922	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	C	0	C	, ,	0	73.00
	07400 RENAL DI ALYSI S	0	0	0	0,0,1,20.	0	74.00
	07501 CARDI AC REHAB 07502 SLEEP LAB			0	669, 096	0	75.01 75.02
	07502 SLEEP LAB			0	0	0	75.02
	07504 PAIN MANAGEMENT		o o	C	820, 552	0	
	07697 CARDI AC REHABI LI TATI ON	C	0 0	C	0	0	76.97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	-	0	76.98
76.99	07699 LI THOTRI PSY		0	0	0	0	76.99
90.00	OUTPATIENT SERVICE COST CENTERS	0		0	2,081,143	0	90.00
	09001 PATIENT TREATMENT CENTER	(0	2, 612, 688	0	90.00
	09002 REHAB SERVI CES-BLOOMI NGDALE	0	o o	C	0	0	90.02
	09003 CANTERA	(C	0 0	C	0	0	90.03
90.04	09004 MENTAL HEALTH 0/P			0	1, 839, 306		90.04
90.05 90.06	09005 WOMENS CLINIC 09006 WOUND CARE			U O	232, 082	0	90.05 90.06
			<u>, o</u>	0	252,002	0	1 70.00

Health Financial Systems	CENTRAL DUPA	GE HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		eriod:	Worksheet B-1	
				rom 09/01/2021 o 08/31/2022	Date/Time Pre	narod
			'	0 00/31/2022	1/28/2023 6: 3	
Cost Center Description	ADMI TTI NG	ACCOUNTS F	Reconciliation	ADMI NI STRATI ON		
	(I NPATI ENT	RECEI VABLE AND		& GENERAL	REPAI RS	
	REVENUE)	CASHI ERS		(ACCUM. COST)	(SQUARE FEET)	
		(DOLLAR VALUE)				
	5.40	5.50	5A. 60	5.60	6.00	
91.00 09100 EMERGENCY	0	0	0	20, 729, 439	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
99. 10 09910 CORF	0	0	0	0	0	99.10
99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY	0	0	0	0	0	99.20
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	-225, 761, 423	657, 995, 434	0	118.00
NONREI MBURSABLE COST CENTERS		-	-		-	
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	-	0	451, 971		190.00
190. 01 19001 KOFEE KORNER	0	0	0	0		190.01
191.00 19100 RESEARCH	0	0	0	1, 114, 016		191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	8, 914, 291		192.00
192. 01 19201 WSKF	0	0	0	0		192.01
193. 01 19301 DEVELOPMENT	0	0	0	0		193.01
193. 02 19302 MARKETI NG	0	0	0	0		193.02
193. 04 19303 PHYSI CI AN ANSWERI NG SERVI CE	0	0	0	0		193. 04 193. 05
193. 05 19304 CAR SEAT SAFETY PROGRAM 193. 07 19305 JOINT VENTURE	0	0	0	0		193.05
193. 07/19305/JOINT VENTURE 193. 08/19306/PARKINSONS_CENTER	0	0	0	0		193.07
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
200.00 Regative Cost Centers						200.00
201.00 Negative cost centers 202.00 Cost to be allocated (per Wkst. B,	0	0		225, 761, 423	0	201.00
Part I)	0	0		225, 701, 423	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	0.000000		0. 337726	0. 000000	202 00
204.00 Cost to be allocated (per Wkst. B,	0.000000	0.000000		25, 082, 064		203.00
Part II)	0	0		23,002,004	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0,000000		0. 037521	0. 000000	205 00
	0.000000	0.000000		0.037321	0.000000	203.00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						
		· ·				

	Financial Systems ALLOCATION - STATISTICAL BASIS	CENTRAL DUPA	GE HOSPITAL Provider C		In Lie eriod: rom 09/01/2021	u of Form CMS-: Worksheet B-1	
					08/31/2022	Date/Time Pre	
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	(POUNDS OF	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERV ED))	1/28/2023 6:3 CAFETERIA (FTES SERVE D))	
		7.00	LAUNDRY)) 8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS	1	1				
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 10\\ 5.\ 30\\ 5.\ 50\\ 5.\ 50\\ 5.\ 60\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FI XT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00540 NON PATI ENT TELEPHONES 00560 PURCHASI NG AND STORES 00570 ADMI TTI NG 00580 ACCOUNTS RECEI VABLE AND CASHI ERS 00590 ADMI NI STRATI ON & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM 02100 I & SERVI CES-SALARY & FRI NGES APPRV 02200 I & SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-PARAMED EDU	780, 859 4, 931 16, 232 17, 399 13, 517 0 6, 968 10, 164 6, 047 0 1, 502 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 525, 014 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	756, 719 17, 399 13, 517 0 6, 968 10, 164 6, 047 0 1, 502 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	284, 736 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	287, 965 0 1, 624 7, 166 6, 482 0 4, 924 0 0 0 0 0 315	12.00 13.00 14.00 15.00 16.00 17.00 19.00 20.00 21.00 22.00
30. 00 31. 00 32. 00 35. 00 40. 00 43. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 02060 NEONATAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04300 NURSERY	194, 911 34, 445 8, 397 11, 034 41, 146 9, 385	541, 821 77, 184 0 0 0	194, 911 34, 445 8, 397 11, 034 41, 146	233, 571 26, 193 0 0 24, 972	50, 778 9, 102 3, 202 6, 128 8, 881 1, 549	30.00 31.00 32.00
	ANCILLARY SERVICE COST CENTERS		1	1			
$\begin{array}{c} 62.\ 00\\ 62.\ 30\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 70.\ 00\\ 71.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 75.\ 01\\ 75.\ 02\\ 75.\ 03\\ 75.\ 04\\ 76.\ 98\\ \end{array}$	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OL SOTOPE 05700 CT SCAN 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROENEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07501 CARDI AC REHAB 07503 I NPATI ENT DI ALYSI S 07504 PAI N MANAGEMENT 07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	93, 734 11, 962 24, 412 1, 718 33, 334 39, 317 3, 282 5, 112 4, 158 49, 325 1, 729 0 619 4, 957 10, 289 316 459 32, 818 4, 396 0 0 0 0 0 0 0 0 0 0 0 0 0	35, 064 90, 037 0 103, 671 0 39, 027 0 2, 590 0 10, 858 0 10, 858 0 76, 381 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11, 962 24, 412 1, 718 33, 334 39, 317 3, 282 5, 112 4, 158 49, 325 1, 729 0 619 4, 957 10, 289 316 459 32, 818 4, 396 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		17, 919 7, 251 7, 788 1, 112 6, 724 10, 169 618 2, 225 2, 701 77, 314 1, 597 0 729 3, 993 12, 624 1, 997 1, 126 6, 514 1, 873 0 0 0 0 0 648 0 0 0 0 499 0 0 0	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 55.\ 00\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 60.\ 00\\ 62.\ 00\\ 64.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 67.\ 00\\ 68.\ 00\\ 70.\ 00\\ 70.\ 00\\ 71.\ $
90. 01 90. 02 90. 03 90. 04 90. 05	09000 CLINIC 09001 PATIENT TREATMENT CENTER 09002 REHAB SERVICES-BLOOMINGDALE 09003 CANTERA 09004 MENTAL HEALTH 0/P 09005 WOMENS CLINIC 09006 WOUND CARE	20, 946 8, 446 0 5, 436 0 219		8, 446 0 0 5, 436 0	0 0 0 0	2, 066 0 1, 950 0	90. 01 90. 02 90. 03 90. 04

Heal th Finar	ncial Systems	CENTRAL DUPA	GE HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCA	TION – STATISTICAL BASIS		Provider C		eriod:	Worksheet B-1	
					rom 09/01/2021 0 08/31/2022	Date/Time Pre	narod
					00/31/2022	1/28/2023 6: 3	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERIA	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERV	(FTES SERVE	
		(SQUARE FEET)	(POUNDS OF		ED))	D))	
			LAUNDRY))				
		7.00	8.00	9.00	10.00	11.00	
	EMERGENCY	40, 798	222, 762	40, 798	0	12, 222	91.00
	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	REIMBURSABLE COST CENTERS	1	I				
99.10 09910		0	0	0	0	0	, , , , , , , , , , , , , , , , , , , ,
	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	
	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
	AL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	777, 882	1, 525, 014	756, 719	284, 736	286, 898	118.00
	IMBURSABLE COST CENTERS						
	GIFT FLOWER COFFEE SHOP & CANTEEN	2, 041		0	0		190.00
	KOFEE KORNER	0	-	0	0		190. 01
191.0019100		191		0	0		191.00
	PHYSICIANS PRIVATE OFFICES	745	0	0	0		192.00
192. 01 19201		0	0	0	0		192.01
	DEVELOPMENT	0	0	0	0		193. 01
193. 02 19302		0	0	0	0		193.02
	PHYSICIAN ANSWERING SERVICE	0	0	0	0		193.04
	CAR SEAT SAFETY PROGRAM	0	0	0	0		193.05
	JOINT VENTURE	0	0	0	0		193.07
	PARKINSONS CENTER	0	0	0	0	0	193.08
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	(0.045.000	1 044 055	45 000 544	10 150 1/5	0 700 444	201.00
202. 00	Cost to be allocated (per Wkst. B,	69, 845, 300	1, 246, 855	15, 393, 514	10, 458, 165	3, 729, 441	202.00
202.00	Part I)	00 446750	0 017(0)	20 242444	24 720220	10 051000	202 00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	89.446750			36. 729339		
204.00	Part II)	24, 269, 509	290, 277	1, 276, 889	1, 265, 220	858, 338	204.00
205.00	Unit cost multiplier (Wkst. B, Part	31, 080527	0. 190344	1. 687402	4, 443484	2. 980703	205 00
205.00	III)	31.060327	0. 190344	1.007402	4. 443404	2. 960703	205.00
206.00	NAHE adjustment amount to be allocated						206.00
200.00	(per Wkst. B-2)						200.00
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
207.00	Parts III and IV)						207.00
I		I	I	I	I		

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	CENTRAL DUPAC	<u>SE HOSPITAL</u> Provider CC	CN: 14-0242	<u>In Lie</u> eriod: rom 09/01/2021	u of Form CMS-2 Worksheet B-1	
			T		Date/Time Pre 1/28/2023 6:3	
Cost Center Description	(NUMBER HOUSED)	NURSI NG ADMI NI STRATI ON (DI RECT NRS G HRS))	CENTRAL SERVI CES & SUPPLY (COSTED REQ UI S))	PHARMACY (COSTED REQ UIS))	MEDI CAL RECORDS & LI BRARY (GROSS REVE NUE)	
GENERAL SERVICE COST CENTERS	12.00	13.00	14.00	15.00	16.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.10 00540 NON PATIENT TELEPHONES 5.30 00560 PURCHASING AND STORES 5.40 00570 ADMITTING & GENERAL 6.00 00590 ADMINISTRATION & GENERAL 6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 01000 10.00 01200 MAINTENANCE OF PERSONNEL 13.00 01300 NURSI NG ADMINISTRATION 01400 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 15.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 17.00 01700 SOCI AL SERVICE 10.00 16.00 01600 NONPHYSICI AN ANESTHETISTS <td></td> <td>1, 917, 004 36 0 62, 859 0 0 0 0 276</td> <td>91, 946, 985 255, 497 0 37 0 0 0 0 0 0 0 198, 201</td> <td>99, 473, 470 105 0 0 0 0 0 3, 981</td> <td>6, 261, 892, 365 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td>17.00</td>		1, 917, 004 36 0 62, 859 0 0 0 0 276	91, 946, 985 255, 497 0 37 0 0 0 0 0 0 0 198, 201	99, 473, 470 105 0 0 0 0 0 3, 981	6, 261, 892, 365 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 O3000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT 40.00 04000 SUBPROVIDER - IPF 43.00 04300 NURSERY		627, 666 149, 137 52, 161 112, 627 53, 683 25, 652	3, 647, 518 1, 056, 060 427, 160 530, 824 24, 923 0	28, 117 3, 301 1, 239 2, 138 296 0	281, 847, 078 51, 947, 010 17, 733, 184 63, 138, 684 43, 209, 825 11, 352, 126	31.00 32.00 35.00 40.00
ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY-THERAPEUTI C 56.00 05600 RADI OLOGY-THERAPEUTI C 56.00 05600 RADI OLOGY-THERAPEUTI C 56.00 05600 RADI OLOGY-THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MRI 60.00 06500 LABORATORY 62.00 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 66.00 06600 PHYSI CAL THERAPY 68.00 06800 SPECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY <t< td=""><td></td><td>$\begin{array}{c} 214, 292\\ 102, 354\\ 113, 469\\ 1, 500\\ 13, 961\\ 97, 816\\ 30\\ 1, 548\\ 10\\ 2, 251\\ 0\\ 0\\ 0\\ 14, 726\\ 47\\ 0\\ 0\\ 0\\ 14, 726\\ 47\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$</td><td>$\begin{array}{c} 6, 114, 149\\ 615, 769\\ 514, 659\\ 1, 613, 378\\ 394, 457\\ 1, 248, 596\\ 217, 481\\ 497, 759\\ 977, 865\\ 3, 304, 032\\ 3, 024, 144\\ 0\\ 199, 783\\ 815, 874\\ 148, 132\\ 48, 188\\ 1, 464\\ 806, 532\\ 340, 909\\ 30, 498, 979\\ 32, 004, 921\\ 0\\ 0\\ 0\\ 6, 561\\ 0\\ 0\\ 0\\ 153, 449\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$</td><td>73, 518 249, 947 656, 599 0 7, 200 94, 90 0 61 648 436 0 107, 724 0 0 97, 709, 903 0 97, 709, 903 0 268 0 19, 630 0 0 0</td><td>230, 215, 303 109, 058, 212 1, 510, 432, 638 22, 043, 384 0 74, 106, 930 66, 902, 296 101, 257, 491 18, 197, 955 9, 380, 652 284, 073, 310 37, 542, 268 494, 292, 215 300, 700, 202 1, 123, 632, 793 11, 378, 294 3, 012, 603 0 0 2, 401, 166 0 0 0</td><td>$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 60.\ 00\\ 62.\ 00\\ 62.\ 00\\ 62.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 66.\ 00\\ 67.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 75.\ 01\\ 75.\ 01\\ 75.\ 02\\ 75.\ 03\\ 75.\ 04\\ 76.\ 98\\ 76.\ 99\\ 76.\ 98\\ 76.\ 98\\ 76.\ 99\\ 76.\ 98\\ 76.\ 99\\ 76.\ 98\\ 76.\ 99\\ 76.\ 98\\ 76.\ 99\\ 76.\ 98\\ 76.\ 99\\ 76.\ 98\\ 76.\$</td></t<>		$\begin{array}{c} 214, 292\\ 102, 354\\ 113, 469\\ 1, 500\\ 13, 961\\ 97, 816\\ 30\\ 1, 548\\ 10\\ 2, 251\\ 0\\ 0\\ 0\\ 14, 726\\ 47\\ 0\\ 0\\ 0\\ 14, 726\\ 47\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	$\begin{array}{c} 6, 114, 149\\ 615, 769\\ 514, 659\\ 1, 613, 378\\ 394, 457\\ 1, 248, 596\\ 217, 481\\ 497, 759\\ 977, 865\\ 3, 304, 032\\ 3, 024, 144\\ 0\\ 199, 783\\ 815, 874\\ 148, 132\\ 48, 188\\ 1, 464\\ 806, 532\\ 340, 909\\ 30, 498, 979\\ 32, 004, 921\\ 0\\ 0\\ 0\\ 6, 561\\ 0\\ 0\\ 0\\ 153, 449\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	73, 518 249, 947 656, 599 0 7, 200 94, 90 0 61 648 436 0 107, 724 0 0 97, 709, 903 0 97, 709, 903 0 268 0 19, 630 0 0 0	230, 215, 303 109, 058, 212 1, 510, 432, 638 22, 043, 384 0 74, 106, 930 66, 902, 296 101, 257, 491 18, 197, 955 9, 380, 652 284, 073, 310 37, 542, 268 494, 292, 215 300, 700, 202 1, 123, 632, 793 11, 378, 294 3, 012, 603 0 0 2, 401, 166 0 0 0	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 60.\ 00\\ 62.\ 00\\ 62.\ 00\\ 62.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 66.\ 00\\ 67.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 75.\ 01\\ 75.\ 01\\ 75.\ 02\\ 75.\ 03\\ 75.\ 04\\ 76.\ 98\\ 76.\ 99\\ 76.\ 98\\ 76.\ 98\\ 76.\ 99\\ 76.\ 98\\ 76.\ 99\\ 76.\ 98\\ 76.\ 99\\ 76.\ 98\\ 76.\ 99\\ 76.\ 98\\ 76.\ 99\\ 76.\ 98\\ 76.\ $
90.00 09000 CLINIC 90.01 09001 PATI ENT TREATMENT CENTER 90.02 09002 REHAB SERVICES-BLOOMINGDALE 90.03 09003 CANTERA 90.04 09004 MENTAL HEALTH 0/P 90.05 09005 WOMENS CLINIC	0 0 0 0 0 0	34, 776 22, 396 0 0 1, 557 0	105, 439 203, 187 0 669 0	1, 342 6, 072 0 0 0 0 0	19, 505, 631 47, 826, 756 0 18, 124, 890 0	90. 02 90. 03

COST ALLOCATION - STATISTICAL BASIS Provider CN: 14-0242 Provider CN: 14-0242 Provider CN: 14-0242 Worksheet B-1 bit 6/Time Prepared: 1/28/2028 6: 30 pm Cost Center Description MAINTEMANCE OF PERSONNEL (NUMBER HOUSE) NURSING PERSONNEL HRS)) NURSING CONTED RED UIS) NURSING PHARMACY (COSTED RED UIS)) Worksheet B-1 bit 6/Time Prepared: 1/28/2028 6: 30 pm 90. 66 09006 MOUND CARE HRS)) 12.00 NURSING (DIRECT NRS 6 UIS)) SERVICES & UIS)) MED CAL UIS) MED CAL UIS) MED CAL UIS) NURSING (COSTED RED UIS)) NURSING (C	Health Financial Systems	CENTRAL DUPA	GE HOSPITAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description MAINTENANCE OF PERSONNEL (NUMBER HOUSED) NURSING (NINSTRATION (NURSING) CENTRAL SUPPLY (NUSTOR RC) (UIS)) PHARMACY (SGSD REV (UIS)) MEDICAL RECORDS & UIS)) RECORDS & NEPENDATE (NUMBER HOUSED) 90.06 09006 MOUND CARE 12.00 13.00 14.00 15.00 16.00 90.06 09006 MUNDI CARE 0 4.101 32.386 5.668 3.127.867 90.06 90.00 OURDED CHERCENCY 0 147.617 1,917.861 74.134 245,963.669 91.00 99.10 OPRE 0 0 0 0 99.20 99.20 99.20 99.40 99.40 99.40 99.40 99.40 99.40 99.40 99.40 99.40 99.40 99.40 99.40 99.40 99.40.21.823.361 18.00 190.00 INPOSE COST CENTERS 0 0 0 0 0 0 99.40.21.823.361 18.00 190.00 INPOSE COST CENTERS 0 0 0 0 0 0 0	COST ALLOCATION - STATISTICAL BASIS		Provider CO			Worksheet B-1	
Cost Center Description MAINTENANCE OF PERSONNEL HOUSED NURSING NUREY (COSTED RED (DIRECT NRS G (005TE) RED (DIRECT NRS G (005TE) RED (DIRECT NRS G (005TE) RED (DIS)) PHARMACY (COSTED RED UIS)) REDICAL RECORDS & UIS) 90.06 09006 WOUND CARE 0 4.101 32.366 5.6668 9.100 91.00 09100 DERGENCY 0 14.00 15.00 16.00 92.00 92.00 09200 0055EV/X110N DEDS (NON-DISTINCT PART 0 147,617 1,917,861 74,134 245,963,656 91.00 99.10 09910 007910 CORF 0 0 0 0 99.10 99.10 09920 001PATLENT PHYSI CAL THERAPY 0 0 0 0 99.40 99.40 09940 01PATLENT PHYSI CAL THERAPY 0 0 0 0 0 99.40 90.019000 0001FE FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 0 0 0 0 0 0 0						Data (Time Dea	
Cost Center Description MAINTENANCE OF PERSONNEL (NUMEER HOUSED) OF DIRECTINES G (NUMEER (COSTED REC) (DIRECTINES G (COSTED REC) (COSTED REC) (10	0 08/31/2022		
PERSONNEL POLINMER HOUSED ADMI NI STRATI ON CIT RECT INES & (COSTED RED UIS)) CCOSTED RED UIS) PERCORDS & LIBRAR (CROSS REVE UIS)) 90.06 00006 WUMD CARE 0 13.00 15.05 66.83.127.867 90.06 91.00 09200 DBSERVATION BEDS (NON-DISTINCT PART 0 147.617 1.917.861 74.134 245.963.656 91.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 99.10 099210 CORF 0 0 0 0 99.10 99.10 O99200 DIFART IENT PHYSI CAL THERAPY 0 0 0 0 99.30 99.10 O99210 CORF 0 0 0 0 99.33 99.40 O99400 0 0 0 0 0 99.473.470 6.261.892.365 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 1.913.634 91.946.843 99.473.470 6.261.892.365 100.01 IMPROSE COST CENTERS 0 0 <	Cost Center Description	MAINTENANCE OF		CENTRAL	PHARMACY		
Image: constraint of the second sec							
HOUSED (DI RECT NRS G (COSTED REO UIS) (CROSS REVE IS) 90.06 09006 WOUND CARE 0 4.101 32,386 5,668 3,127,867 90.06 90.06 09200 DEERRENCY 0 14.00 15.00 16.00 90.06 90.100 EMERGENCY 0 147,617 1,917,661 74,134 245,963,656 91.00 90.10 OP9100 CENTERS 0 0 0 0 99.10 99.10 OP910 CORF 0 0 0 0 99.20 99.20 99.20 99.20 0 0 0 0 99.40 99.40 0 0 0 0 99.40 99.473,470 6,261,892,365 118.00 118.00 SPECIAL_PURPOSE COST CENTERS 118.00 0 0 0 0 0 0 0 0 0 0 119.00 190.01 190.01 190.01 0 0 0 0 0 0 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
P0.06 09006 WOUND CARE 12.00 13.00 14.00 15.00 16.00 P1.00 91.00 09100 EMERCENCY 0 4,101 32.366 5,668 3,127,867 90.06 91.00 07100 EMERCENCY 0 147,617 1,917,861 74,134 245,963,656 91.00 07101 OP100 CORF 0 0 0 0 99.10 99.10 OP10 CORF 0 0 0 0 99.10 99.20 09930 OUTPATI ENT PHYSICAL THERAPY 0 0 0 0 99.20 99.30 OUTPATI ENT SPECH PATHOLOGY 0 0 0 0 0 99.40 SUBTOTALS (SUM OF LINES 1 through 117) 0 1,913,634 91,946,843 99,473,470 6,261,892,365 118.00 190.00 1001000 GIFT FLNERNER 0 0 0 0 191.00 191.00 191.00 191.00 191.00 190.00 190.			(DIRECT NRS G				
90.06 09006 WONND CARE 0 4,101 32,366 5,668 3,127,867 90.06 91.00 09100 EMERCENCY 0 147,617 1,917,861 74,134 245,963,656 91.00 92.00 0THER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 92.00 92.00 99.10 09910 CORF 0 0 0 0 0 99.10 99.10 99.10 99.10 99.40 99.30 99.40 0 0 0 0 0 99.40 99.40 99.40 0 0 0 99.40 99.473,470 6,261,892,365 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 1,913,634 91,946,843 99,473,470 6,261,892,365 118.00 NOMEL IMBURSABLE COST CENTERS NOMEL IMBURSABLE COST CENTERS 0 0 0 0 190.00 190.00 190.00 190.00 190.00 190.00		,	HRS))	UIS))		NUE)	
91.00 DIPOD EMERGENCY 0 147, 617 1, 917, 861 74, 134 245, 963, 656 91. 00 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92		12.00	13.00	14.00	15.00	16.00	
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 000 0 0 0 0 0 99.10 99.10 09910 000 0 0 0 0 0 0 0 0 0 0 0 99.10 99.10 09910 000 0 0 0 0 0 0 0 0 0 99.10 99.10 0 0 0 0 0 0 99.10 99.10 0 0 0 0 0 0 0 99.30 99.30 007411 0 1,913,634 91,946,843 99,473,470 6,261,892,365 118.00 NONRE MBURSABLE COST CENTERS 118.00 100.00 190.00 19000 (GFT FLAURER COFFE SNOP & CANTEEN 0 0 0 0 0 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00	90.06 09006 WOUND CARE	(4, 101	32, 386	5, 668	3, 127, 867	90.06
OTHER REL MURSABLE COST CENTERS 99.10 OP910 CORF O <td>91.00 09100 EMERGENCY</td> <td>(</td> <td>147, 617</td> <td>1, 917, 861</td> <td>74, 134</td> <td>245, 963, 656</td> <td>91.00</td>	91.00 09100 EMERGENCY	(147, 617	1, 917, 861	74, 134	245, 963, 656	91.00
99.10 00910 CORF 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>92.00</td></t<>							92.00
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99.30 09930 0UTPATI ENT OCCUPATI ONAL THERAPY 0		(0 0	0	0	0	
99.40 09940 0UTPATIENT SPEECH PATHOLOGY 0 0 0 0 0 0 0 99.40 SPECIAL PURPOSE COST CENTERS NONRE IMBURSABLE COST CENTERS 190.00 1900 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00 0 0 0 190.00 0 0 0 190.00 0 0 0 0 190.00 0 0 0 0 190.00 190.01 0 0 0 0 0 0 0 0 0 0 0 0 190.00 190.01 190.01 190.01 190.01 190.01 190.01 191.00 191.00 0 0 0 0 0 192.01 192.01 192.01 192.01 192.01 192.01 192.01 193.04 193.02 NARKET ING 0 0 0 0 193.01 193.04 193.04 193.04 193.04 193.04 193.04		(0 0	0	0	0	
SPECIAL PURPOSE COST CENTERS Image: Cost Centers 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 1,913,634 91,946,843 99,473,470 6,261,892,365 118.00 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 0 0 190.00 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 0 0 0 190.00 190.00 190.00 190.01 190.01 0			-	-	0	0	
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NONRE I MBURSABLE COST CENTERS 190.00 00 0		i.	1		I		
1900.00 GIFT FLOWER COFFEE SHOP & CANTEEN 0		(0 1, 913, 634	91, 946, 843	99, 473, 470	6, 261, 892, 365	118.00
190.01 KOFEE KORNER 0 0 0 0 190.01 191.00 19100 RESEARCH 0 3,370 142 0 0 191.00 192.00 19200 PHYSI CLANS PRI VATE OFFICES 0 0 0 0 192.00 192.01 19201 WSKF 0 0 0 0 0 192.00 193.01 19302 MARKETI NG 0 0 0 0 0 193.02 193.02 19303 PHYSI CLAN ANSWERING SERVICE 0 0 0 0 193.02 193.05 19304 CAR SEAT SAFETY PROGRAM 0 0 0 0 193.05 193.06 PARKI NSONS CENTER 0 0 0 0 193.08 200.00 0 193.08 200.00 0 193.08 200.00 0 193.08 200.00 0 193.08 200.00 0 0 193.08 200.00 0 193.08 200.00 0 193.08 200.00 201.00 203.00 201.00 203.00		1					
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193.04 19303 PHYSICIAN ANSWERING SERVICE 0 0 0 0 193.04 193.05 19304 CAR SEAT SAFETY PROGRAM 0 0 0 0 193.05 193.07 19305 JOINT VENTURE 0 0 0 0 0 193.07 193.08 19306 PARKINSONS CENTER 0 0 0 0 0 193.08 200.00 Cross Foot Adjustments 0 0 0 0 0 193.08 200.00 201.00 Negative Cost Centers 200.00 20.00 20.300 20.400 20.300 20.300 20.400 20.300 20.300 20.400 20.300 20.300 20.400				0	Ű		
193.05 19304 CAR SEAT SAFETY PROGRAM 0 0 0 0 193.05 193.07 19305 JOINT VENTURE 0 0 0 0 0 193.07 193.08 19306 PARKINSONS CENTER 0 0 0 0 0 193.07 193.08 19306 PARKINSONS CENTER 0 0 0 0 193.08 200.00 Cross Foot Adj ustments 0 0 0 0 200.00 201.00 Negative Cost Centers 201.00 202.00 203.00 20.100 203.00 20.300 20.000 20.300 20.000 <t< td=""><td></td><td></td><td></td><td>0</td><td>0</td><td></td><td></td></t<>				0	0		
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200.00 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 0.000000 2.100736 0.169613 0.115751 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 0.000000 2.100736 0.169613 0.115751 0.000000 203.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.259710 0.010893 0.006743 0.000000 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0.000000 0.259710 0.010893 0.006743 0.000000 206.00				0	0		
201.00 Negative Cost Centers 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 0.000000 4,027,120 15,595,370 11,514,107 2,313 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 2.100736 0.169613 0.115751 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 0.000000 497,866 1,001,563 670,752 66 204.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.259710 0.010893 0.006743 0.000000 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0.000000 0.259710 0.010893 0.006743 0.000000 206.00			0	0	0		
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203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 2.100736 0.169613 0.115751 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 0.000000 497,866 1,001,563 670,752 66 204.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.259710 0.010893 0.006743 0.000000 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0.00000 0.259710 0.010893 0.006743 0.00000 205.00			4,027,120	15, 595, 370	11, 514, 107	2, 313	202.00
204.00 Cost to be allocated (per Wkst. B, Part II) 0 497,866 1,001,563 670,752 66 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 0.259710 0.010893 0.006743 0.000000 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0.00000 0.259710 0.010893 0.006743 0.00000 205.00		0,00000	2 100736	0 169613	0 115751	0 000000	203 00
205.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)							
205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.259710 0.010893 0.006743 0.000000 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE adjustment amount to be adjustment amount to be adjustment amount to be adjustment amount to be adjustment amount amount to be adjustment amount amount to be adjustment amount to be adjustment amount to be adjustment amount amount amount amount amount amount amount amount amount				.,	0,0,,02		2011.00
206.00 II) NAHE adjustment amount to be allocated (per Wkst. B-2) 206.00		0. 000000	0. 259710	0. 010893	0. 006743	0.000000	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 206.00							
(per Wist. B-2)							206.00
207.00 NAHE unit cost multiplier (Wkst. D, 207.00							
							207.00
Parts III and IV)	Parts III and IV)						

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	CENTRAL DUPA	GE HOSPITAL Provider CC	·N· 14_0242	In Lie Period:	u of Form CMS-2 Worksheet B-1	
COST ALLOCATION - STATISTICAL DASIS			N. 14-0242	From 09/01/2021 To 08/31/2022		
					1/28/2023 6:3	
				INTERNS &	RESI DENTS	
Cost Center Description	SOCIAL SERVICE		NURSI NG	SERVI CES-SALAR		
	(PATIENT DA	ANESTHETI STS (ASSI GNED	PROGRAM (ASSI GNED	Y & FRI NGES APPRV	PRGM COSTS APPRV	
	YS)	TIME)	TIME)	(ASSI GNED	(ASSI GNED	
	17.00	19.00	20.00	TIME) 21.00	TIME) 22.00	
GENERAL SERVICE COST CENTERS			20100	21100	22100	
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 10 00540 NON PATI ENT TELEPHONES 5. 30 00560 PURCHASI NG AND STORES						5.10 5.30
5. 40 00570 ADMI TTI NG						5.30
5. 50 00580 ACCOUNTS RECEI VABLE AND CASHI ERS					- -	5.50
5. 60 00590 ADMI NI STRATI ON & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS						5.60 6.00
7.00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8.00 9.00
10. 00 01000 DI ETARY						10.00
11.00 01100 CAFETERIA 12.00 01200 MAINTENANCE OF PERSONNEL						11.00 12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY						14.00 15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY						16.00
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS	110, 663 0	0				17.00 19.00
20. 00 02000 NURSI NG PROGRAM	0	0		0		20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0			0	0	21.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMED ED PRGM-PARAMED EDU	0				0	22.00 23.00
INPATIENT ROUTINE SERVICE COST CENTERS	77.057					20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	77, 857 8, 731	0		0 0 0 0	0	30.00 31.00
32.00 03200 CORONARY CARE UNIT	3, 125	0		0 0	0	32.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF	7,670	0		0 0 0 0	0	35.00 40.00
43.00 04300 NURSERY	4, 956	0		0 0	0	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	52.00 53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0	0			0	55.00 56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MRI 60.00 06000 LABORATORY	0	0			0	58.00 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 64. 00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	62.30 64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	0	0		0 0	0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	70.00 71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S	0	0			0	73.00 74.00
75. 01 07501 CARDI AC REHAB	0	0		0 0	0	75.01
75. 02 07502 SLEEP LAB 75. 03 07503 I NPATI ENT DI ALYSI S	0	0			0	75.02 75.03
75.04 07504 PAIN MANAGEMENT	0	0		0 0	0	75.04
76. 97 07697 CARDI AC REHABI LI TATI ON 76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 97 76. 98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLINI C	0	0		0 0	0	90.00
90. 01 09001 PATI ENT TREATMENT CENTER	0	0		0 0	0	90. 01
90. 02 09002 REHAB SERVI CES-BLOOMI NGDALE 90. 03 09003 CANTERA	0	0		0 0 0 0	0	90. 02 90. 03
· [····]· ···	. 0	<u>۱</u>				

Heal th Fina	ncial Systems	CENTRAL DUPA	GE HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provider C	CN: 14-0242	Period:	Worksheet B-1	
					From 09/01/2021		
					To 08/31/2022	Date/Time Pre 1/28/2023 6:3	
					INTEDNS &	RESI DENTS	
					TINTERNS &	KESI DENI S	
	Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN	NURSI NG	SEDVICES_SALAD	SERVI CES-OTHER	
	cost center bescription	SUCIAL SERVICE	ANESTHETI STS	PROGRAM	Y & FRINGES	PRGM COSTS	
		(PATIENT DA	(ASSI GNED	(ASSI GNED	APPRV	APPRV	
		YS)	TIME)	TIME)	(ASSI GNED	(ASSI GNED	
		13)	11 ME)		TIME)	TIME)	
		17.00	19.00	20.00	21.00	22.00	
90.04 09004	MENTAL HEALTH O/P	0	0		0 0		90.04
	WOMENS CLINIC	0	0		0 0	0	
	WOUND CARE	0	0		0 0	0	
	EMERGENCY	0	0			0	
	OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	91.00
	REIMBURSABLE COST CENTERS						92.00
	CORF	0	0		0 0	0	99, 10
	OUTPATIENT PHYSICAL THERAPY	0	0		0 0		
	OUTPATIENT OCCUPATIONAL THERAPY	0	0		0 0	-	
	OUTPATIENT SPEECH PATHOLOGY	0	0		0 0		99.40
	AL PURPOSE COST CENTERS				<u> </u>	, <u> </u>	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	110, 663	0		0 0	0	1118.00
	EIMBURSABLE COST CENTERS	110,000			<u> </u>	<u> </u>	1.101.00
	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	KOFEE KORNER	0	0		0 0		190.01
191.0019100		0	0		0 0		191.00
	PHYSICIANS PRIVATE OFFICES	0	0		0 0	-	192.00
192.01 19201		0	0		0 0		192.01
	DEVELOPMENT	0	0		0 0		193.01
193. 02 19302		0	0		0 0		193.02
	PHYSICIAN ANSWERING SERVICE	0	0			-	193.04
	CAR SEAT SAFETY PROGRAM	0	0		0 0		193.05
	JOINT VENTURE	0	0				193.07
	5 PARKI NSONS CENTER	0	0				193.08
200.00	Cross Foot Adjustments	0	0		0	0	200.00
200.00	Negative Cost Centers						200.00
201.00	Cost to be allocated (per Wkst. B,	8, 893, 268	0		0 0	0	201.00
202.00	Part I)	0, 093, 200	0		0 0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	80. 363518	0. 000000	0. 0000	0. 000000	0. 000000	203 00
203.00	Cost to be allocated (per Wkst. B,	354, 238		0.0000	0 0.000000		203.00
204.00	Part II)	334, 230			0		204.00
205.00	Unit cost multiplier (Wkst. B, Part	3. 201052	0. 000000	0. 0000	0. 000000	0. 000000	205 00
200.00		3. 201032	0.00000	0.0000	0.00000	0.00000	200.00
206.00	NAHE adjustment amount to be allocated				0		206.00
200.00	(per Wkst. B-2)				0		200.00
207.00	NAHE unit cost multiplier (Wkst. D,			0, 0000	00		207.00
207.00	Parts III and IV)			0.0000			
I		I	l	I	1	I	1

	Financial Systems LLOCATION - STATISTICAL BASIS	CENTRAL DUPAGE	HOSPITAL Provider CCN: 14-0242	In Lie Period:	u of Form CMS-2552-10 Worksheet B-1
				From 09/01/2021 To 08/31/2022	Date/Time Prepared: 1/28/2023 6:30 pm
	Cost Center Description	PARAMED ED PRGM-PARAMED EDU (ASSI GNED		<u> </u>	
		TIME) 23.00			
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT				1.00
$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 10\\ 5.\ 30\\ 5.\ 40\\ 5.\ 50\\ 5.\ 60\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	00100 CAP REL COSIS-BLDG & FTAT 00200 CAP REL COSIS-BLDG & FTAT 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NON PATI ENT TELEPHONES 00560 PURCHASI NG AND STORES 00570 ADMI TTI NG 00580 ACCOUNTS RECEI VABLE AND CASHI ERS 00590 ADMI NI STRATI ON & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM 02100 I & SERVI CES-SALARY & FRI NGES APPRV 02200 I & SERVI CES-OTHER PRGM COSTS APPRV				1.00 2.00 4.00 5.10 5.30 5.40 5.50 5.60 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 19.00 20.00 21.00 22.00
	02300 PARAMED ED PRGM-PARAMED EDU	158			23. 00
31.00 32.00 35.00 40.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04300 NURSERY	14 8 0 0 0 0			30.00 31.00 32.00 35.00 40.00 43.00
50.00		10			50.00
$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 62.\ 00\\ 62.\ 00\\ 62.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 71.\ 00\\ 71.\ 00\\ 71.\ 00\\ 71.\ 00\\ 72.\ 00\\ 71.\ 00\\ 75.\ 01\\ 75.\ 02\\ 75.\ 03\\ 75.\ 04\\ 76.\ 97\\ 76.\ 98\\ 76.\ 99\end{array}$	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 06400 I NTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07501 CARDI AC REHAB 07503 I NPATI ENT DI ALYSI S 07504 PAI N MANAGEMENT 07699 LI THOTRI PSY 001TPATI ENT SERVICE COST CENTERS 09000 I LI NUC				50.00 51.00 52.00 53.00 54.00 55.00 56.00 57.00 58.00 60.00 62.00 62.00 62.30 64.00 65.00 65.00 66.00 67.00 68.00 69.00 71.00 71.00 72.00 73.00 74.00 75.01 75.02 75.03 75.04 76.98 76.99
90. 01 90. 02 90. 03 90. 04	09000 CLINIC 09001 PATIENT TREATMENT CENTER 09002 REHAB SERVICES-BLOOMINGDALE 09003 CANTERA 09004 MENTAL HEALTH 0/P 09005 WOMENS CLINIC				90.00 90.01 90.02 90.03 90.04 90.05

Health Financial Systems	CENTRAL DUPAGE	HOSPI TAI	In Lieu of Form CN	15-2552-10
COST ALLOCATION - STATISTICAL BASIS	CENTIONE DOTAGE	Provi der CCN: 14-0242	Period: Worksheet B	
Soon Aleboarton Statistical Basis			From 09/01/2021	
			To 08/31/2022 Date/Time F	
			1/28/2023 6	<u>5:30 pm</u>
Cost Center Description	PARAMED ED			
	PRGM-PARAMED			
	EDU			
	(ASSI GNED			
	TIME)			
	23.00			
90. 06 09006 WOUND CARE	0			90.06
91.00 09100 EMERGENCY	104			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
OTHER REIMBURSABLE COST CENTERS				
99. 10 09910 CORF	0			99.10
99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY	0			99.20
99. 30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY	0			99.30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0			99.40
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	158			118.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0			190.00
190. 01 19001 KOFEE KORNER	0			190. 01
191. 00 19100 RESEARCH	0			191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0			192.00
192. 01 19201 WSKF	0			192.01
193. 01 19301 DEVELOPMENT	0			193.01
193. 02 19302 MARKETI NG	0			193.02
193. 04 19303 PHYSI CLAN ANSWERI NG SERVI CE	0			193.04
193.05 19304 CAR SEAT SAFETY PROGRAM	0			193.05
193. 07 19305 JOI NT VENTURE	0			193.07
193. 08 19306 PARKI NSONS CENTER	0			193.08
200.00 Cross Foot Adjustments				200.00
201.00 Negative Cost Centers				201.00
202.00 Cost to be allocated (per Wkst. B,	1, 031, 884			202.00
Part I)	, ,			
203.00 Unit cost multiplier (Wkst. B, Part I)	6, 530. 911392			203.00
204.00 Cost to be allocated (per Wkst. B,	84, 526			204.00
Part II)	, -20			
205.00 Unit cost multiplier (Wkst. B, Part	534, 974684			205.00
206.00 NAHE adjustment amount to be allocated	o			206.00
(per Wkst. B-2)				200.00
207.00 NAHE unit cost multiplier (Wkst. D,	0. 000000			207.00
Parts III and IV)	0.000000			2011.00
	I I			1

Health Financial Systems	CENTRAL DUPA	GE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 14-0242	Period: From 09/01/2021 To 08/31/2022	Worksheet C Part I	
					1/28/2023 6: 3	0 pm
			× XVIII	<u>Hospital</u> Costs	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs		Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30.00 03000 ADULTS & PEDIATRICS	133, 024, 110		133, 024, 11			
31. 00 03100 I NTENSI VE CARE UNI T	27, 495, 694		27, 495, 69			
32.00 03200 CORONARY CARE UNIT	8, 223, 802		8, 223, 80			
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	14, 717, 240		14, 717, 24			•
40. 00 04000 SUBPROVIDER - IPF	20, 063, 352		20, 063, 35			
43.00 04300 NURSERY	4, 401, 553	5	4, 401, 55	53 0	4, 401, 553	43.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM	E2 (E4 200	<u></u>	E2 (E4 20		E2 (E4 200	
50. 00 05000 0PERATING ROOM 51. 00 05100 RECOVERY ROOM	53, 654, 380 14, 754, 271		53, 654, 38 14, 754, 27			
52.00 05200 DELIVERY ROOM & LABOR ROOM	18, 008, 035		18, 008, 03			
53. 00 05300 ANESTHESI OLOGY	4, 761, 672		4, 761, 67			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	16, 709, 772		16, 709, 77			
55. 00 05500 RADI OLOGY-THERAPEUTI C	23, 930, 198		23, 930, 19		23, 977, 909	
56. 00 05600 RADI OLSOTOPE	3, 589, 445		3, 589, 44		3, 589, 445	
57. 00 05700 CT SCAN	4, 966, 064		4, 966, 06		4, 966, 064	
58. 00 05800 MRI	6, 886, 458		6, 886, 45			
60. 00 06000 LABORATORY	176, 042, 003		176, 042, 00		176, 042, 003	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	7, 178, 152		7, 178, 15			
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0		1
64.00 06400 I NTRAVENOUS THERAPY	1, 778, 724		1, 778, 72			
65.00 06500 RESPIRATORY THERAPY	9, 385, 739				9, 385, 739	
66.00 06600 PHYSI CAL THERAPY	19, 397, 286				19, 397, 286	
67.00 06700 OCCUPATI ONAL THERAPY	3, 026, 512		3, 026, 5		3, 026, 512	
68.00 06800 SPEECH PATHOLOGY	1, 820, 354		1, 820, 35			
69.00 06900 ELECTROCARDI OLOGY	18, 222, 634	ļ	18, 222, 63	34 0	18, 222, 634	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	4, 167, 977	7	4, 167, 97	6, 022	4, 173, 999	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	46, 042, 089		46, 042, 08	39 0	46, 042, 089	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	48, 242, 234	-	48, 242, 23	34 0	48, 242, 234	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	135, 717, 605	5	135, 717, 60	05 0	135, 717, 605	73.00
74.00 07400 RENAL DI ALYSI S	4, 135, 180		4, 135, 18	30 0	4, 135, 180	
75. 01 07501 CARDI AC REHAB	915, 901		915, 90	01 0	915, 901	75.01
75.02 07502 SLEEP LAB	C			0 0	0	75.02
75.03 07503 INPATIENT DIALYSIS	C			0 0	0	
75.04 07504 PAIN MANAGEMENT	1, 475, 727		1, 475, 72			
76. 97 07697 CARDI AC REHABI LI TATI ON	C			0 0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	C			0 0		
76. 99 07699 LI THOTRI PSY	C			0 0	0	76.99
	F 252 052	,F	F 252 0		F 252 052	
90.00 09000 CLINIC	5, 353, 853		5, 353, 85			
90. 01 09001 PATIENT TREATMENT CENTER	4, 531, 311		4, 531, 31			
90. 02 09002 REHAB SERVI CES-BLOOMI NGDALE 90. 03 09003 CANTERA	0			0 0	0	
90. 03 09003 CANTERA 90. 04 09004 MENTAL HEALTH 0/P	3, 085, 940		3, 085, 94		-	•
90. 05 09005 WOMENS CLINIC	3, 005, 940		3,003,92	0 0	3,085,940	90.04
90. 06 09006 WOUND CARE	351, 821		351, 82	21 0	-	•
91. 00 09100 EMERGENCY	33, 873, 102		33, 873, 10		33, 873, 102	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	23, 192, 990		23, 192, 99		23, 192, 990	
OTHER REIMBURSABLE COST CENTERS	20,172,770		20,172,7	-1	23, 172, 770	1
99. 10 09910 CORF	C			0	0	99.10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY				0	0	•
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY				0	0	1
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY				0	0	
200.00 Subtotal (see instructions)	903, 123, 180	0	903, 123, 18	53, 733		
201.00 Less Observation Beds	23, 192, 990		23, 192, 99		23, 192, 990	
202.00 Total (see instructions)	879, 930, 190					
			•			

	Financial Systems TION OF RATIO OF COSTS TO CHARGES	CENTRAL DUPAG	Provi der C	CN: 14-0242	Peri od:	Worksheet C	2552-10
				GN. 14-0242	From 09/01/2021 To 08/31/2022	Part I	
			Title	e XVIII	Hospi tal	PPS	bo pili
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	-
I	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	233, 889, 581		233, 889, 58			30.00
	03100 INTENSIVE CARE UNIT	51, 013, 003		51, 013, 00)3		31.00
	D3200 CORONARY CARE UNIT	17, 478, 031		17, 478, 03			32.00
	D2060 NEONATAL INTENSIVE CARE UNIT	63, 138, 684		63, 138, 68			35.00
	04000 SUBPROVIDER - IPF	43, 193, 450		43, 193, 45			40.00
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	11, 352, 126		11, 352, 12	26		43.00
	D5000 OPERATI NG ROOM	165, 447, 644	270, 878, 583	436, 326, 22	0. 122968	0. 000000	50.00
	D5100 RECOVERY ROOM	20, 262, 470					
	D5200 DELIVERY ROOM & LABOR ROOM	41, 771, 819					
	05300 ANESTHESI OLOGY	44, 414, 254	66, 567, 960			0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	31, 951, 326	94, 105, 446				
	05500 RADI OLOGY-THERAPEUTI C	26, 550, 268	168, 396, 206				
56.00	05600 RADI OI SOTOPE	5, 392, 892	29, 768, 682	35, 161, 57	0. 102084	0. 000000	56.00
57.00 0	D5700 CT SCAN	70, 432, 545	159, 782, 758	230, 215, 30	0. 021571	0. 000000	57.00
	05800 MRI	23, 381, 492					
	06000 LABORATORY	152, 837, 246				0. 000000	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	15, 589, 013				0. 000000	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0.00000	0. 000000	
	06400 I NTRAVENOUS THERAPY	11, 287, 888	62, 819, 042			0. 000000	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	62, 358, 657 9, 293, 404	4, 543, 639 91, 964, 087			0. 000000 0. 000000	
	06700 OCCUPATI ONAL THERAPY	6, 192, 305	12, 005, 650			0. 000000	
	06800 SPEECH PATHOLOGY	5, 659, 565	3, 721, 087			0. 000000	
	06900 ELECTROCARDI OLOGY	103, 963, 901	180, 109, 409				
	D7000 ELECTROENCEPHALOGRAPHY	14, 380, 128				0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	245, 371, 287	248, 920, 928				
72.00	D7200 IMPL. DEV. CHARGED TO PATIENTS	155, 306, 713	145, 393, 489	300, 700, 20	0. 160433	0. 000000	72.00
	07300 DRUGS CHARGED TO PATIENTS	326, 912, 959	796, 719, 834	1, 123, 632, 79	0. 120785	0. 000000	73.00
	07400 RENAL DI ALYSI S	10, 784, 842	593, 452			0. 000000	
	07501 CARDI AC REHAB	6, 919	3, 005, 684			0. 000000	
	07502 SLEEP LAB	0	0		0 0.00000		
	07503 I NPATI ENT DI ALYSI S	0	0		0 0.00000		
	D7504 PALN MANAGEMENT D7697 CARDIAC REHABILITATION	43, 642	2, 357, 524 0		0. 614588 0. 000000		
	D7698 HYPERBARI C OXYGEN THERAPY	0	0		0 0.000000		
	07699 LI THOTRI PSY	0	0		0 0.000000		
	DUTPATIENT SERVICE COST CENTERS	0	0		0 0.00000	0.00000	/ /0. //
90.00	09000 CLINIC	930, 782	18, 574, 849	19, 505, 63	0. 274477	0. 000000	90.00
	09001 PATIENT TREATMENT CENTER	11, 100, 827					
	09002 REHAB SERVI CES-BLOOMI NGDALE	0	0		0 0. 000000		
	09003 CANTERA	0	0		0 0. 000000		
90.04	09004 MENTAL HEALTH 0/P	3, 137, 207	14, 987, 683	18, 124, 89	0. 170260	0. 000000	90.04
	09005 WOMENS CLINIC	0	0		0 0. 000000		
	09006 WOUND CARE	30, 440	3, 097, 427				
1	09100 EMERGENCY	66, 689, 619					
	09200 OBSERVATION BEDS (NON-DISTINCT PART	15, 778, 703	37, 129, 001	52, 907, 70	0. 438367	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS				0		00 10
	09920 OUTPATIENT PHYSICAL THERAPY	0	0		0		99.10 99.20
	09930 OUTPATIENT PHYSICAL THERAPY		0		0		99.20
	09940 OUTPATIENT SPEECH PATHOLOGY		0		0		99.30
200.00	Subtotal (see instructions)	2,067,325,632	4, 194, 566, 733	6.261 892 34	5		200.00
200.00	Less Observation Beds	_,,,	., . , ., .,, ,] _, _0, _, 0, _, 0			200.00
		1		1 · · · · · · · · · · · · · · · · · · ·	1		

Heal th	Financial Systems	CENTRAL DUPAGE	HOSPI TAL	In Lieu	J of Form CMS-2552-1
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0242	Period: From 09/01/2021	Worksheet C Part I
				To 08/31/2022	Date/Time Prepared
			Title XVIII	Hospi tal	1/28/2023 6:30 pm PPS
	Cost Center Description	PPS Inpatient			
		Rati o 11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30.00	03000 ADULTS & PEDIATRICS				30.0
31.00	03100 I NTENSI VE CARE UNI T				31.0
32.00 35.00	03200 CORONARY CARE UNIT				32.0
40.00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF				35.0 40.0
43.00	04300 NURSERY				43.0
	ANCI LLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 122968			50.0
51.00	05100 RECOVERY ROOM	0. 148102			51.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.342050			52.0
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0. 042905 0. 132558			53.0 54.0
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 122997			55.0
56.00	05600 RADI OI SOTOPE	0. 102084			56.0
57.00	05700 CT SCAN	0. 021571			57.0
58.00	05800 MRI	0.063145			58.0
60.00	06000 LABORATORY	0. 116551			60.0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 325637			62.0
62.30 64.00	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.3 64.0
65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0. 024002 0. 140290			65.0
66.00	06600 PHYSI CAL THERAPY	0. 191564			66.0
67.00	06700 OCCUPATI ONAL THERAPY	0. 166311			67.0
68.00	06800 SPEECH PATHOLOGY	0. 194054			68.0
69.00	06900 ELECTROCARDI OLOGY	0.064148			69.0
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 111181			70.0
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0.093148			71.0
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0. 160433			72. 0 73. 0
74.00	07400 RENAL DIALYSIS	0. 120785 0. 363427			73.0
75.01	07501 CARDI AC REHAB	0. 304023			75.0
75.02	07502 SLEEP LAB	0.000000			75.0
75.03	07503 I NPATI ENT DI ALYSI S	0.000000			75.0
75.04	07504 PAIN MANAGEMENT	0. 614588			75.0
76.97	07697 CARDI AC REHABI LI TATI ON	0.00000			76.9
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0.000000			76.9
70.99	OUTPATIENT SERVICE COST CENTERS	0.000000			/0.9
90.00	09000 CLINIC	0. 274477			90.0
90.01	09001 PATIENT TREATMENT CENTER	0. 094744			90.0
	09002 REHAB SERVI CES-BLOOMI NGDALE	0. 000000			90.0
	09003 CANTERA	0.000000			90.0
	09004 MENTAL HEALTH 0/P	0. 170260			90.0
90. 05 90. 06	09005 WOMENS CLINIC 09006 WOUND CARE	0.000000 0.112480			90.0 90.0
90.00 91.00	09100 EMERGENCY	0. 137716			90.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 438367			92.0
	OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF				99. 1
99.20	09920 OUTPATIENT PHYSICAL THERAPY				99.2
	09930 OUTPATIENT OCCUPATIONAL THERAPY				99.3
99.40 200.00	09940 OUTPATIENT SPEECH PATHOLOGY Subtotal (see instructions)				99. 4 200. 0
200.00					200.0
201.00					201.0
		· ·			1

Health Financial Systems	CENTRAL DUPA	GE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 14-0242	Period: From 09/01/2021 To 08/31/2022	Worksheet C Part I Date/Time Pre 1/28/2023 6:3	
		Ti tl	e XIX	Hospi tal	Cost	<u>o piii</u>
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	Costs RCE Disallowance	Total Costs	
	26)	2.00	2.00	4.00	F 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	133, 024, 110		133, 024, 1	10 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	27, 495, 694		27, 495, 6		0	
32.00 03200 CORONARY CARE UNIT	8, 223, 802		8, 223, 8	02 0	0	32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	14, 717, 240		14, 717, 2	40 0	0	35.00
40. 00 04000 SUBPROVIDER - IPF	20, 063, 352		20, 063, 3	52 0	0	40.00
43.00 04300 NURSERY	4, 401, 553	6	4, 401, 5	53 0	0	43.00
ANCILLARY SERVICE COST CENTERS		1				
50.00 05000 OPERATING ROOM	53, 654, 380		53, 654, 3		0	
51.00 05100 RECOVERY ROOM	14, 754, 271		14, 754, 2		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	18, 008, 035		18, 008, 0		0	52.00
53.00 05300 ANESTHESI OLOGY	4, 761, 672		4, 761, 6		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	16, 709, 772		16, 709, 7		0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	23, 930, 198		23, 930, 1		0	55.00
56. 00 05600 RADI OI SOTOPE	3, 589, 445		3, 589, 4		0	56.00
57. 00 05700 CT SCAN	4, 966, 064		4, 966, 0		0	57.00
58. 00 05800 MRI	6, 886, 458		6, 886, 4		0	58.00
	176, 042, 003		176, 042, 0		0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	7, 178, 152		7, 178, 1	0 0	0	62.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 64. 00 06400 INTRAVENOUS THERAPY	-		1 770 7	-	0	62.30 64.00
65. 00 06500 RESPIRATORY THERAPY	1, 778, 724 9, 385, 739		1, 778, 7 9, 385, 7		0	65.00
66. 00 06600 PHYSI CAL THERAPY	19, 397, 286				0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	3, 026, 512				0	67.00
68. 00 06800 SPEECH PATHOLOGY	1, 820, 354			-	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	18, 222, 634		18, 222, 6		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	4, 167, 977		4, 167, 9		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	46, 042, 089		46, 042, 0		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	48, 242, 234		48, 242, 2		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	135, 717, 605		135, 717, 6		0	73.00
74.00 07400 RENAL DIALYSIS	4, 135, 180		4, 135, 1		0	74.00
75. 01 07501 CARDI AC REHAB	915, 901		915, 9		0	75.01
75.02 07502 SLEEP LAB	C			0 0	0	75.02
75. 03 07503 I NPATI ENT DI ALYSI S	C			0 0	0	75.03
75.04 07504 PAIN MANAGEMENT	1, 475, 727		1, 475, 7	27 0	0	75.04
76. 97 07697 CARDI AC REHABI LI TATI ON	C			0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	C			0 0	0	76.98
76. 99 07699 LI THOTRI PSY	C			0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS	-	1	1			
90.00 09000 CLINIC	5, 353, 853		5, 353, 8			
90.01 09001 PATIENT TREATMENT CENTER	4, 531, 311		4, 531, 3		0	
90. 02 09002 REHAB SERVI CES-BLOOMI NGDALE	C			0 0	0	
90. 03 09003 CANTERA	C			0 0	0	90.03
90.04 09004 MENTAL HEALTH 0/P	3, 085, 940		3, 085, 9	40 0	0	90.04
90. 05 09005 WOMENS CLINIC	051 001		054.0	0 0	0	90.05
90. 06 09006 WOUND CARE	351, 821		351, 8		0	90.06
91.00 09100 EMERGENCY	33, 873, 102		33, 873, 1		0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS	23, 192, 990	/	23, 192, 9	70	0	92.00
99.10 09910 CORF	C			0	0	99.10
99. 10 09910 CORF 99. 20 09920 OUTPATIENT PHYSICAL THERAPY				0	0	1
99. 30 09930 OUTPATIENT PHISICAL THERAPY				0	0	
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY				0	0	
200.00 Subtotal (see instructions)	903, 123, 180	o o	903, 123, 1	80 0		200.00
201.00 Less Observation Beds	23, 192, 990		23, 192, 9			200.00
202.00 Total (see instructions)	879, 930, 190					202.00
	, , , , , , , , , , , , , , , , , , , ,		,		, u	

COMPUT	Financial Systems ATION OF RATIO OF COSTS TO CHARGES		GE HOSPITAL Provider C		Period: From 09/01/2021 To 08/31/2022	u of Form CMS-: Worksheet C Part I Date/Time Pre 1/28/2023 6:3	pared:
		_	Titl	e XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	Charges Outpati ent	Total (col. (+ col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	233, 889, 581		233, 889, 58			30.00
31.00	03100 INTENSIVE CARE UNIT	51, 013, 003		51, 013, 00	3		31.00
	03200 CORONARY CARE UNIT	17, 478, 031		17, 478, 03	1		32.00
	02060 NEONATAL INTENSIVE CARE UNIT	63, 138, 684		63, 138, 68			35.00
	04000 SUBPROVI DER – I PF	43, 193, 450		43, 193, 45			40.00
	04300 NURSERY	11, 352, 126		11, 352, 12	6		43.00
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM	165, 447, 644	270, 878, 583				
	05100 RECOVERY ROOM	20, 262, 470	79, 360, 194			0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM	41, 771, 819	10, 875, 529			0. 000000	
	05300 ANESTHESI OLOGY	44, 414, 254	66, 567, 960			0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	31, 951, 326	94, 105, 446			0. 000000	
	05500 RADI OLOGY-THERAPEUTI C	26, 550, 268	168, 396, 206	194, 946, 47		0. 000000	
	05600 RADI OI SOTOPE	5, 392, 892	29, 768, 682			0. 000000	
	05700 CT SCAN	70, 432, 545	159, 782, 758			0. 000000	
	05800 MRI	23, 381, 492	85, 676, 720		2 0. 063145	0. 000000	
	06000 LABORATORY	152, 837, 246	1, 357, 595, 392	1, 510, 432, 63		0. 000000	
52.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	15, 589, 013	6, 454, 371	22, 043, 38	4 0. 325637	0. 000000	62.00
52.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0. 000000	0. 000000	62.30
54.00	06400 I NTRAVENOUS THERAPY	11, 287, 888	62, 819, 042	74, 106, 93	0 0. 024002	0. 000000	64.00
65.00	06500 RESPI RATORY THERAPY	62, 358, 657	4, 543, 639	66, 902, 29	6 0. 140290	0. 000000	65.00
66.00	06600 PHYSI CAL THERAPY	9, 293, 404	91, 964, 087	101, 257, 49	1 0. 191564	0. 000000	66.00
57.00	06700 OCCUPATI ONAL THERAPY	6, 192, 305	12, 005, 650	18, 197, 95	5 0. 166311	0. 000000	67.00
58.00	06800 SPEECH PATHOLOGY	5, 659, 565	3, 721, 087	9, 380, 65	2 0. 194054	0. 000000	68.00
59.00	06900 ELECTROCARDI OLOGY	103, 963, 901	180, 109, 409	284, 073, 31	0 0. 064148	0. 000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	14, 380, 128	23, 162, 140	37, 542, 26	8 0. 111021	0. 000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	245, 371, 287	248, 920, 928	494, 292, 21	5 0. 093148	0. 000000	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	155, 306, 713	145, 393, 489	300, 700, 20	2 0. 160433	0. 000000	72.00
	07300 DRUGS CHARGED TO PATIENTS	326, 912, 959	796, 719, 834	1, 123, 632, 79	3 0. 120785	0. 000000	73.00
	07400 RENAL DI ALYSI S	10, 784, 842	593, 452	11, 378, 29	4 0. 363427	0. 000000	74.00
75.01	07501 CARDI AC REHAB	6, 919	3, 005, 684	3, 012, 60	3 0. 304023	0. 000000	75.01
75.02	07502 SLEEP LAB	0	0		0 0. 000000	0. 000000	75.02
	07503 INPATIENT DIALYSIS	0	0		0 0. 000000	0. 000000	75.03
	07504 PAIN MANAGEMENT	43, 642	2, 357, 524	2, 401, 16		0. 000000	
	07697 CARDI AC REHABI LI TATI ON	0	0		0 0. 000000	0. 000000	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0. 000000	0. 000000	76.98
76.99	07699 LI THOTRI PSY	0	0		0 0. 000000	0. 000000	76.99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	930, 782	18, 574, 849		1 0. 274477	0. 000000	
	09001 PATIENT TREATMENT CENTER	11, 100, 827	36, 725, 929	47, 826, 75			
90. 02	09002 REHAB SERVI CES-BLOOMI NGDALE	0	0		0 0. 000000	0. 000000	
	09003 CANTERA	0	0		0 0. 000000	0. 000000	90.03
90.04	09004 MENTAL HEALTH 0/P	3, 137, 207	14, 987, 683	18, 124, 89	0 0. 170260	0. 000000	90.04
90.05	09005 WOMENS CLINIC	0	0		0 0. 000000	0. 000000	90.05
90.06	09006 WOUND CARE	30, 440	3, 097, 427	3, 127, 86	7 0. 112480	0. 000000	90.06
	09100 EMERGENCY	66, 689, 619	179, 274, 038		7 0. 137716	0. 000000	91.00
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	15, 778, 703	37, 129, 001	52, 907, 70	4 0. 438367	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09910 CORF	0	0		0		99.10
	09920 OUTPATIENT PHYSICAL THERAPY	0	0		0		99.20
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0		0		99.3
	09940 OUTPATIENT SPEECH PATHOLOGY	0	0		0		99.4
200. 00		2, 067, 325, 632	4, 194, 566, 733	6, 261, 892, 36	5		200.00
201.00							201.00
202.00	Total (see instructions)	2 067 325 632	4, 194, 566, 733	6 261 892 36	5		202.0

Heal th	Financial Systems	CENTRAL DUPAGE	HOSPI TAL	In Lieu	」of Form CMS-2552-
	ATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 14-0242	Period: From 09/01/2021 To 08/31/2022	Worksheet C Part I Date/Time Prepared
			Title XIX	Hospi tal	1/28/2023 6:30 pm Cost
	Cost Center Description	PPS Inpatient Ratio 11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS	1 11.00			
30.00	03000 ADULTS & PEDIATRICS				30.
31.00	03100 INTENSIVE CARE UNIT				31.
32.00	03200 CORONARY CARE UNIT				32.
35.00	02060 NEONATAL INTENSIVE CARE UNIT				35.
40.00	04000 SUBPROVI DER – I PF				40.
43.00	04300 NURSERY				43.
	ANCI LLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000			50.
51.00	05100 RECOVERY ROOM	0.000000			51.
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.
53.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0.000000			53.
54.00 55.00	05500 RADI OLOGY - DI AGNOSTI C	0.000000			54. 55.
55.00 56.00	05500 RADI OLOGY - THERAPEOTIC	0.000000			55.
57.00	05700 CT SCAN	0.000000			57.
57.00	05800 MRI	0.000000			58.
60.00	06000 LABORATORY	0.000000			60.
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.
64.00	06400 I NTRAVENOUS THERAPY	0.000000			64.
65.00	06500 RESPI RATORY THERAPY	0.000000			65.
66.00	06600 PHYSI CAL THERAPY	0.000000			66.
67.00	06700 OCCUPATI ONAL THERAPY	0.000000			67.
68.00	06800 SPEECH PATHOLOGY	0.000000			68.
69.00	06900 ELECTROCARDI OLOGY	0.000000			69.
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.
74.00	07400 RENAL DI ALYSI S	0.000000			74.
75.01	07501 CARDI AC REHAB	0.000000			75.
75.02	07502 SLEEP LAB	0.000000			75.
75.03	07503 I NPATI ENT DI ALYSI S	0.000000			75.
75.04	07504 PAIN MANAGEMENT	0.000000			75.
76.97	07697 CARDI AC REHABI LI TATI ON	0.000000			76.
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0.000000			76.
/0.99		0. 000000			
90.00	OUTPATIENT SERVICE COST CENTERS	0.000000			90.
90.00 90.01	09001 PATIENT TREATMENT CENTER	0.000000			90.
	09002 REHAB SERVICES-BLOOMINGDALE	0.000000			90.
	09003 CANTERA	0.000000			90.
90.04		0.000000			90.
90.05	09005 WOMENS CLINIC	0.000000			90.
90.06	09006 WOUND CARE	0.000000			90.
91.00	09100 EMERGENCY	0.000000			91.
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.
	OTHER REIMBURSABLE COST CENTERS				721
99.10	09910 CORF				99.
99.20	09920 OUTPATIENT PHYSICAL THERAPY				99.
99.30					99.
99.40	09940 OUTPATIENT SPEECH PATHOLOGY				99.
200.00	Subtotal (see instructions)				200.
201.00					201.
202.00	Total (see instructions)				202.

Health Financial Systems	CENTRAL DUPA	GE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	CN: 14-0242	Period: From 09/01/2021	Worksheet D	
				To 08/31/2022		pared.
				10 00/01/2022	1/28/2023 6: 3	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30.00 ADULTS & PEDIATRICS	15, 524, 041	0	15, 524, 04			
31.00 INTENSIVE CARE UNIT	2, 847, 157		2, 847, 15		326.10	
32.00 CORONARY CARE UNI T	718, 265		718, 26			32.00
35.00 NEONATAL INTENSIVE CARE UNIT	1, 050, 965		1, 050, 96			
40.00 SUBPROVIDER - IPF	2, 876, 580		2, 876, 58		345.58	
43.00 NURSERY	642, 979		642, 97			43.00
200.00 Total (lines 30 through 199)	23, 659, 987		23, 659, 98	7 127, 104		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	-			
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30.00 ADULTS & PEDIATRICS	26, 507					30.00
31.00 INTENSIVE CARE UNIT	2, 771	903, 623				31.00
32.00 CORONARY CARE UNIT	0	0				32.00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35.00
40.00 SUBPROVIDER - IPF	1, 155	399, 145				40.00
43.00 NURSERY	0	0	1			43.00
200.00 Total (lines 30 through 199)	30, 433	5, 666, 615				200.00

CN: 14-0242	Period:	eu of Form CMS-: Worksheet D	2002-10
CN. 14-0242	From 09/01/2021 To 08/31/2022	Part II	pared:
e XVIII	Hospi tal	PPS	o pii
Ratio of Cos		Capital Costs	
to Charges	Program	(column 3 x	
(col. 1 ÷ col		column 4)	
2)	Ŭ		
3.00	4.00	5.00	
	-		
0. 01532		827, 710	50.00
0. 01099		57, 228	51.00
0. 0361	71 54, 493	1, 971	52.00
0. 0022	12 14, 199, 762	31, 410	53.00
0. 01833	36 11, 945, 039	219, 024	54.00
0. 01450	69 12, 322, 090	179, 521	55.00
0.00794	45 2, 352, 889	18, 694	56.00
0. 00184		51, 475	57.00
0. 0039	15 8, 289, 018	32, 452	58.00
0.00515	58 49, 044, 878	252, 973	60.00
0. 01430	60 4, 791, 068	68, 800	62.00
0. 00000	00 00	0	62.30
0.00120	03 2, 602, 674	3, 131	64.00
0.00852	23 18, 613, 357	158, 642	65.00
0. 01122	3, 837, 961	43,070	66.00
0.00593	32 2, 683, 281	15, 917	67.00
0.00839	96 2, 583, 775	21, 693	68.00
0.00813			69.00
0.00950			
0.0029			71.00
0.0051			72.00
0.00369			1
0.01019			
0.00940			
0.0000			75.02
0.0000	00 00	0	75.03
0. 08486		1, 212	75.04
0.0000			•
0,0000		0	•
0.0000	00 0	0	76.99
		-	1
0. 0867	18 78, 128	6, 775	90.00
0. 01252			•
0. 00000			
0. 00000		-	•
0. 02100			
0.0000			•
0.00790			
			•
	0. 0131	0. 013113 23, 327, 690 0. 051158 6, 020, 652	0. 013113 23, 327, 690 305, 896

Cost Center Description Nursing Program Adjustments Nursing Program 1A Nursing Program Adjustments Allied Health Cost Allied Health Cost Allied Health Cost Allied Health Cost Allied Health Cost Allied Health Medica 30.00 03000 (ADULTS & PEDIATRICS 1A 1.00 2A 2.00 3.00 30.00 03000 (ADULTS & PEDIATRICS 0 0 0 0 0 0 30.00 03200 (CORONARY CARE UNIT 0<	MS-2	552-1
Cost Center Description Nursing Program Adjustments Nursing Program Adjustments Allied Health Post-Stepdown Adjustments Allied Health Cost Allied Health Cost Allied Health Medica 30.00 03000 ADULTS & PEDIATRICS 1A 1.00 2A 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 0 <td>Prep</td> <td>oared:) pm</td>	Prep	oared:) pm
Program Post-Stepdown Adjustments Program Adjustments Post-Stepdown Adjustments Cost Medica Education 30.00 03000 ADULTS & PEDIATRICS 0 </td <td>S</td> <td></td>	S	
Post-STepdown Adjustments Adjustments Education 1A 1.00 2A 2.00 3.00 0.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 30.00 03100 INTENSI VE CARE UNIT 0	-	
Adj ustments Adj ustments<		
INPATIENT ROUTINE SERVICE COST CENTERS 0	ost	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 </td <td></td> <td></td>		
30.00 O3000 ADULTS & PEDIATRICS 0 0 0 0 31.00 O3100 INTENSI VE CARE UNIT 0 0 0 0 32.00 CORONARY CARE UNIT 0 0 0 0 0 32.00 CORONARY CARE UNIT 0 0 0 0 0 35.00 O2060 NEONATAL INTENSIVE CARE UNIT 0 0 0 0 40.00 SUBPROVIDER - IPF 0 0 0 0 0 200.00 Total (lines 30 through 199) 0 0 0 0 0 200.00 Total Restrictions) Swing-Bed Adjustment Amount (see instructions) Total Costs (sum of cols. 1 through 3, minus col. 4) Total Patient Per Diem (col. 5 ÷ col. 6) Inpatie 30.00 O3000 ADULTS & PEDIATRICS 0 0 8.00 20 31.00 03100 INTENSIVE CARE UNIT 0 3.1 through 3, minus col. 4) 0 3.125 0.00 2 32.00 03000 ADULTS & PEDIATRICS 0 0 3.125 0.00 2		
31.00 03100 INTENSIVE CARE UNIT 0 0 0 0 32.00 03200 CORONARY CARE UNIT 0 0 0 0 35.00 02060 NEONATAL INTENSIVE CARE UNIT 0 0 0 0 40.00 04000 SUBPROVIDER - IPF 0 0 0 0 0 200.00 Total (lines 30 through 199) 0 0 0 0 0 0 Cost Center Description Swing-Bed Adjustment Amount (see instructions) Total Costs (sum of cols. 1 through 3, instructions) Total Costs (sum of cols. 1 through 3, instructions) Total Patient Days Per Diem (col . 5 + col . 6) Inpatie Program I 30.00 03000 ADULTS & PEDIATRICS 0 0 6.00 7.00 8.00 31.00 03100 INTENSIVE CARE UNIT 0 3,125 0.00 24 32.00 03200 CORNARY CARE UNIT 0 3,125 0.00 24 32.00 03200 CORNARY CARE UNIT 0 3,324 0.00 4,956 0 4,956 0 4,956 0 4,9		
32.00 03200 CORONARY CARE UNIT 0 0 0 0 35.00 02060 NEONATAL INTENSIVE CARE UNIT 0 0 0 0 40.00 O4000 SUBPROVIDER - IPF 0 0 0 0 200.00 Total (lines 30 through 199) 0 0 0 0 0 200.00 Total (lines 30 through 199) 0 0 0 0 0 Cost Center Description Swing-Bed Adjustment Amount (see instructions) Total Costs minus col. 4) Total Patient Days Per Diem (col. 5 + col. 6) Inpatie 1 NPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 03000 0 0 3.00 2.00 31.00 03000 ADULTS & PEDIATRICS 30.00 0 0 3.125 0.00 32.00 03200 CORONARY CARE UNIT 0 0 3.125 0.00 32.00 03200 CORONARY CARE UNIT 0 0 3.24 0.00 43.00 04300 NURSERY 0 4.956 0.00 200.00 Total (lines 30 through 199) 0 127,104 30 Cost Center Description	0	30.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT 0 0 0 0 40.00 SUBPROVIDER - IPF 0 0 0 0 0 43.00 O4300 NURSERY 0 0 0 0 0 200.00 Total (Lines 30 through 199) 0 0 0 0 0 0 Cost Center Description Swing-Bed Adjustment INPATIENT ROUTINE SERVICE COST CENTERS Total Costs (sum of cols. 1 through 3, instructions) minus col. 4) Total Patient Days Per Diem (col. 5 ÷ col. 6) Inpatie Program I INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 94,298 0.00 26 31.00 03000 ADULTS & PEDIATRICS 0 0 8,731 0.00 26 32.00 03200 CORONARY CARE UNIT 0 0 3,125 0.00 26 35.00 02060 NEONATAL INTENSIVE CARE UNIT 0 0 7,670 0.00 26 35.00 02060 NEONARY CARE UNIT 0 0 127,104 0 20 32.00 02060 NEON	0	31.00
40.00 04000 SUBPROVI DER - IPF 0 0 0 0 0 200.00 Total (lines 30 through 199) 0 0 0 0 0 0 Cost Center Description Swing-Bed Adjustment Amount (see instructions) Total Costs (sum of cols. 1 through 3, minus col. 4) Total Patient Days Per Diem (col. 5 ÷ col. 6) Inpatie Program I 30.00 03000 ADULTS & PEDIATRICS 0 6.00 7.00 8.00 31.00 03100 INTENSI VE CARE UNI T 0 8,731 0.00 220 32.00 02060 NURSERY 0 0 7,670 0.00 24 32.00 02060 NEDRAL INTENSI VE CARE UNI T 0 8,324 0.00 24 35.00 02060 NURSERY 0 4,956 0.00 24 200.00 Total (lines 30 through 199) 1 0 127,104 30 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x 1 30 30	0	32.00
43.00 04300 NURSERY 0	0	35.00
200.00 Total (lines 30 through 199) 0	0	40.00
Cost Center DescriptionSwing-Bed Adjustment Amount (see instructions)Total Costs (sum of cols. 1 through 3, minus col. 4)Total Patient DaysPer Diem (col. 5 ÷ col. 6)Inpatie Program 130.0003000 03000 ADULTS & PEDIATRICSINPATIENT ROUTINE SERVICE COST CENTERS000.007.008.0030.0003000 03000 ADULTS & PEDIATRICS0094,2980.002430.0003000 03000 1NTENSI VE CARE UNIT08,7310.002431.0003200 03200 04000 40.00000100010002432.0003200 04000 04000 04000 2000NURATAL INTENSI VE CARE UNIT07,6700.0043.0004300 04300 00NURSERY100010004,9560.001000200.00Total (lines 30 through 199)01npatient Program Pass-Through Cost (col. 7 x1000127,10430	0	43.00
Adj ustment Amount (see instructions) Call ustment I through 3, minus col. 4) Days 5 ÷ col. 6) Program I 1 Mount (see instructions) 1 through 3, minus col. 4) 5 ÷ col. 6) Program I 30.00 03000 ADULTS & PEDIATRICS 0 6.00 7.00 8.00 31.00 03100 INTENSI VE CARE UNIT 0 8,731 0.00 26 32.00 03200 CORNARY CARE UNIT 0 3,125 0.00 26 35.00 02060 NEONATAL INTENSI VE CARE UNIT 0 7,670 0.00 26 43.00 04300 NURSERY 0 0 4,956 0.00 27 200.00 Total (lines 30 through 199) 0 127,104 30 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x 0 127,104 30	02	200. 00
Amount (see instructions) 1 through 3, minus col. 4) 3 <t< td=""><td>:</td><td></td></t<>	:	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 35.00 02600 NEONATAL INTENSIVE CARE UNIT 35.00 04000 SUBPROVIDER - IPF 0 0 43.00 04300 NURSERY 200.00 Total (lines 30 through 199) 1 1 1 0 200.00 Total (lines 30 through 199) 1 1 1 0 1 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0	ys	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 0 0 94, 298 0.00 26 31. 00 03100 INTENSI VE CARE UNI T 0 8, 731 0.00 26 32. 00 03200 CORONARY CARE UNI T 0 3, 125 0.00 2 35. 00 02060 NEONATAL INTENSI VE CARE UNI T 0 7, 670 0.00 2 40. 00 04000 SUBPROVI DER - 1 PF 0 0 8, 324 0.00 2 200. 00 Total (Lines 30 through 199) 0 127, 104 30 30 Cost Center Description		
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 94,298 0.00 26 31.00 03100 INTENSIVE CARE UNIT 0 8,731 0.00 26 32.00 03200 CORONARY CARE UNIT 0 3,125 0.00 2 35.00 02060 NEONATAL INTENSIVE CARE UNIT 0 7,670 0.00 2 40.00 04000 SUBPROVIDER - IPF 0 0 8,324 0.00 2 200.00 Total (lines 30 through 199) 0 127,104 30 Cost Center Description		
30. 00 03000 ADULTS & PEDIATRICS 0 0 94, 298 0. 00 26 31. 00 03100 INTENSIVE CARE UNIT 0 8, 731 0. 00 22 32. 00 03200 CORNARY CARE UNIT 0 3, 125 0. 00 20 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 0 7, 670 0. 00 40. 00 04000 SUBPROVIDER - IPF 0 0 8, 324 0. 00 43. 00 04300 NURSERY 0 4, 956 0. 00 0 200. 00 Total (lines 30 through 199) 0 127, 104 30 Cost Center Description		
31.00 03100 INTENSIVE CARE UNIT 0 8,731 0.00 2 32.00 03200 CORONARY CARE UNIT 0 3,125 0.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 0 7,670 0.00 40.00 04000 SUBPROVIDER - IPF 0 0 8,324 0.00 43.00 04300 NURSERY 0 4,956 0.00 0 200.00 Total (lines 30 through 199) 0 127,104 30 Cost Center Description		
32.00 03200 CORONARY CARE UNIT 0 3,125 0.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 0 7,670 0.00 40.00 04000 SUBPROVIDER - IPF 0 0 8,324 0.00 43.00 04300 NURSERY 0 4,956 0.00 200.00 Total (lines 30 through 199) 0 127,104 30 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x	507	30.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 0 7,670 0.00 40. 00 04000 SUBPROVIDER - IPF 0 0 8,324 0.00 43. 00 04300 NURSERY 0 4,956 0.00 200. 00 Total (lines 30 through 199) 0 127,104 30 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x	771	31.00
40.00 04000 SUBPROVIDER - IPF 0 0 8,324 0.00 43.00 04300 NURSERY 0 4,956 0.00 200.00 Total (lines 30 through 199) 0 127,104 30 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x	0	32.00
43.00 04300 NURSERY 0 4,956 0.00 200.00 Total (lines 30 through 199) 0 127,104 30 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x	0	35.00
200.00 Total (lines 30 through 199) 0 127,104 30 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x	155	40.00
Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x	0	43.00
Program Pass-Through Cost (col. 7 x	433 2	200.00
Pass-Through Cost (col. 7 x		
Cost (col. 7 x		
col 8)		
9.00		
INPATIENT ROUTINE SERVICE COST CENTERS		
30. 00 03000 ADULTS & PEDIATRICS 0		30.00
31.00 03100 INTENSIVE CARE UNIT 0		31.00
32. 00 03200 CORONARY CARE UNIT 0		32.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 0		35.00
40. 00 04000 SUBPROVIDER - I PF 0		40.00
43. 00 04300 NURSERY 0		43.00
200.00 Total (lines 30 through 199) 0		200.00

Health Financial Systems	CENTRAL DUPA	GE HOSPI TAL			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	ERVICE OTHER PAS	S Provider C	CN: 14-0242	P€ Fr To	eriod: com 09/01/2021 p 08/31/2022	Worksheet D Part IV Date/Time Pre 1/28/2023 6:3	
		Title	XVIII		Hospi tal	PPS	
Cost Center Description	Non Physi ci an	Nursi ng	Nursi ng		Allied Health	Allied Health	
	Anesthetist	Program	Program		Post-Stepdown		
	Cost	Post-Stepdown			Adjustments		
		Adjustments					
	1.00	2A	2.00		ЗA	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0			0	0	0	50.00
51.00 05100 RECOVERY ROOM	0			0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0	0	0	56.00
57.00 05700 CT SCAN	0	0		0	0	0	57.00
58.00 05800 MRI	0	0		0	0	0	58.00
60. 00 06000 LABORATORY	0	0		0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	0	62.30
64.00 06400 INTRAVENOUS THERAPY	0	0		0	0	0	64.00
65.00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0	0	0	74.00
75. 01 07501 CARDI AC REHAB	0	0		0	0	0	75.01
75.02 07502 SLEEP LAB	0	0		0	0	0	75.02
75.03 07503 INPATIENT DIALYSIS	0	0		0	0	0	75.03
75.04 07504 PAIN MANAGEMENT	0	0		0	0	0	75.04
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	0	76.98
76. 99 07699 LI THOTRI PSY	0	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS				- 1			
90. 00 09000 CLINIC	0	0		0	0	0	90.00
90. 01 09001 PATIENT TREATMENT CENTER	0			0	0	0	90.01
90. 02 09002 REHAB SERVI CES-BLOOMI NGDALE	0	0		0	0	0	90.02
90. 03 09003 CANTERA	0	0		0	0	0	90.03
90.04 09004 MENTAL HEALTH 0/P	0	0		0	0	0	90.04
90. 05 09005 WOMENS CLINIC	0			0	0	0	90.05
90. 06 09006 WOUND CARE	0	0		0	0	0	90.06
91. 00 09100 EMERGENCY	0	-		0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-		0	Ū	0	92.00
200.00 Total (lines 50 through 199)	0			0	0		200.00
in age in a general sector and a general secto			1	~	0	0	

	LONNENT OF LNDATLENT (OUTDATLENT ANOLULAD)(O	DULAE ATUED DAG		01 44 0040		We dealer to be	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI H COSTS	ERVICE OTHER PAS	S Provider C		Period: From 09/01/2021 To 08/31/2022		pared:
						1/28/2023 6:3	0 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	All Other Medical	Total Cost (sum of cols.	Total Outpatient	(from Wkst. C,	Ratio of Cost to Charges	
		Education Cost		Cost (sum of	•	(col. 5 ÷ col.	
			4)	cols. 2, 3,		(001. 5 ÷ 001. 7)	
			(4)	and 4)	0)	(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0 436, 326, 227	0. 000000	50.00
51.00	05100 RECOVERY ROOM	0	0		0 99, 622, 664	0. 000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 52, 647, 348	0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0		0 110, 982, 214	0. 000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 126,056,772	0. 000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 194, 946, 474	0.000000	1
56.00	05600 RADI OI SOTOPE	0	0		0 35, 161, 574	0.000000	1
57.00	05700 CT SCAN	0	0	1	0 230, 215, 303	0. 000000	
58.00	05800 MRI	0	0		0 109, 058, 212	0. 000000	1
60.00	06000 LABORATORY	0	0		0 1, 510, 432, 638	0. 000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	-		0 22,043,384	0. 000000	1
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0. 000000	
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 74, 106, 930	0. 000000	
65.00	06500 RESPI RATORY THERAPY	0	0		0 66, 902, 296	0. 000000	
66.00	06600 PHYSI CAL THERAPY	0	o o		0 101, 257, 491	0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	0	o o		0 18, 197, 955	0. 000000	
68.00	06800 SPEECH PATHOLOGY	0	o o		0 9, 380, 652	0. 000000	
69.00	06900 ELECTROCARDI OLOGY	0	o o		0 284, 073, 310	0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 37, 542, 268	0. 000000	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	l o		0 494, 292, 215	0. 000000	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	l o		0 300, 700, 202	0. 000000	1
	07300 DRUGS CHARGED TO PATIENTS	0	l o		0 1, 123, 632, 793	0. 000000	
74.00	07400 RENAL DI ALYSI S	0	l o		0 11, 378, 294	0. 000000	1
	07501 CARDI AC REHAB	0	0		0 3, 012, 603	0. 000000	
	07502 SLEEP LAB	0	0		0 0	0. 000000	
75.03	07503 I NPATI ENT DI ALYSI S	0	0		0 0	0. 000000	
	07504 PAIN MANAGEMENT	0	0		0 2, 401, 166	0. 000000	
	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0. 000000	
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0	1	0 0	0. 000000	1
	07699 LI THOTRI PSY	0			0 0	0. 000000	
/0. //	OUTPATIENT SERVICE COST CENTERS			1	0	0.000000	/0.//
90.00	09000 CLINIC	0	0		0 19, 505, 631	0. 000000	90.00
90.01	09001 PATIENT TREATMENT CENTER	0			0 47, 826, 756	0. 000000	1
90.01	09002 REHAB SERVI CES-BLOOMI NGDALE	0			0 47,020,730	0. 000000	
90.02 90.03	09003 CANTERA	0	0		0 0	0. 000000	1
90.03 90.04	09004 MENTAL HEALTH 0/P	0			0 18, 124, 890	0. 000000	
90.04 90.05	09005 WOMENS CLINIC	0	0		0 10, 124, 070	0. 000000	
90.05	09006 WOUND CARE	0	0		0 3, 127, 867	0. 000000	
	09100 EMERGENCY	0			0 245, 963, 657	0. 000000	
91 00				1		0.000000	1 21.00
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 52, 907, 704	0. 000000	92.00

Health Financial Systems	CENTRAL DUPAGE				u of Form CMS-2	<u>2552-10</u>
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS	SERVICE OTHER PASS	Provider C	CN: 14-0242	Period: From 09/01/2021 To 08/31/2022	Worksheet D Part IV Date/Time Pre 1/28/2023 6:3	pared: 0 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS	0.000000			0 50 450 004		
50. 00 05000 OPERATING ROOM	0. 000000	53, 999, 893		0 58, 150, 201	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	5, 203, 465		0 19, 602, 412	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	54, 493		0 30, 381	0	52.00
53.00 05300 ANESTHESI OLOGY	0.000000	14, 199, 762		0 14, 475, 942	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	11, 945, 039		0 13, 595, 996	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	12, 322, 090		0 62, 111, 885	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	2, 352, 889		0 11, 485, 124	0	56.00
57.00 05700 CT SCAN	0. 000000	27, 854, 392		0 42, 213, 325	0	57.00
58.00 05800 MRI	0. 000000	8, 289, 018		0 20, 246, 216	0	58.00
60. 00 06000 LABORATORY	0. 000000	49, 044, 878		0 33, 469, 159	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	4, 791, 068		0 969, 963	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
64.00 06400 INTRAVENOUS THERAPY	0. 000000	2, 602, 674		0 9, 550, 176	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	18, 613, 357		0 902, 906	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	3, 837, 961		0 543, 422	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	2, 683, 281		0 63, 668	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	2, 583, 775		0 34, 206	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	39, 900, 478		0 53, 359, 931	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	4, 901, 039		0 4, 660, 631	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	82, 297, 434		0 63, 586, 631	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	80, 365, 851		0 48, 954, 027	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	100, 059, 982		0 255, 945, 428	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	4, 443, 367		0 493, 340	0	74.00
75. 01 07501 CARDI AC REHAB	0. 000000	4, 043		0 1, 176, 791	0	75.01
75.02 07502 SLEEP LAB	0. 000000	0		0 0	0	75.02
75. 03 07503 I NPATI ENT DI ALYSI S	0. 000000	0		0 0	0	75.03
75.04 07504 PAIN MANAGEMENT	0. 000000	14, 283		0 878, 877	0	75.04
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	78, 128		0 1, 388, 256	0	90.00
90. 01 09001 PATIENT TREATMENT CENTER	0. 000000	3, 378, 832		0 11, 326, 702	0	90.01
90. 02 09002 REHAB SERVI CES-BLOOMI NGDALE	0. 000000	0		0 0	0	90.02
90. 03 09003 CANTERA	0. 000000	0		0 0	0	90.03
90.04 09004 MENTAL HEALTH 0/P	0.000000	243, 849		0 592, 484	0	90.04
90. 05 09005 WOMENS CLINIC	0.000000	0		0 0	0	90.05
90. 06 09006 WOUND CARE	0.000000	19, 604		0 1, 030, 282	0	90.06
91.00 09100 EMERGENCY	0. 000000	23, 327, 690		0 25, 918, 130	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	6, 020, 652		0 7, 847, 166	0	92.00

	Financial Systems IONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	CENTRAL DUPAG	Provider C		Period: From 09/01/2021 To 08/31/2022	u of Form CMS-: Worksheet D Part V Date/Time Pre 1/28/2023 6:3	pared:
			Title	2 XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see		Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins (see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50.00	05000 OPERATI NG ROOM	0. 122968	58, 150, 201	1	0 0	7, 150, 614	50.00
51.00	05100 RECOVERY ROOM	0. 148102	19, 602, 412		0 0	2, 903, 156	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 342050	30, 381		0 0	10, 392	
53.00	05300 ANESTHESI OLOGY	0. 042905	14, 475, 942		0 0	621,090	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 132558	13, 595, 996		0 0	1, 802, 258	•
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 122753	62, 111, 885		0 0	7, 624, 420	
56.00	05600 RADI OLOGI - ITILKAP LOTI C	0. 102084	11, 485, 124		0 0	1, 172, 447	56.00
56.00 57.00	05700 CT SCAN	0. 021571	42, 213, 325		0 0	910, 584	57.00
58.00	05800 MRI	0.063145	20, 246, 216		0 0	1, 278, 447	58.00
60.00	06000 LABORATORY	0. 116551	33, 469, 159		0 0	3, 900, 864	
62.00	062000 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 325637	969, 963		0 0	3, 900, 864 315, 856	1
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	909, 903 N		0 0	0	62.30
64.00	06400 I NTRAVENOUS THERAPY	0. 024002	9, 550, 176		0 0	229, 223	
65.00	06500 RESPI RATORY THERAPY	0. 140290	902, 906		0 0	126, 669	1
66.00	06600 PHYSI CAL THERAPY	0. 140290	902, 900 543, 422		0 0	120, 009	•
67.00	06700 OCCUPATIONAL THERAPY	0. 191304	63, 668		0 0	10, 589	•
68.00	06800 SPEECH PATHOLOGY	0. 194054	34, 206		0 0	6, 638	•
69.00	06900 ELECTROCARDI OLOGY	0. 194054	53, 359, 931		0 0		•
70.00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	0. 111021			0 0	3, 422, 933	•
70.00			4, 660, 631			517, 428	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 093148	63, 586, 631		-	5, 922, 968	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATTENTS 07300 DRUGS CHARGED TO PATTENTS	0. 160433 0. 120785	48, 954, 027			7, 853, 841 30, 914, 369	
73.00	07300 DRUGS CHARGED TO PATTENTS 07400 RENAL DIALYSIS	0. 363427	255, 945, 428		0 116, 324 0 0	179, 293	
74.00 75.01	07400 RENAL DIALYSIS 07501 CARDIAC REHAB		493, 340				•
75.01	07502 SLEEP LAB	0. 304023	1, 176, 791	1	0 0 0 0	357, 772	
75.02	07502 SLEEP LAB 07503 I NPATI ENT DI ALYSI S	0. 000000	0		0 0	0	75.02
75.03 75.04	07504 PAIN MANAGEMENT	0.000000	0			0 540, 147	75.03
75.04 76.97	07504 PATN MANAGEMENT 07697 CARDIAC REHABILITATION	0. 614588 0. 000000	878, 877				
76.97		0. 000000	0		0 0	0	
76.98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	
/0.99		0.000000	0	1	0 0	0	/0.99
00 00	OUTPATIENT SERVICE COST CENTERS	0. 274477	1 200 254	1	0 0	201 044	00 00
90.00 90.01	09000 PATIENT TREATMENT CENTER	0. 274477 0. 094744	1, 388, 256		0 0	381,044	90.00
90.01 90.02			11, 326, 702	1		1, 073, 137	
	09002 REHAB SERVI CES-BLOOMI NGDALE	0. 000000	0			0	90.02
90.03	09003 CANTERA	0.000000	0			0	
90.04	09004 MENTAL HEALTH 0/P	0. 170260	592, 484		0 0	100, 876	1
90.05	09005 WOMENS CLINIC	0.000000	1 000 000		0 0	115 00(90.05
90.06	09006 WOUND CARE	0. 112480	1,030,282		0 0	115, 886	1
91.00	09100 EMERGENCY	0. 137716	25, 918, 130		0 0	3, 569, 341	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 438367	7, 847, 166		0 0	3, 439, 939	
200.00	Subtotal (see instructions)		764, 603, 658	112, 45		86, 556, 321	
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
202.00	Only Charges Net Charges (line 200 - line 201)		764, 603, 658	110 4	54 116, 324	86, 556, 321	202.00
		1	104,003,058	112, 4	110.324	I XD 33D 371	

Health Financial Systems	CENTRAL DUPAG	E HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 14-0242	Period: From 09/01/2021 To 08/31/2022	Worksheet D Part V Date/Time Pre 1/28/2023 6:3	epared: 30 pm
		Title	XVIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Services Subject To	Services Not Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS	I					
50.00 05000 OPERATI NG ROOM	0	0)			50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00 05300 ANESTHESI OLOGY	0	0				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1			54.00
55.00 05500 RADI OLOGY-THERAPEUTI C	0	0	1			55.00
56. 00 05600 RADI OI SOTOPE	0	0	•			56.00
57. 00 05700 CT SCAN	0	0				57.00
58. 00 05800 MRI	0	0				58.00
	0	0				60.00 62.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0	1			68.00
69.00 06900 ELECTROCARDI OLOGY	0	0				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	18, 041	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	14, 050	1			73.00
74.00 07400 RENAL DI ALYSI S	0	0	•			74.00
75. 01 07501 CARDI AC REHAB	0	0	1			75.01
75. 02 07502 SLEEP LAB	0	0	•			75.02
75.03 07503 INPATIENT DIALYSIS 75.04 07504 PAIN MANAGEMENT	0	0				75.03
75. 04 07504 PATR MANAGEMENT 76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0	0				76.98
76. 99 07699 LI THOTRI PSY	0	0				76.99
OUTPATIENT SERVICE COST CENTERS	-		1			
90. 00 09000 CLINIC	0	0				90.00
90.01 09001 PATIENT TREATMENT CENTER	0	0				90.01
90. 02 09002 REHAB SERVI CES-BLOOMI NGDALE	0	0				90.02
90. 03 09003 CANTERA	0	0				90.03
90.04 09004 MENTAL HEALTH 0/P	0	0				90.04
90. 05 09005 WOMENS CLINIC	0	0				90.05
90. 06 09006 WOUND CARE	0	0	1			90.06
91.00 09100 EMERGENCY	0	0	1			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	0	1			92.00
200.00 Subtotal (see instructions)	18, 041	14, 050	1			200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00 Net Charges (line 200 - line 201)	18, 041	14, 050				202.00
	10,041	11,000	1			

Health Financial Systems	CENTRAL DUPAG				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C		Period: From 09/01/2021	Worksheet D Part II	
		Component		To 08/31/2022	Date/Time Pre	pared:
					Date/Time Prep 1/28/2023 6:30	0 pm
		Title	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	<u>26)</u> 1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	6, 687, 987	436, 326, 227	0. 01532	28 12, 262	188	50.00
51. 00 05100 RECOVERY ROOM	1, 095, 667	99, 622, 664			1, 743	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 904, 333	52, 647, 348			0	52.00
53.00 05300 ANESTHESI OLOGY	245, 475	110, 982, 214			81	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 311, 432	126, 056, 772			589	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 840, 111	194, 946, 474			257	55.00
56. 00 05600 RADI OI SOTOPE	279, 351	35, 161, 574		15 0	0	56.00
57.00 05700 CT SCAN	425, 551	230, 215, 303	0. 00184	18 71, 223	132	57.00
58.00 05800 MRI	426, 953	109, 058, 212	0. 00391	26, 700	105	58.00
60. 00 06000 LABORATORY	7, 791, 260	1, 510, 432, 638	0.00515	68 462, 403	2, 385	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	316, 554	22, 043, 384	0. 01436	50 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000	0 0	0	62.30
64.00 06400 INTRAVENOUS THERAPY	89, 177	74, 106, 930	0. 00120	30, 131	36	64.00
65.00 06500 RESPI RATORY THERAPY	570, 178	66, 902, 296	0. 00852	36, 576	312	65.00
66.00 06600 PHYSI CAL THERAPY	1, 136, 338	101, 257, 491			97	66.00
67.00 06700 OCCUPATI ONAL THERAPY	107, 959	18, 197, 955			19	67.00
68.00 06800 SPEECH PATHOLOGY	78, 764	9, 380, 652			47	68.00
69.00 06900 ELECTROCARDI OLOGY	2, 311, 205	284, 073, 310			331	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	358, 901	37, 542, 268			0	70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	1, 478, 535	494, 292, 215			89	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 549, 471	300, 700, 202			0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 148, 290				2, 446	73.00
74.00 07400 RENAL DI ALYSI S	115, 985	11, 378, 294			0	74.00
75. 01 07501 CARDI AC REHAB	28, 506	3, 012, 603				75.01
75. 02 07502 SLEEP LAB	0	0			0	75.02
75. 03 07503 INPATIENT DIALYSIS 75. 04 07504 PAIN MANAGEMENT	-	0	0.00000		0	75.03 75.04
75. 04 07504 PAIN MANAGEMENT 76. 97 07697 CARDIAC REHABILITATION	203, 778	2, 401, 166 0				75.04
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0	0	1		-	76.97
76. 99 07699 LI THOTRI PSY	0	0				76.99
OUTPATIENT SERVICE COST CENTERS		0	0.00000			/0. //
90. 00 09000 CLINIC	1, 691, 499	19, 505, 631	0. 08671	18 0	0	90.00
90. 01 09001 PATIENT TREATMENT CENTER	598, 960	47, 826, 756			1	90.01
90. 02 09002 REHAB SERVI CES-BLOOMI NGDALE	0	0	1		0	90.02
90. 03 09003 CANTERA	0	0	0.00000		0	90.03
90.04 09004 MENTAL HEALTH 0/P	381, 702	18, 124, 890	0. 02106	292, 051	6, 151	90.04
90. 05 09005 WOMENS CLINIC	0	0	0. 00000	0 0	0	90.05
90. 06 09006 WOUND CARE	24, 723	3, 127, 867	0.00790	04 0	0	90.06
91.00 09100 EMERGENCY	3, 225, 424	245, 963, 657			4, 933	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)	0	52, 907, 704 5, 841, 827, 490		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 19, 942	92.00

51:00 OS100 RECOVERY ROOM LABOR ROOM O O O O S1:00 S1	Health Financial Systems	CENTRAL DUPAGE	E HOSPITAL		In Lie	u of Form CMS-:	2552-10
Introduct Gool Component CCN: 14-5242 To 06/37/2022 Date/Time Prepared Program Cost Center Description Nor Physician Ansthetist Nursing Program Nursing Program Allied Health Allied Health Program Allied Health Pro		RVICE OTHER PASS	Provider C	CN: 14-0242			
Title XVIII Subprovider - IPE PPS Cost Center Description Non Physician Cost it Anesthetisin Cost it Alustinum Nursing Program Post-Stepdown Adjustments Allied Heal th Program Post-Stepdown Adjustments Allied Heal th Prost-Stepdown Adjustments Allied Heal th Prost-Stepdown Adjustments 0.00 000000000000000000000000000000000000	THROUGH COSTS		Component (CCN: 14-S242		Date/Time Pre	pared:
Cost Center Description Non Physician Anesthetic Nursing Cost Nursing Program Adjustments Nursing Program Adjustments MNCILLARY SERVICE COST CENTERS 1.00 2A 3.00 50.00 05000 OPERATING ROM 52.00 05000 APECOVERY ROM Adjustments 0 0 0 0 50.00 50.00 05200 APESTATING ROM 05200 ARESTHESI LOGY 0 0 0 0 51.00 50.00 05200 ARESTHESI LOGY 0 0 0 0 51.00 51.00 05400 RADI LOGY-HERAPEUTIC 0 0 0 0 54.00 0 0 0 55.00 0 0 0 0 55.00 0 56.00 0 0 0 0 0 0 0 55.60 0 0 0 0 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56			Title	XVIII			0 pm
Anci LLARY SERVICE COST CENTERS Program Program Program Post-Stepdown Adjustments ANCI LLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 50.00 05000 OPERATI INS ROM 0 0 0 0 0 50.0 51.00 05000 ARESTRY ROM 0 0 0 0 51.0 52.00 06200 DELVERY ROM 0.0 0 0 0 51.0 52.00 06200 ARESTRY ROM 0 0 0 0 53.0 53.00 05500 RADI LOGY-TARAMENTI C 0 0 0 0 55.0 56.00 05500 RADI LOGY-TARAMENTY 0 0 0 0 55.0 57.00 05700 CT SCAN 0 0 0 0 0 57.0 58.00 05600 MRI 0 0 0 0 0 66.0 64.00 046.00 A PACKED RED BLOOD CELL 0 0 0 66.0 66.0 <tr< td=""><td></td><td></td><td></td><td>N</td><td></td><td></td><td></td></tr<>				N			
Cost Post-Stepdown Adjustments Adjustments 50.00 05000 OPERATI NG ROOM 00	Cost Center Description					Allied Health	
Adjustments Adjustments Adjustments ANCILLARY SERVICE COST CENTERS 0				Frogram			
Income 1.00 2A 2.00 3A 3.00 ANALLLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 51.00 0 51.00 0 0 0 0 0 0 0 0 0 0 0 0 0 51.00 0		0031	•		najustilientis		
NUCLLARY SERVICE COST CENTERS 0		1.00		2.00	3A	3, 00	
51.00 DSTOD PECOVERY ROOM 0 0 0 0 51.00 S2.00 S2.00 </td <td>ANCI LLARY SERVICE COST CENTERS</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	ANCI LLARY SERVICE COST CENTERS						
52.00 OS200 DEL VERV ROOM O O O D <thd< th=""> <thd< th=""></thd<></thd<>	50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
53.00 DoS300 ANESTHESI OLOGY 0 0 0 53.0 54.00 DS500 RADI OLOGY-THERAPEUTI C 0 0 0 55.6 56.00 DS600 RADI OLOGY-THERAPEUTI C 0 0 0 55.6 56.00 DS600 RADI OLOGY-THERAPEUTI C 0 0 0 55.6 57.00 DS700 CT SCAN 0 0 0 56.6 58.00 DS800 MRI 0 0 0 0 56.6 58.00 DS800 LABORATORY 0 0 0 0 66.2 62.30 D62200 HHOLE BLOOD & RESPI RATORY 0 0 0 0 62.6 63.00 D6200 RESPI RATORY THERAPY 0 0 0 0 66.6 65.00 D6200 CESPI RATORY THERAPY 0 0 0 0 66.6 65.00 D6200 SPECEH PATHOLOGY 0 0 0 0 67.0 70.00 DCCUPATI VAL THERAPY 0 0 0 0 70	51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
54.00 05400 RADI OLGOY-DI AGNOSTI C 0 0 0 54.0 55.00 OSGO0 RADI OLGOY-DI AGNOSTI C 0 0 0 55.4 55.00 OSGO0 RADI OLGOY-DI AGNOSTI C 0 0 0 55.6 56.00 OSGO0 RADI OLGOY-DI AGNOSTI C 0 0 0 55.6 56.00 SOGO RADI OLGOY-DI AGNOSTI C 0 0 0 0 55.6 57.00 OSGOO RADI OLGOY-DI AGNOSTI C 0 0 0 0 55.6 68.00 DSGOO MAIL OSGOO NAND 0 0 0 0 56.6 60.00 OGOO OLABORATORY 0 0 0 0 66.7 6 6 6.6 6	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 0 55.5 56.00 05600 RADIOLOGY-THERAPEUTIC 0 0 0 0 55.5 57.00 05700 CT SCAN 0 0 0 0 0 57.7 58.00 05800 MRI 0 0 0 0 0 0 57.7 58.00 05800 LBORATORY 0 0 0 0 0 0 0 60.0 62.0 62.0 62.0 62.0 0 0 0 0 62.0 62.0 62.0 62.0 62.0 62.0 62.0 62.0 62.0 62.0 62.0 62.0 62.0 62.0 63.0 65.0 65.0 66.0 65.0 66.0 65.0 66.0 66.0 66.0 66.0 66.0 66.0 66.0 66.0 66.0 66.0 66.0 66.0 66.0 66.0 67.0 0 0 0 0 67.0 67.0 67.0 67.0 67.0 67.0	53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
56.00 O O O O O O S.6.0 57.00 05700 CT SCAN O O O O S.6.0 58.00 DSBOD (MR) O O O O O S.8.0 60.00 D6000 LABORATORY O O O O O C.8.0 60.00 D6000 LABORATORY O O O O O C.8.0 S.8.0 60.00 OLODO & PACKED RED BLOOD CELL O O O O O C.8.0 S.6.0 RESPI RATORY THERAPY O O O O C.8.0 S.6.0 RESPI RATORY THERAPY O O O O O C.8.0 S.6.0 RESPI RATORY THERAPY O <		0	0		0 0	0	54.00
57.00 05700 CT SCAN 0 0 0 57.00 CT SCAN 0 0 0 0 58.00 0 05800 MI 0 0 0 0 0 58.00 0 0000 1.4807 0 <t< td=""><td></td><td>0</td><td></td><td></td><td></td><td>0</td><td>55.00</td></t<>		0				0	55.00
58.00 OSSOO MRI O O O O 58.00 C S58.00 S5		0	0		0 0	0	
60.00 0000 LABORATORY 0	57.00 05700 CT SCAN	0	0		0 0	0	57.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 62.1 62.30 06200 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 62.1 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.4 65.00 06500 PESPI RATORY THERAPY 0 0 0 0 64.4 66.00 06000 PHSI CAL THERAPY 0 0 0 0 66.0 66.00 06000 SPEECH PATHOLOGY 0 0 0 0 67.0 68.00 06900 ELECTROCARDI OLOGY 0		0	0			0	58.00
62.30 62.50 BLOOD CLOTTING FOR HEMOPHILLACS 0		0	0				
64.00 INTRAVENDUS THERAPY 0 <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td>			-				
65.00 06500 RESPI RATORY THERAPY 0 <td< td=""><td></td><td>-</td><td></td><td></td><td></td><td></td><td>•</td></td<>		-					•
66.00 06000 PHYSI CAL THERAPY 0<		-					
67.00 06700 0CCUPATIONAL THERAPY 0 <td< td=""><td></td><td>-</td><td>-</td><td></td><td></td><td></td><td></td></td<>		-	-				
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.0 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 69.0 70.00 07000 ELECTROCARDIOLOGY 0 0 0 0 0 69.0 71.00 07000 ELECTROCARDIOLAL GRAPHY 0 0 0 0 0 70.0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.0 73.00 07300 RUGS CHARGED TO PATIENTS 0 0 0 0 73.0 75.01 07501 CARDIAC REHAB 0 0 0 0 74.0 75.01 07502 SLEEP LAB 0 0 0 0 75.0 75.03 17503 17647 CARDIAC REHAB 0 0 0 0 75.0 75.04 07504 PAIN MANAGEMENT 0 0 0 0 75.0 76.97 CARDIAC REHABILITATION 0 0 0 0 <td< td=""><td></td><td>-</td><td></td><td></td><td></td><td></td><td>•</td></td<>		-					•
69.00 06900 ELECTROCARDIOLOGY 0<		0					
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 73.00 73.00 07300 REVAS CHARGED TO PATIENTS 0 0 0 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 74.40 75.01 07501 CARDIA C REHAB 0 0 0 0 75.02 75.02 07502 SLEEP LAB 0 0 0 0 75.02 75.03 07503 INPATIENT DIALYSIS 0 0 0 0 75.02 76.97 CARDIA C REHABILITATION 0 0 0 0 75.02 76.97 CARDIA C REHABILITATION 0 0 0 0 76.62 07699 LITHOTRIENT 0 0 0 0 0 0 7		0	-		-		
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 74.00 75.01 07501 CARDIAC REHAB 0 0 0 0 75.01 75.02 07502 SLEEP LAB 0 0 0 0 75.01 75.04 07503 INPATIENT DI ALYSIS 0 0 0 0 75.01 76.97 07502 CARDIAC REHABILITATION 0 0 0 0 75.02 76.97 CARDIAC REHABILITATION 0 0 0 0 0 76.02 76.97 CARDIAC REHABIL CAREHAPY 0 0 0 0 0 0 76.02 76.99 DITPATIENT REATMENT CENTER 0 0 0 0 0 0 0		-					•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.0 74.00 07400 RENAL DIALYSIS 0 0 0 0 73.0 75.01 07501 CARDIAC REHAB 0 0 0 0 75.0 75.02 07502 SLEEP LAB 0 0 0 0 75.0 75.03 07504 PATIENT DIALYSIS 0 0 0 0 75.0 75.04 07504 PATIENT DIALYSIS 0 0 0 0 75.0 75.04 07504 PATIENT DIALYSIS 0 0 0 0 75.0 76.97 ORADIAC REHABILITATION 0 0 0 0 76.6 76.7 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.6 90.00 OPOOPOLINIC 0 0 0 0 0 0 0 0 0		-	-				
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 75.01 07501 CARDI AC REHAB 0 0 0 0 0 75.02 75.02 07502 SLEEP LAB 0 0 0 0 0 75.02 75.03 INPATI ENT DI ALYSI S 0 0 0 0 0 75.02 75.04 07507 CARDI AC REHABI LITATI ON 0 0 0 75.02 76.97 07697 CARDI AC REHABI LITATI ON 0 0 0 76.02 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.02 0 07600 CLINI C 0							•
74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 75.01 07501 CARDI AC REHAB 0 0 0 0 75.00 75.02 07502 SLEEP LAB 0 0 0 0 75.00 75.03 07503 INPATI ENT DI ALYSI S 0 0 0 0 75.01 75.04 07504 PAI N MANAGEMENT 0 0 0 0 75.02 76.97 CARDI AC REHABI LI TATI ON 0 0 0 0 75.03 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.02 00.00 09000 CLINI C 0 0 0 0 76.02 01.01 PAI IENT SERVICE COST CENTERS 0 <		0					
75.01 07501 CARDIAC REHAB 0 0 0 0 75.02 75.02 07502 SLEEP LAB 0 0 0 0 0 75.02 75.03 07503 INPATI ENT DI ALYSI S 0 0 0 0 75.02 75.04 07504 PAI N MANAGEMENT 0 0 0 0 75.02 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.97 76.99 07699 LI THOTRI PSY 0 0 0 0 76.97 00 09000 CLI NI C 0 0 0 0 76.97 00.01 09001 PATI ENT SERVI CE COST CENTERS 0 0 0 0 0 90.01 090.02 REHAB SERVI CES-BLOOMI INGDALE 0 0 0 0 90.02 90.02 0 0 90.02 0 0 90.04 90.04 90.04 <t< td=""><td></td><td>0</td><td>-</td><td></td><td>-</td><td></td><td></td></t<>		0	-		-		
75.02 07502 SLEEP LAB 0 0 0 0 0 75.03 75.03 07503 INPATIENT DIALYSIS 0 0 0 0 0 0 75.04 75.04 07504 PAIN MANAGEMENT 0 0 0 0 0 0 0 0 75.04 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 0 0 0 0 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 76.97 07699 LITHOTRIPSY 0 0 0 0 0 0 76.97 07699 LITHOTRIPSY 0 0 0 0 0 0 76.97 07699 DUTPATIENT SERVICE COST CENTERS 0 0 0 0 90.00 90.00 OPO002 REHAB SERVICES-BLOOMINGDALE 0 0 0 0 0 0 0 0 0 0 0							•
75.03 07503 INPATIENT DIALYSIS 0 0 0 0 0 75.04 75.04 07504 PAIN MANAGEMENT 0 0 0 0 0 75.04 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76.97 76.99 07699 LITHOTRIPSY 0 0 0 0 0 76.97 76.99 07699 LITHOTRIPSY 0 0 0 0 0 76.97 90.00 09000 CLINIC 0 0 0 0 90.01 90.01 09001 PATIENT TREATMENT CENTER 0 0 0 90.02 90.02 REHAB SERVICES-BLOOMI NGDALE 0 0 0 90.02 90.02 90.03 09003 CANTERA 0 0 0 90.04 90.04 MENTAL HEALTH 0/P 0 0 0 0 90.05 90055 WORENS CLINIC		-			-		
75.04 07504 PAIN MANAGEMENT 0 0 0 0 0 75.04 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76.97 76.98 07699 LI THOTRI PSY 0 0 0 0 0 76.97 76.98 07699 LI THOTRI PSY 0 0 0 0 0 76.97 76.99 07699 LI THOTRI PSY 0 0 0 0 0 76.97 90.00 09000 CLI NI C 0 0 0 0 90.01 9000 0 0 90.02 90002 REHAB SERVI CES-BLOOMI NGDALE 0 0 0 90.02 9003 CANTERA 0 0 0 0 90.02 90.03 09003 CANTERA 0 0 0 0 0 90.02 90.04 09004 MENTAL HEALTH 0/P 0 0		Ŭ	•		-	-	
76.97 07697 CARDI AC REHABILITATION 0 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76.97 76.99 07699 LI THOTRI PSY 0 0 0 0 0 76.97 00000 CLINIC 0 0 0 0 0 0 90.00 90.00 09000 CLINIC 0 0 0 0 90.00		0					•
76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 76.97 76.99 07699 LI THOTRI PSY 0 0 0 0 0 76.97 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 90.00 0 0 90.00 0 0 90.00 90.01 90.01 PATI ENT TREATMENT CENTER 0 0 0 0 90.02 90.02 REHAB SERVICES-BLOOMI NGDALE 0 0 0 90.02 90.03 09003 CANTERA 0 0 0 0 90.02 90.04 MENTAL HEALTH 0/P 0 0 0 0 90.02 90.02 90.03 09003 CANTERA 0 0 0 0 90.02 90.04 MENTAL HEALTH 0/P 0 0 0 90.02 90.05 WOMENS CLINIC 0 0 0 0 0 0 90.02 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.05 90.05 90.05 90.05 90.06		0	-			-	
76.99 07699 LI THOTRI PSY 0		0	-				•
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0							
90.00 09000 CLINIC 0		-		1	-1 -	-	1
90.02 09002 REHAB SERVI CES-BLOOMI NGDALE 0 0 0 0 0 0 90.02 90.03 09003 CANTERA 0 0 0 0 0 90.02 90.04 09004 MENTAL HEALTH 0/P 0 0 0 0 0 90.02 90.05 09005 WOMENS CLINIC 0 0 0 0 90.02 90.06 09006 WOUND CARE 0 0 0 0 90.02 91.00 09100 EMERGENCY 0 0 0 0 91.0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.0		0	0		0 0	0	90.00
90.02 09002 REHAB SERVI CES-BLOOMI NGDALE 0	90. 01 09001 PATIENT TREATMENT CENTER	0	0		0 0	0	90.01
90.04 09004 MENTAL HEALTH 0/P 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>90.02</td>		0	0		0 0	0	90.02
90.05 09005 WOMENS CLINIC 0 0 0 0 90.05 90.06 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>90.03</td>		0	0		0 0	0	90.03
90.05 09005 WOMENS CLINIC 0 0 0 0 90.05 90.06 </td <td>90.04 09004 MENTAL HEALTH 0/P</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>90.04</td>	90.04 09004 MENTAL HEALTH 0/P	0	0		0 0	0	90.04
91.00 09100 EMERGENCY 0 0 0 91.00 91.00 91.00 92.00 0 0 0 91.00 91.00 91.00 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00		0	0		0 0	0	90.05
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.0	90.06 09006 WOUND CARE	0	0		0 0	0	90.06
	91.00 09100 EMERGENCY	0	0		0 0	0	91.00
	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
200.00 Total (lines 50 through 199) 0	200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S		GE HOSPITAL S Provider C	CN: 14-0242	Peri od:	Worksheet D	2552-
HROUGH COSTS				From 09/01/2021	Part IV	
		Component	CCN: 14-S242	To 08/31/2022	Date/Time Pre 1/28/2023 6:3	epared 30 pm
		Title	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medical	(sum of cols.	Outpatient			
	Education Cost	1, 2, 3, and 4)	Cost (sum o cols. 2, 3,		(col. 5 ÷ col. 7)	
		4)	and 4)	0)	(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
D. 00 05000 OPERATI NG ROOM	0	0		0 436, 326, 227		
1.00 05100 RECOVERY ROOM	0	0		0 99, 622, 664		
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 52, 647, 348		
8. 00 05300 ANESTHESI OLOGY	0	0		0 110, 982, 214		
I. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 126, 056, 772		
5. 00 05500 RADI OLOGY-THERAPEUTI C 5. 00 05600 RADI OI SOTOPE	0			0 194, 946, 474 0 35, 161, 574		
2. 00 05600 RADIOISOTOPE 2. 00 05700 CT SCAN	0			0 35, 161, 574 0 230, 215, 303		
8. 00 05800 MRI	0	0		0 109, 058, 212		
0. 00 06000 LABORATORY	0	0		0 1, 510, 432, 638		
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 22,043,384		
. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 22,010,001	0. 000000	
. 00 06400 I NTRAVENOUS THERAPY	0	0		0 74, 106, 930		
. 00 06500 RESPI RATORY THERAPY	0	0		0 66, 902, 296		
. 00 06600 PHYSI CAL THERAPY	0	0)	0 101, 257, 491	0. 000000	66.
2.00 06700 OCCUPATI ONAL THERAPY	0	0		0 18, 197, 955	0. 000000	67.
B. 00 06800 SPEECH PATHOLOGY	0	0		0 9, 380, 652		
P. 00 06900 ELECTROCARDI OLOGY	0	0		0 284, 073, 310		
0.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 37, 542, 268		
. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0 494, 292, 215		
. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 300, 700, 202		
. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 1, 123, 632, 793		
. 00 07400 RENAL DI ALYSI S . 01 07501 CARDI AC REHAB	0			0 11, 378, 294 0 3, 012, 603		
. 01 07501 CARDI AC REHAB . 02 07502 SLEEP LAB	0			0 3, 012, 603		
. 03 07503 I NPATI ENT DI ALYSI S	0	0		0 0	0. 000000	
5. 04 07504 PAIN MANAGEMENT	0			0 2, 401, 166		
5. 97 07697 CARDI AC REHABI LI TATI ON	0			0 2,401,100		
. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0		
5. 99 07699 LI THOTRI PSY	0	Ő		0 0	0. 000000	
OUTPATIENT SERVICE COST CENTERS				•		
0. 00 09000 CLINIC	0	0		0 19, 505, 631		90.
. 01 09001 PATIENT TREATMENT CENTER	0	0		0 47, 826, 756		
. 02 09002 REHAB SERVI CES-BLOOMI NGDALE	0	0		0 0	01000000	
0. 03 09003 CANTERA	0	0		0 0	0. 000000	
0.04 09004 MENTAL HEALTH 0/P	0	0		0 18, 124, 890		
0. 05 09005 WOMENS CLINIC	0	0		0 0	0. 000000	
0. 06 09006 WOUND CARE	0	0		0 3, 127, 867		
. 00 09100 EMERGENCY	0	0		0 245, 963, 657		
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 52,907,704		
00.00 Total (lines 50 through 199)	0	0	4	0 5, 841, 827, 490	4	200.

Health Financial Systems	CENTRAL DUPAGE				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PASS	Provider C	CN: 14-0242	Period: From 09/01/2021	Worksheet D Part IV	
THROUGH COSTS		Component	CCN: 14-S242	To 08/31/2022		pared:
		Title	e XVIII	Subprovider -	PPS	<u> </u>
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	h Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS	0,000000	10.0/0		0	0	
50. 00 05000 OPERATING ROOM	0.000000	12, 262		0 0		50.00
51.00 05100 RECOVERY ROOM	0. 000000	158, 517	1	0 0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0.000000	36, 645		-	0	53.00
54. 00 05400 RADI OLOGY -DI AGNOSTI C	0.000000	32, 141		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.000000	17, 640		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	71, 223		0 0	0	57.00
58.00 05800 MRI	0. 000000	26, 700		0 0	0	58.00
60.00 06000 LABORATORY	0. 000000	462, 403	1	0 3, 257	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELI		0		0 0	0	62.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
64.00 06400 I NTRAVENOUS THERAPY	0. 000000	30, 131		0 0	0	64.00
65.00 06500 RESPI RATORY THERAPY	0. 000000	36, 576		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	8, 648		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	3, 207		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	5, 632		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	40, 743		0 458	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI EN		29, 651		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	662, 434	1	0 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0.000000	0		0 0	0	74.00
75. 01 07501 CARDI AC REHAB	0. 000000	0		0 0	0	75.01
75.02 07502 SLEEP LAB	0. 000000	0		0 0	0	75.02
75. 03 07503 I NPATIENT DI ALYSI S	0. 000000	0		0 0	0	75.03
75.04 07504 PAIN MANAGEMENT	0. 000000	0		0 0	0	75.04
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
76.98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	
76. 99 07699 LI THOTRI PSY	0.000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90.01 09001 PATIENT TREATMENT CENTER	0. 000000	92		0 0		90.01
90. 02 09002 REHAB SERVI CES-BLOOMI NGDALE	0. 000000	0		0 0	0	90.02
90. 03 09003 CANTERA	0. 000000	0		0 0	0	90.03
90.04 09004 MENTAL HEALTH 0/P	0. 000000	292, 051		0 2, 102	0	90.04
90. 05 09005 WOMENS CLINIC	0. 000000	0		0 0	0	90.05
90.06 09006 WOUND CARE	0. 000000	0		0 0	0	90.06
91.00 09100 EMERGENCY	0. 000000	376, 204	1	0 8, 631	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		2, 302, 900	1	0 14, 448	0	200.00

<u>Heal th</u>	Financial Systems	CENTRAL DUPAG	GE HOSPITAL			u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C	CN: 14-0242	Period: From 09/01/2021	Worksheet D Part V	
			Component	CCN: 14-S242	To 08/31/2022	Date/Time Pre 1/28/2023 6:3	epared: 30 pm
			Title	e XVIII	Subprovider - IPF	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge		Cost Reimbursed	Cost Reimbursed	PPS Services	
		Ratio From Worksheet C,	Services (see inst.)	Servi ces	Servi ces Not	(see inst.)	
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins	. Ded. & Coins.		
				(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
50.00	ANCILLARY SERVICE COST CENTERS	0, 122968	0		0 0	C	50,00
51.00	05100 RECOVERY ROOM	0. 148102			0 0	-	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 342050	0		0 0	0	
53.00	05300 ANESTHESI OLOGY	0. 042905	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 132558	0		0 0	C	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 122753	0		0 0	0	
56.00	05600 RADI OI SOTOPE	0. 102084	0		0 0	C	
57.00	05700 CT SCAN	0. 021571	0		0 0	0	
58.00		0.063145	0		0 0	0	
60.00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 116551	3, 257		0 0	380	1
62.00 62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 325637 0. 000000					1
64.00	06400 I NTRAVENOUS THERAPY	0. 024002					
65.00	06500 RESPI RATORY THERAPY	0. 140290			0 0		
66.00	06600 PHYSI CAL THERAPY	0. 191564			0 0		
67.00	06700 OCCUPATI ONAL THERAPY	0. 166311	0		0 0	C	
68.00	06800 SPEECH PATHOLOGY	0. 194054	0		0 0	C	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 064148	458		0 0	29	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 111021	0		0 0	0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 093148	0		0 0	0	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 160433	0		0 0	0	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0. 120785 0. 363427					
74.00 75.01	07501 CARDI AC REHAB	0. 304023					
75.02	07502 SLEEP LAB	0.000000			0 0		
75.03	07503 I NPATI ENT DI ALYSI S	0. 000000			0 0		
75.04	07504 PAIN MANAGEMENT	0. 614588	0		0 0	C	75.04
76.97	07697 CARDI AC REHABI LI TATI ON	0.000000	0		0 0	0	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	
76.99	07699 LI THOTRI PSY	0.000000	0		0 0	0	76.99
00.00	OUTPATIENT SERVICE COST CENTERS	0 074477	0	1	0 0		00.00
90. 00 90. 01	09000 CLINIC 09001 PATIENT TREATMENT CENTER	0. 274477 0. 094744					
90.01 90.02	09002 REHAB SERVICES-BLOOMINGDALE	0. 000000					
	09003 CANTERA	0. 000000					
	09004 MENTAL HEALTH 0/P	0. 170260	2, 102		0 0	358	
	09005 WOMENS CLINIC	0. 000000			0 0	0	1
90.06	09006 WOUND CARE	0. 112480	0		0 0	C	
91.00	09100 EMERGENCY	0. 137716	8, 631		0 0	1, 189	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 438367	0		0 0	0	
200.00			14, 448		0 0	1, 956	200.00
201.00					0 0		201.00
202.00	Only Charges Net Charges (line 200 - line 201)		14, 448		0 0	1 954	202.00
202.00		1	1 1, 140	1	-	1,750	

PPORTI ONMENT OF	<u>Systems</u> MEDICAL, OTHER HEALTH SERVICES AND	CENTRAL DUPAG		CCN: 14-0242	Period:	u of Form CMS- Worksheet D	-2002
	MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 14-5242	From 09/01/2021 To 08/31/2022	Part V Date/Time Pr	
			Titl	e XVIII	Subprovi der -	1/28/2023 6: PPS	<u>30 piii</u>
		Cos	to		I PF		
Cost	Center Description	Cost	Cost	-			
0031		Reimbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	SERVICE COST CENTERS						
	RATING ROOM DVERY ROOM	0					50.
	VERY ROOM & LABOR ROOM	0					52.
	STHESI OLOGY	0					53
	OLOGY-DI AGNOSTI C						54
	OLOGY-THERAPEUTIC	0					55
. 00 05600 RADI		o					56
7.00 05700 CT S		0					57
3. 00 05800 MRI		0	(b			58
). 00 06000 LABO	DRATORY	0	(b			60
2. 00 06200 WHOL	E BLOOD & PACKED RED BLOOD CELL	0	(b			62
2. 30 06250 BLOO	DD CLOTTING FOR HEMOPHILIACS	0	(c			62
1. 00 06400 I NTF	RAVENOUS THERAPY	0	(c			64
5. 00 06500 RESF	PIRATORY THERAPY	0		D			65
	SI CAL THERAPY	0		D			66
	JPATI ONAL THERAPY	0		D			67
	CH PATHOLOGY	0					68
		0		D			69
	CTROENCEPHALOGRAPHY	0					70
	CAL SUPPLIES CHARGED TO PATIENT DEV. CHARGED TO PATIENTS	0					71
	S CHARGED TO PATIENTS	0					73
	AL DIALYSIS	0					74
5. 01 07501 CARE		0					75
5. 02 07502 SLEE		0 0					75
	ATIENT DIALYSIS	0	(b			75
	N MANAGEMENT	0	(b			75
6.97 07697 CARE	DIAC REHABILITATION	0	(c			76
5. 98 07698 HYPE	ERBARIC OXYGEN THERAPY	0		p			76
5. 99 07699 LI TH		0	(76
	T SERVICE COST CENTERS						
0.00 09000 CLIN		0					90
1 1	ENT TREATMENT CENTER	0					90
0. 02 09002 REHA 0. 03 09003 CANT	AB SERVI CES-BLOOMI NGDALE	0					90
D. 04 09003 CAN		0					90
D. 05 09005 WOME		0					90
0.06 09006 WOUN		0					90
1.00 09100 EMER		0					91
	ERVATION BEDS (NON-DISTINCT PART	0					92
	total (see instructions)	0					200
	s PBP Clinic Lab. Services-Program	0					201
Onl y	/ Charges						
02.00 Net	Charges (line 200 - line 201)	0	(b			202

Health Financial Systems	CENTRAL DUPA	GE HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	CN: 14-0242	Period: From 09/01/2021	Worksheet D	
				To 08/31/2022		nared
				10 00/01/2022	1/28/2023 6: 3	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 ADULTS & PEDIATRICS	15, 524, 041	0	15, 524, 04			
31.00 INTENSIVE CARE UNIT	2, 847, 157		2, 847, 15		326. 10	
32.00 CORONARY CARE UNI T	718, 265		718, 26			32.00
35.00 NEONATAL INTENSIVE CARE UNIT	1, 050, 965		1, 050, 96			
40. 00 SUBPROVI DER – I PF	2, 876, 580		2, 876, 58			40.00
43.00 NURSERY	642, 979		642, 97	9 4, 956	129.74	43.00
200.00 Total (lines 30 through 199)	23, 659, 987		23, 659, 98	7 127, 104		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	-			
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30.00 ADULTS & PEDIATRICS	3, 547		•			30.00
31.00 INTENSIVE CARE UNIT	360					31.00
32.00 CORONARY CARE UNIT	0	-	1			32.00
35.00 NEONATAL INTENSIVE CARE UNIT	115					35.00
40.00 SUBPROVIDER - IPF	550					40.00
43.00 NURSERY	1, 941					43.00
200.00 Total (lines 30 through 199)	6, 513	1, 158, 990	1			200.00

PORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI		Provider C	CN: 14-0242	Period: From 09/01/2021	Worksheet D Part II	
Cost Center Description	1			To 08/31/2022	Date/Time Pre 1/28/2023 6:3	pared:
Cost Center Description		Titl	e XIX	Hospi tal	Cost	<u> </u>
	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			4
0. 00 05000 OPERATING ROOM	6, 687, 987				0	
. 00 05100 RECOVERY ROOM	1, 095, 667				0	
2.00 05200 DELIVERY ROOM & LABOR ROOM	1, 904, 333				0	
8. 00 05300 ANESTHESI OLOGY	245, 475				0	
. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 311, 432				0	
5. 00 05500 RADI OLOGY-THERAPEUTI C	2, 840, 111				0	
0. 00 05600 RADI 0I SOTOPE	279, 351				0	
7.00 05700 CT SCAN	425, 551				0	
3. 00 05800 MRI	426, 953	109, 058, 212			0	58.00
0. 00 06000 LABORATORY	7, 791, 260	1, 510, 432, 638	0.00515		0	60.00
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	316, 554	22, 043, 384	0. 01436	50 0	0	62.00
2.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.0000	0 0	0	62.30
. 00 06400 I NTRAVENOUS THERAPY	89, 177	74, 106, 930	0.00120		0	64.00
5. 00 06500 RESPI RATORY THERAPY	570, 178	66, 902, 296	0. 00852	23 0	0	65.00
0. 00 06600 PHYSI CAL THERAPY	1, 136, 338	101, 257, 491	0. 01122	22 0	0	66.00
2.00 06700 OCCUPATI ONAL THERAPY	107, 959	18, 197, 955	0.00593	32 0	0	67.00
3. 00 06800 SPEECH PATHOLOGY	78, 764	9, 380, 652	0.00839	96 0	0	68.00
2. 00 06900 ELECTROCARDI OLOGY	2, 311, 205	284, 073, 310	0.00813	36 0	0	69.00
0.00 07000 ELECTROENCEPHALOGRAPHY	358, 901	37, 542, 268	0.00956	60 0	0	70.00
. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	1, 478, 535	494, 292, 215	0.00299	0	0	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 549, 471	300, 700, 202	0.00515	53 0	0	72.00
8.00 07300 DRUGS CHARGED TO PATIENTS		1, 123, 632, 793	0.00369	02 0	0	73.00
. 00 07400 RENAL DIALYSIS	115, 985	11, 378, 294	0. 01019	94 0	0	74.00
5. 01 07501 CARDI AC REHAB	28, 506	3, 012, 603	0.00946	52 0	0	75.01
5. 02 07502 SLEEP LAB	0		1	0 0	0	75.02
5.03 07503 INPATIENT DIALYSIS	0	0			0	75.03
5. 04 07504 PAIN MANAGEMENT	203, 778	2, 401, 166	0. 08486	6 0	0	75.04
97 07697 CARDI AC REHABI LI TATI ON	0	0	0.0000	0 0	0	76.97
. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.0000	0 0	0	76.98
5. 99 07699 LI THOTRI PSY	0	0			0	76.99
OUTPATIENT SERVICE COST CENTERS		•				1
0. 00 09000 CLINIC	1, 691, 499	19, 505, 631	0. 0867	18 0	0	90.00
0. 01 09001 PATI ENT TREATMENT CENTER	598, 960	47, 826, 756	0. 01252	24 0	0	90.01
0. 02 09002 REHAB SERVI CES-BLOOMI NGDALE	0		1		0	
0. 03 09003 CANTERA	0	-	1		0	
0. 04 09004 MENTAL HEALTH 0/P	381, 702	-	1		0	
0. 05 09005 WOMENS CLINIC	0				0	
0. 06 09006 WOUND CARE	24, 723	-	1		0	
. 00 09100 EMERGENCY	3, 225, 424				0	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 706, 645				0	
00.00 Total (lines 50 through 199)		5, 841, 827, 490		0	-	200.00

Health Financial Systems	CENTRAL DUPAGE	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COSTS			Period: From 09/01/2021 To 08/31/2022	1/28/2023 6:3	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Nursi ng	Nursi ng		h Allied Health	All Other	
	Program	Program	Post-Stepdow		Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0)	0 0	0	32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0 0	0	35.00
40.00 04000 SUBPROVIDER - IPF	0	0		0 0	0	40.00
43.00 04300 NURSERY	0	0)	0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0)	0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem (col.	I npati ent	
		sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		ninus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS			I			
30.00 03000 ADULTS & PEDIATRICS	0	0	· · · · · · · · · · · · · · · · · · ·		3, 547	•
31.00 03100 INTENSIVE CARE UNIT		0	8, 73		360	
32.00 03200 CORONARY CARE UNIT		0	3, 12		0	
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0	7,67		115	
40. 00 04000 SUBPROVI DER – I PF	0	0	8, 32		550	
43. 00 04300 NURSERY		0	4, 95			
200.00 Total (lines 30 through 199)		0	127, 10)4	6, 513	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00		-			
INPATIENT ROUTINE SERVICE COST CENTERS	- 1					
30.00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
32.00 03200 CORONARY CARE UNIT	0					32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0					35.00
40. 00 04000 SUBPROVI DER – I PF	0					40.00
						1 40 00
43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0					43.00

APPORT IDMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider COS: 14-0242 From 09/01/2021 To 08/31/2023 Morksheet D Fart 1V Program Progrom Progrom Program Program Program Program Program Program Prog	Heal th	Financial Systems	CENTRAL DUPA	GE HOSPITAL			In Lie	u of Form CMS-2	2552-10
Cost Center Description Non Physician Anesthetist Cost Nursing Program 24 All Led Health Program 24 All Led Health Prost-Stepdown Adjustments ANCI LLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 ANCI LLARY SERVICE COST CENTERS 0			RVICE OTHER PAS	S Provider C	CN: 14-0242	Fr	om 09/01/2021	Part IV Date/Time Pre	
Anci LLARY SERVICE COST CENTERS Program Cost Program Val justments Adjustments Program Adjustments Program Adjustments Program Adjustments NCI LLARY SERVICE COST CENTERS 0 <td></td> <td></td> <td></td> <td>Titl</td> <td>e XIX</td> <td></td> <td>Hospi tal</td> <td>Cost</td> <td></td>				Titl	e XIX		Hospi tal	Cost	
Anci LLARY SERVICE COST CENTERS Program Cost Program Val justments Adjustments Program Adjustments Program Adjustments Program Adjustments NCI LLARY SERVICE COST CENTERS 0 <td></td> <td>Cost Center Description</td> <td>Non Physi ci an</td> <td>Nursi ng</td> <td>Nursi ng</td> <td>1</td> <td>Allied Health</td> <td>Allied Health</td> <td></td>		Cost Center Description	Non Physi ci an	Nursi ng	Nursi ng	1	Allied Health	Allied Health	
Image: stream in the image:				Program	Program	I	Post-Stepdown		
HOLLLARY SERVICE COST CENTERS 0			Cost	Post-Stepdown			Adjustments		
ANCILLARY SERVICE COST CENTERS Image: Control of the con									
50:00 05000 0PERATING ROOM 0			1.00	2A	2.00		3A	3.00	
51:00 65100 PEOVERY ROM 61:00 651:00 652:00 52:00 652:00 0 0 0 0 0 52:00 53:00 05400 ANDIOLOSY-INERAPEUTIC 0 0 0 0 52:00 54:00 05400 RADIOLOSY-INERAPEUTIC 0 0 0 0 55:00 50:00 05500 RADIOLOSY-INERAPEUTIC 0 0 0 0 55:00 50:00 05600 RADIOLOSY-INERAPEUTIC 0 0 0 0 55:00 50:00 05600 RADIOLASTOP 0 0 0 0 56:00 00 05800 MRIN 0 0 0 0 66:00 60:00 06000 LABORATORY 0 0 0 0 66:00 60:00 06000 RESPIRATORY HERAPY 0 0 0 0 66:00 60:00 06400 INTRAVENOUS THERAPY 0 0 0 0 66:00 60:00 06400 OCCLIPATIONAL THERAPY 0 0									
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 52.00 53.00 05300 RADIOLOGY-DI AGNOSTI C 0 0 0 53.00 55.00 05500 RADIOLOGY-DI AGNOSTI C 0 0 0 55.00 56.00 05500 RADIOLOGY-THERAPEUTI C 0 0 0 55.00 56.00 05500 CT SCAN 0 0 0 55.00 50.00 05700 CT SCAN 0 0 0 57.00 50.00 05600 RADIOLOGY-THERAPENT 0 0 0 65.00 60.00 06000 LABORATORY 0 0 0 62.30 60.00 06000 LINRAVENDUS THERAPY 0 0 0 64.00 66.00 06500 PHATORY THERAPY 0 0 0 65.00 66.00 06500 PLECTROENCEPHALORGARHY 0 0 0 70.00 70.00 <			-				-	-	
53.00 05300 ANESTHEST 0LOGY 0 0 53.00 54.00 05400 RADIOLOGY-THERAPEUTIC 0 0 0 54.00 55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 55.00 56.00 05600 RADIOLOGY-THERAPEUTIC 0 0 0 0 55.00 57.00 05700 CT SCAN 0 0 0 0 55.00 58.00 05800 NRI 0 0 0 0 55.00 62.00 04200 LABORATORY 0 0 0 0 62.00								-	
54.00 054.00 RADIOLOGY-DIAGNOSTIC 0 0 0 56.00 55.00 55.00 RADIOLOGY-DIAGNOSTIC 0 0 0 0 55.00 56.00 RADIOLOSTAPE 0 0 0 0 56.00 56.00 DSTOD RADIOLOSTAPE 0 0 0 56.00 57.00 DSTOD RSTOL 0 0 0 57.00 55.00 58.00 NRI 0 0 0 0 56.00 <td></td> <td></td> <td>0</td> <td>-</td> <td></td> <td></td> <td>0</td> <td>-</td> <td></td>			0	-			0	-	
55.00 DS500 RADIO LOGY-THERAPEUTI C 0 0 0 0 56.00 56.00 56.00 57.00 0			0				-	-	
56.00 056.00 RAD IO ISOTOPE 0 0 0 0 0 0 57.00 58.00 66.00 67.00 0 0 0 67.00 0 0 67.00 0 0 67.00 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>-</td><td>-</td><td></td></td<>							-	-	
57.00 05700 CT SCAN 0 0 0 57.00 CT SCAN 0 0 0 0 58.00 0 58.00 0			0				0	-	
58.00 OSB00 NI O	56.00		0	0		0	0	0	56.00
60.00 0000 LABORATORY 0			0				0	0	
62.00 0c200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 <td>58.00</td> <td>05800 MRI</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>58.00</td>	58.00	05800 MRI	0	0		0	0	0	58.00
62.30 6250 BLOOD CLOTTING FOR HEMOPHI LIACS 0	60.00	06000 LABORATORY	0	0		0	0	0	60.00
64.00 INTRAVENOUS THERAPY 0 <td>62.00</td> <td>06200 WHOLE BLOOD & PACKED RED BLOOD CELL</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>62.00</td>	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	0	62.00
65.00 06500 RESPI RATORY THERAPY 0 0 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 0 0 0 0 0 66.00 67.00 0 0 0 0 66.00 67.00 0 0 0 0 66.00 67.00 0 0 0 0 67.00 67.00 0 0 0 0 67.00 67.00 <	62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	0	62.30
66.00 06000 PHYSI CAL THERAPY 0<	64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
67.00 06700 0CCUPATIONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 0 68.00 09.00 6000 LECTROENCARDI OLOGY 0 0 0 0 0 69.00 70.00 OT000 ELECTROENCEPHALOGRAPHY 0	65.00	06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
68:00 06800 SPEECH PATHOLOGY 0 0 0 0 68:00 69:00 CECTROCARDI OLOGY 0	66.00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
69:00 06900 ELECTROCARDIOLOGY 0<	67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70.00 71.00 O7100 MEDI CAL_SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.00 72.00 07200 INPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.00 73.00 07300 RENAL DI ALYSI S 0 0 0 0 73.00 75.01 75.03 1NPATIENT DI ALYSI S 0 0 0 75.03 75.03 07503 INPATIENT DI ALYSI S 0 0 0 0 75.03 76.97 76476 ARDIAC REHABILITATION 0 0 0 0 76.97 76.99 07699 LITHOTRIPSY 0 0	68.00	06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 74.00 75.01 07501 CARDIA C REHAB 0 0 0 0 75.01 75.02 07502 SLEEP LAB 0 0 0 0 0 75.02 75.03 07503 INPATIENT DI ALYSIS 0 0 0 0 0 75.03 75.04 07504 PAIN MANAGEMENT 0 0 0 0 0 75.03 76.98 HYBERARI C 0XYGEN THERAPY 0 0 0 0 76.97 76.99 HARBARI C CXYGEN THERAPY 0 0 0 0 0 76.98 76.99 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0	69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 73.00 75.01 07501 CARDI AC REHAB 0 0 0 0 75.01 75.02 07502 SLEEP LAB 0 0 0 0 0 75.02 75.03 07503 INPATI ENT DI ALYSI S 0 0 0 0 75.03 75.04 07504 PAIN MANAGEMENT 0 0 0 0 75.04 76.97 CARDI AC REHAB LI TATI ON 0 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.98 70.09 07497 CARDI AC REHAB SERVI CE COST CENTERS 0 0 0 0 90.00 90.00 09000 CLINI C 0 0 0 0 0 90.00 <td>70.00</td> <td>07000 ELECTROENCEPHALOGRAPHY</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>70.00</td>	70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
73.00 O7300 DRUGS CHARGED TO PATI ENTS 0 0 0 73.00 74.00 O7400 RENAL DI ALYSI S 0 0 0 0 74.00 75.01 O7501 CARDI AC REHAB 0 0 0 0 0 75.01 75.02 OSC02 SLEEP LAB 0 0 0 0 0 75.02 75.03 INPATI ENT DI ALYSI S 0 0 0 0 0 75.03 75.04 O7507 CARDI AC REHABI LI TATI ON 0 0 0 0 75.04 76.97 O7697 CARDI AC REHABI LI TATI ON 0 0 0 0 76.97 76.98 O7698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.98 90.00 O9000 CLINIC 0 0 0 0 0 0 0 0 90.01 O9001 PATI ENT TREATMENT CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 <td>71.00</td> <td>07100 MEDICAL SUPPLIES CHARGED TO PATIENT</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>71.00</td>	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 75.01 07501 CARDI AC REHAB 0 0 0 0 75.01 75.02 07502 SLEEP LAB 0 0 0 0 75.01 75.03 07503 INPATI ENT DI ALYSI S 0 0 0 0 75.03 75.04 07504 PAIN MANAGEMENT 0 0 0 0 0 75.04 76.97 CARDI AC REHABI LI TATI ON 0 0 0 0 0 76.97 76.98 07699 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.98 0000 09000 CLINIC 0 0 0 0 0 76.98 90.00 09000 CLINIC 0 0 0 0 0 0 90.00 90.01 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
75.01 07501 CARDIAC REHAB 0 0 0 0 75.01 75.02 07502 SLEEP LAB 0 0 0 0 0 75.02 75.03 07503 INPATI ENT DI ALYSI S 0 0 0 0 0 75.03 75.04 07504 PAIN MANAGEMENT 0 0 0 0 75.04 76.97 07697 CARDIA C REHABI LI TATI ON 0 0 0 0 76.93 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.98 76.99 LI THOTRI PSY 0 0 0 0 0 76.98 0000 09000 CLINI C 0 0 0 0 90.01 00.01 09001 PATI ENT SREAVI CE S-BLOOMI NGDALE 0 0 0 0 90.02 09002 REHAB SERVI CES-BLOOMI NGDALE 0 0 0 0 0 90.03 90.04 09004 MENTAL HEALTH 0/P 0 0 0 0	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
75.02 07502 SLEEP LAB 0 0 0 0 75.02 75.03 07503 INPATI ENT DI ALYSI S 0 0 0 0 0 75.03 75.04 07504 PAI N MANAGEMENT 0 0 0 0 0 0 75.03 75.04 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 76.97 76.99 07699 LI THOTRI PSY 0 0 0 0 76.99 07699 LI THOTRI PSY 0 0 0 0 0 76.99 0000 CLI NI C 0 0 0 0 0 90.00 90.00 09001 PATI ENT TREATMENT CENTER 0 0 0 90.02 90.01 90012 REHAB SERVI CES-BLOOMI NGDALE 0 0 0 90.03 90.02 REHAB SERVI CES-BLOOMI INGDALE 0 0 0 0	74.00	07400 RENAL DI ALYSI S	0	0		0	0	0	74.00
75.03 07503 INPATIENT DIALYSIS 0 0 0 0 75.03 75.04 07504 PAIN MANAGEMENT 0 0 0 0 0 75.04 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 0 76.98 706.99 LI THOTRI PSY 0 0 0 0 0 0 76.98 706.99 LI THOTRI PSY 0 0 0 0 0 76.98 706.99 LI THOTRI PSY 0 0 0 0 0 76.98 70109 LI NI C 0 0 0 0 0 90.00 90.00 90.00 PATIENT TREATMENT CENTER 0 0 0 0 90.01 90.02 REHAB SERVICES-BLOOMINGDALE 0 0 0 0 <td>75.01</td> <td>07501 CARDI AC REHAB</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>75.01</td>	75.01	07501 CARDI AC REHAB	0	0		0	0	0	75.01
75.04 07504 PAIN MANAGEMENT 0 0 0 0 75.04 76.97 O7697 CARDIAC REHABILITATION 0 0 0 0 0 0 76.97 76.98 O7698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 76.98 76.98 O7699 LI THOTI PSY 0 0 0 0 0 0 76.98 76.99 UTPATIENT SERVICE COST CENTERS 0	75.02	07502 SLEEP LAB	0	0		0	0	0	75.02
76.97 O7697 CARDIAC REHABILITATION 0 0 0 0 76.97 76.98 O7698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76.98 76.99 O7699 LI THOTRI PSY 0 0 0 0 0 76.99 OUTPATI ENT SERVICE COST CENTERS OUTPATI ENT SERVICE COST CENTER 90.00 O9000 CLINIC 0 0 0 90.00 90.01 09001 PATI ENT TREATMENT CENTER 0 0 0 90.01 90.01 90.02 09002 REHAB SERVICES-BLOOMINGDALE 0 0 0 90.02 90.02 90.03 09003 CANTERA 0 0 0 0 90.03 90.04 09004 MENTAL HEALTH 0/P 0 0 0 0 90.04 90.05 09005 WOMENS CLINIC 0 0 0 90.04 90.06 90.06 09006 WOUND CARE 0 0 0 0 90.06 90.	75.03	07503 I NPATI ENT DI ALYSI S	0	0		0	0	0	75.03
76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 76.98 76.98 76.99 0 0 0 0 0 0 76.98 76.98 76.99 0	75.04	07504 PAIN MANAGEMENT	0	0		0	0	0	75.04
76.99 07699 L1 HOTRI PSY 0 0 0 0 0 76.99 OUTPATI ENT SERVICE COST CENTERS O O O O O 0		07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 0 0 90.00 90.01 09001 PATIENT TREATMENT CENTER 0 0 0 0 0 0 0 90.01 90.01 90.02 09002 REHAB SERVICES-BLOOMINGDALE 0 0 0 0 0 0 90.02 90.03 09003 CANTERA 0 0 0 0 0 90.03 90.04 90.04 90.04 90.05 9005 WMENS CLINIC 0 0 0 0 90.04 90.05 90.05 90.05 90.06 90.06 90.05 90.05 90.05 90.05 90.06 9	76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	0	76. 98
90.00 09000 CLINIC 0 0 0 0 0 90.00 90.01 09001 PATIENT TREATMENT CENTER 0 0 0 0 0 90.01 90.02 09002 REHAB SERVI CES-BLOOMINGDALE 0 0 0 0 0 90.02 90.03 09003 CANTERA 0 0 0 0 0 90.03 90.04 09004 MENTAL HEALTH 0/P 0 0 0 0 90.04 90.05 WOMENS CLINIC 0 0 0 0 0 90.05 90.06 09005 WOMENS CLINIC 0 0 0 0 90.06 90.06 09006 WOUND CARE 0 0 0 0 90.06 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 92.00	76.99	07699 LI THOTRI PSY	0	0		0	0	0	76.99
90.01 09001 PATIENT TREATMENT CENTER 0 0 0 0 90.01 90.02 09002 REHAB SERVICES-BLOOMINGDALE 0 0 0 0 90.02 90.03 09003 CANTERA 0 0 0 0 90.03 90.04 09004 MENTAL HEALTH 0/P 0 0 0 0 90.04 90.05 WOMENS CLINIC 0 0 0 0 90.06 90.06 90.06 WOUND CARE 0 0 0 0 90.06 90.06 90.06 91.00 DEMERGENCY 0 0 0 0 91.00 92.00			-						
90.02 09002 REHAB SERVICES-BLOOMINGDALE 0							-		
90.03 09003 CANTERA 0			-						
90.04 09004 MENTAL HEALTH 0/P 0 0 0 0 0 90.04 90.05 09005 WOMENS CLINIC 0 0 0 0 0 90.05 90.06 09006 WOUND CARE 0 0 0 0 90.06 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09SERVATION BEDS (NON-DISTINCT PART 0 0 0 0 92.00			0				0		
90.05 09005 WOMENS CLINIC 0 0 0 0 90.05 90.06 09006 WOUND CARE 0 0 0 0 0 90.06 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00			0				-		
90.06 09006 WOUND CARE 0 0 0 0 90.06 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 92.00			0			-	-	-	
91.00 09100 EMERGENCY 0 0 0 91.00 91.00 91.00 92.00 0 92.00 0 0 0 91.00 92.00 92.00 0 0 0 0 92.00 0 92.00 0 0 0 0 92.00 0 0 0 0 0 92.00 0 0 0 0 0 0 92.00 0 0 0 0 0 0 0 92.00 0			0				0		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92. 00			0				-		
							0		
200.00 Total (lines 50 through 199) 0									
	200.00) Total (lines 50 through 199)	0	0		0	0	0	200.00

	Financial Systems	CENTRAL DUPA		CN. 14 0040		u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI GH COSTS	ERVICE OTHER PAS	S Provider C		Period: From 09/01/2021 To 08/31/2022		pared:
				e XIX	Hospi tal	1/28/2023 6:3 Cost	o pm
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	cost center bescription	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of	•	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
			, í	and 4)	, í	(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS	- F	1	1	-1		
50.00		0	0		0 436, 326, 227	0. 000000	50.00
51.00	05100 RECOVERY ROOM	0	0		0 99, 622, 664	0. 000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 52, 647, 348	0. 000000	52.00
53.00		0	0		0 110, 982, 214	0. 000000	•
54.00		0	0		0 126, 056, 772	0. 000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 194, 946, 474	0. 000000	55.00
56.00	05600 RADI OI SOTOPE	0	0		0 35, 161, 574	0. 000000	56.00
57.00	05700 CT SCAN	0	0		0 230, 215, 303	0. 000000	57.00
58.00	05800 MRI	0	0		0 109, 058, 212	0. 000000	58.00
60.00	06000 LABORATORY	0	0		0 1, 510, 432, 638	0. 000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0 22, 043, 384	0. 000000	•
62.30		0	0		0 0	0. 000000	62.30
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 74, 106, 930	0. 000000	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 66, 902, 296	0. 000000	65.00
66.00		0	0		0 101, 257, 491	0. 000000	•
67.00		0	0		0 18, 197, 955	0. 000000	•
68.00	06800 SPEECH PATHOLOGY	0	0		0 9, 380, 652	0. 000000	•
69.00		0	0		0 284, 073, 310	0. 000000	•
70.00		0	0		0 37, 542, 268	0. 000000	•
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0 494, 292, 215	0. 000000	•
72.00		0	0		0 300, 700, 202	0. 000000	
73.00		0	0		0 1, 123, 632, 793	0. 000000	•
74.00	07400 RENAL DI ALYSI S	0	0		0 11, 378, 294	0. 000000	•
75.01	07501 CARDI AC REHAB	0	0		0 3, 012, 603	0. 000000	•
75.02		0	0		0 0	0. 000000	•
75.03	07503 I NPATI ENT DI ALYSI S	0	0		0 0	0. 000000	
75.04		0	0		0 2, 401, 166	0. 000000	•
76.97		0	0		0 0	0. 000000	•
76.98	07698 HYPERBARI C OXYGEN THERAPY	0			0 0	0. 000000	•
76.99		0	0		0 0	0. 000000	76.99
	OUTPATIENT SERVICE COST CENTERS			1			
90.00	09000 CLINIC	0			0 19, 505, 631	0. 000000	•
90.01	09001 PATIENT TREATMENT CENTER	0			0 47, 826, 756	0. 000000	
90.02		0	-		0 0	0. 000000	•
90.03	09003 CANTERA	0	0		0 0	0. 000000	1
90.04		0	0		0 18, 124, 890	0. 000000	•
90.05	09005 WOMENS CLINIC	0			0 0	0. 000000	
90.06	09006 WOUND CARE	0	0		0 3, 127, 867	0. 000000	•
91.00		0	0		0 245, 963, 657	0. 000000	•
92.00		0			0 52, 907, 704	0. 000000	
200. 0	D Total (lines 50 through 199)	0	0	1	0 5, 841, 827, 490		200.00

APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der C	CN: 14-0242	Period:	Worksheet D	
	H COSTS			011. 11 0212	From 09/01/2021 To 08/31/2022	Part IV Date/Time Pre	
			Ti †I	e XIX	Hospi tal	1/28/2023 6:3 Cost	io pili
	Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	p	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug		Pass-Through	
		(col. 6 ÷ col.	J	Costs (col.		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCI LLARY SERVI CE COST CENTERS			•			
50.00	05000 OPERATI NG ROOM	0.000000	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0 0	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
	05600 RADI OI SOTOPE	0. 000000	0		0 0	0	
	05700 CT SCAN	0. 000000	0		0 0	0	
	05800 MRI	0. 000000	0		0 0	0	
	06000 LABORATORY	0. 000000	0		0 0	0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	
	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	
	06500 RESPIRATORY THERAPY		0		0 0	0	1
		0.000000	-			0	65.00
	06600 PHYSI CAL THERAPY	0.000000	0			0	
	06700 OCCUPATI ONAL THERAPY	0. 000000	-		0 0	0	
	06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	
	06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	
	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0 0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
75.01	07501 CARDI AC REHAB	0. 000000	0		0 0	0	75.01
75.02	07502 SLEEP LAB	0. 000000	0		0 0	0	75.02
75.03	07503 INPATIENT DIALYSIS	0. 000000	0		0 0	0	75.03
75.04	07504 PAIN MANAGEMENT	0. 000000	0		0 0	0	75.04
76.97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0.000000	0		0 0	0	76.98
76.99	07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
	OUTPATIENT SERVICE COST CENTERS			•			
90.00	09000 CLINIC	0.000000	0		0 0	0	90.00
90.01	09001 PATIENT TREATMENT CENTER	0. 000000	0		0 0	0	
	09002 REHAB SERVI CES-BLOOMI NGDALE	0. 000000	0		0 0	0	
	09003 CANTERA	0. 000000	0		0 0	0	
	09004 MENTAL HEALTH 0/P	0, 000000	0		0 0	0	
	09005 WOMENS CLINIC	0. 000000	0		0 0	0	
	09006 WOUND CARE	0. 000000	0		0 0	0	
	09100 EMERGENCY	0. 000000	0		0 0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	
92.00							

	Financial Systems CENTRAL DUPAGE ATION OF INPATIENT OPERATING COST	Provi der CCN: 14-0242	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 09/01/2021 To 08/31/2022	Date/Time Pre 1/28/2023 6:3	
		Title XVIII	Hospi tal	PPS	-
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS	o avaluding nawharn)		04.200	1.
. 00 . 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			94, 298 94, 298	2.
. 00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	od dave)		77, 857	4.
. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	
	reporting period			_	
. 00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6.
. 00	Total swing-bed NF type inpatient days (including private roo	m days) through Decembe	r 31 of the cost	0	7.
00	reporting period	m dava) after December	21 of the east	0	
. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	in days) after December	31 OF THE COST	0	8.
. 00	Total inpatient days including private room days applicable t	o the Program (excludin	g swing-bed and	26, 507	9.
0. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including privato	room dave)	0	10.
0.00	through December 31 of the cost reporting period (see instruc		room days)	0	10.
1. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.
2 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.
2.00	through December 31 of the cost reporting period	5	5 .	Ũ	
3.00	Swing-bed NF type inpatient days applicable to titles V or XI	3 (31	, ,	0	13.
4.00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.
5.00	Total nursery days (title V or XIX only)			0	15.
6. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.
7.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost	0.00	17.
8.00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18.
9.00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 o	f the cost	0.00	19.
0. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	0.00	20
0.00	reporting period				
1.00	Total general inpatient routine service cost (see instruction	2	ting pariod (ling	133, 024, 110	21.
2.00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	er 31 of the cost repor	ting period (ine	0	22.
3.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporti	ng period (line 6	0	23.
4.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	0	24.
5.00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25.
6.00	x line 20) Total swing-bed cost (see instructions)			0	26.
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		133, 024, 110	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
8.00 9.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed c	harges)	0	28. 29.
	Semi-private room charges (excluding swing-bed charges)			0	30.
1.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
3.00 1.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x li		5.1.013/	0.00	
5.00	Private room cost differential adjustment (line 3 x line 35)	,		0	36.
7.00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	133, 024, 110	37.
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				1
3.00	Adjusted general inpatient routine service cost per diem (see	-		1, 410. 68	
9.00 0.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			37, 392, 895 0	39. 40.
	incar carry needed , private room cost appricable to the rrogi			0	

	Financial Systems ATION OF INPATIENT OPERATING COST	CENTRAL DUPAG	E HOSPITAL Provider CO		Period:	u of Form CMS- Worksheet D-1	
					rom 09/01/2021 o 08/31/2022	Date/Time Pre 1/28/2023 6:3	
	Cost Contor Decorintion	Tatal		XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 + col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00		1.00	2.00	3.00	4.00	5.00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0 0	0	42.00
43.00	I NTENSI VE CARE UNI T	27, 495, 694	8, 731	3, 149. 20	2, 771	8, 726, 433	43.00
44.00	CORONARY CARE UNIT	8, 223, 802	3, 125	2, 631. 62	2 0	0	
45.00 46.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.00 46.00
	NEONATAL INTENSIVE CARE UNIT	14, 717, 240	7, 670	1, 918. 81	0	0	
	Cost Center Description					4.00	
48.00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3.	line 200)			1.00 67,746,552	48.00
	Total Program inpatient costs (sum of lines			ons)		113, 865, 880	
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpa []])	atient routine s	services (from	n Wkst. D, sum	of Parts I and	5, 267, 470	50.00
51.00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	4, 099, 721	51.00
F0 6-	and IV)					o o/=*	
52.00 53.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non-nh	sician anesth	etist and	9, 367, 191 104, 498, 689	
55.00	medical education costs (line 49 minus line !					107, 470, 007	
	TARGET AMOUNT AND LIMIT COMPUTATION					-	
54.00 55.00	Program discharges Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0.00	
57.00	Difference between adjusted inpatient operat	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)	anting pariod	anding 1004	ndated and as	magundad by the	0	
59.00	Lesser of lines 53/54 or 55 from the cost remarket basket	borting period (enarng 1996, t	ipuated and co	inpounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year of					0.00	
61.00	If line 53/54 is less than the lower of line: which operating costs (line 53) are less that					0	61.00
	amount (line 56), otherwise enter zero (see		s (TTHES 54 X	00), 01 1% 01	the target		
	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64.00
	instructions)(title XVIII only)					_	
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	er 31 of the c	ost reporting	period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line (64 plus line 6	5)(title XVII	l only). For	0	66.00
(7.00	CAH (see instructions)		D	C 11			
67.00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 c	or the cost re	porting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	rting period	0	68.00
60 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	coutino costs (ino 67 Lino	(40)		0	69.00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NU			,		0	09.00
	Skilled nursing facility/other nursing facili						70.00
71.00	Adjusted general inpatient routine service of		ne 70 ÷ line	2)			71.00
72.00 73.00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	(line 14 x li	ne 35)			72.00
74.00	Total Program general inpatient routine servi	0	•				74.00
75.00	Capital-related cost allocated to inpatient	routine service	costs (from W	lorksheet B, P	art II, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.00
77.00	Program capital-related costs (line 9 x line	76)					77.00
	Inpatient routine service cost (line 74 minu:	,	ovidor rocorr	le)			78.00
79.00 80.00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				us line 79)		79.00
81.00	Inpatient routine service cost per diem limi				/		81.00
82.00	Inpatient routine service cost limitation (I						82.00
83.00 84.00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:		5)				83.00
	Utilization review - physician compensation		ıs)				85.00
	Total Program inpatient operating costs (sum	of lines 83 th					86.00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					16 //1	87.00
	Total observation bed days (see filstiuctions)	/				16, 441	107.00
87.00 88.00	Adjusted general inpatient routine cost per o	diem (line 27 ÷	line 2)			1, 410. 68	88.00

Health Financial Systems	CENTRAL DUPA	ENTRAL DUPAGE HOSPITAL			In Lieu of Form CMS-2552-1		
COMPUTATION OF INPATIENT OPERATING COST				Period: From 09/01/2021	Worksheet D-1		
				To 08/31/2022	Date/Time Pre 1/28/2023 6:3	pared: O pm	
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	15, 524, 041	133, 024, 110	0. 11670	1 23, 192, 990	2, 706, 645	90.00	
91.00 Nursing Program cost	0	133, 024, 110	0.00000	0 23, 192, 990	0	91.00	
92.00 Allied health cost	0	133, 024, 110	0. 00000	0 23, 192, 990	0	92.00	
93.00 All other Medical Education	0	133, 024, 110	0. 00000	0 23, 192, 990	0	93.00	

COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 14-0242 Component CCN: 14-S242 Title XVIII	Peri od: From 09/01/2021 To 08/31/2022 Subprovi der - I PF	Worksheet D-1 Date/Time Pre 1/28/2023 6:3 PPS	pared:
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS	(c. avaluding nawharn)		0.224	1 1 00
. 00 . 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			8, 324 8, 324	
. 00	Private room days (excluding swing-bed and observation bed da	J <i>i</i>	rivate room days,	0, 324	
	do not complete this line.		J		
. 00	Semi-private room days (excluding swing-bed and observation b		n 21 of the east	8, 324	1
. 00	Total swing-bed SNF type inpatient days (including private ro reporting period	ioni days) through becenbe	er si or the cost	0	5.00
. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
00	reporting period (if calendar year, enter 0 on this line)		- 21 - 6 + +	0	
. 00	Total swing-bed NF type inpatient days (including private roc reporting period	m days) through December	31 OF the cost	0	7.0
. 00	Total swing-bed NF type inpatient days (including private roc	om days) after December (31 of the cost	0	8.0
	reporting period (if calendar year, enter 0 on this line)				
. 00	Total inpatient days including private room days applicable t newborn days) (see instructions)	the Program (excluding	g swing-bed and	1, 155	9.0
0.00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private i	room days)	0	10.0
	through December 31 of the cost reporting period (see instruc			_	
1.00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) after	0	11.0
2.00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.0
	through December 31 of the cost reporting period				
3.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.0
4.00	Medically necessary private room days applicable to the Progr			0	14.0
5.00	Total nursery days (title V or XIX only)	. 5 5	5,	0	
6.00	Nursery days (title V or XIX only)			0	16.0
7.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31 (of the cost	0.00	17.00
	reporting period	Ū.			
8.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost	0.00	18.0
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19.0
	reporting period	Ū.			
20.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of 1	the cost	0.00	20.0
1.00	Total general inpatient routine service cost (see instruction	is)		20, 063, 352	21.0
2.00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	0	
2 00	5 x line 17) Swing had cost applicable to SNE type convices after December	21 of the cost reportin	a pariod (line 4	0	23.0
3.00	Swing-bed cost applicable to SNF type services after December x line 18)	ST OF THE COST TEPOLET	ig period (Title o	0	23.0
24.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24.0
25.00	7 x line 19) Swing had cost applicable to NE type corvices after December	21 of the cost reporting	a portiod (line 9	0	25 0
5.00	Swing-bed cost applicable to NF type services after December x line 20)	ST OF THE COST TEPOLITIQ	g per lou (Trile o	0	25.0
26.00	Total swing-bed cost (see instructions)			0	
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		20, 063, 352	27.0
8.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28.0
9.00	Private room charges (excluding swing-bed charges)		la goo,	0	1
0.00	Semi-private room charges (excluding swing-bed charges)			0	
1.00 2.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷line 28)		0.000000	
3.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
4.00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	34.0
5.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
36.00 37.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 20, 063, 352	
	27 minus line 36)] 37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			2 /10 20	20 0
38.00 39.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			2, 410. 30 2, 783, 897	
0.00	Medically necessary private room cost applicable to the Progr	ram (line 14 x line 35)		0	40.0
1.00	Total Program general inpatient routine service cost (line 39) + line 40)		2, 783, 897	1 41 0

	Financial Systems TATION OF INPATIENT OPERATING COST	CENTRAL DUPAG		CN: 14-0242	Peri od:	worksheet D-1	
			Component	CCN: 14-S242	From 09/01/2021 To 08/31/2022	Date/Time Pre	
			Title	e XVIII	Subprovider -	1/28/2023 6: 3 PPS	30 pm
	Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost	
	cost center bescription	Inpatient Cost		Diem (col. 1 col. 2)	5	(col. 3 x col. 4)	
2.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00) 42.0
2.00	Intensive Care Type Inpatient Hospital Units			, U.			42.
3.00		0	C				
4.00 5.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	Ĺ	0.	00 0	0	44.
5. 00	SURGICAL INTENSIVE CARE UNIT						46.
7.00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	0	C	0.	00 0	0	47.
	· .					1.00	
3.00 9.00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		286, 172 3, 070, 069	
. 00	PASS THROUGH COST ADJUSTMENTS	~ · ·					
0. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	m of Parts I and	399, 145	50.
1.00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	19, 942	51.
2.00	and IV) Total Program excludable cost (sum of lines	50 and 51	-			419, 087	E 2
2.00	Total Program inpatient operating cost exclu		lated, non-ph	ysician anest	hetist, and	2, 650, 982	
	medical education costs (line 49 minus line	52)					
4.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.
5.00	Target amount per discharge					0.00	
5.00 7.00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	raet amount (line 56 minus	line 53)	0	
3.00	Bonus payment (see instructions)		inger anount (s The 33)	0	
9.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	compounded by the	0.00	59.
0. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. up	dated by the	market basket		0.00	60.
1.00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the les	ser of 50% of	the amount by	0	
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% c	of the target		
2.00	Relief payment (see instructions)	riisti detrons)				0	62.
3.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)			0	63.
4.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost report	ing period (See	0	64.
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decomb	or 21 of the	cost roportin	a pariod (Saa	0	65.
5.00	instructions) (title XVIII only)			cost reportin	ig per lou (see		05.
6. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	0	67.
0 00	(line 12 x line 19)	-		+h+			
8.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)		ecember 31 01	the cost rep	orting period	0	68.
9.00				,		0	69.
0. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				")		70.
1.00	Adjusted general inpatient routine service c	ost per diem (l		•			71.
2.00 3.00	Program routine service cost (line 9 x line Medically necessary private room cost applic		line 14 x l	ine 35)			72.
4.00	Total Program general inpatient routine serv						74.
5.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	Worksheet B,	Part II, column		75.
5.00	Per diem capital-related costs (line 75 ÷ li						76.
7.00 3.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77.
9.00	Aggregate charges to beneficiaries for exces	s costs (from p					79.
0.00	Total Program routine service costs for comp		ost limitatio	n (line 78 mi	nus line 79)		80.
1.00 2.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81.
3.00	Reasonable inpatient routine service costs (see instruction					83.
4.00 5.00	Program inpatient ancillary services (see in Utilization review - physician compensation		ne)				84. 85.
5.00 6.00	Total Program inpatient operating costs (sum						85.
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST				-	
7.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			0 00	87.
	Observation bed cost (line 87 x line 88) (se	•					89.

Health Financial Systems	CENTRAL DUPA	GE HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 09/01/2021	Worksheet D-1	
		Component (To 08/31/2022	Date/Time Pre 1/28/2023 6:3	
		Title	XVIII	Subprovider -	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	2, 876, 580	20, 063, 352	0. 14337	/5 0	0	90.00
91.00 Nursing Program cost	0	20, 063, 352	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	20, 063, 352	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	20, 063, 352	0.00000	0 0	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provi der CCN: 14-0242	Period: From 09/01/2021	Worksheet D-1	
			To 08/31/2022	Date/Time Pre	
		Title XIX	Hospi tal	1/28/2023 6: 3 Cost	<u>o</u> pr
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs excluding newborn)	I	94, 298	1 1
00	Inpatient days (including private room days and swing bed day Inpatient days (including private room days, excluding swing			94, 298	2
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation l	ped days)		77, 857	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	
00	reporting period Total swing-bed SNF type inpatient days (including private re	nom dave) after Decomber	21 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	Juli days) al ter beceniber	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	om davs) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)	5			
00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the Program (excludin	g swing-bed and	3, 547	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private	room days)	0	10
00	through December 31 of the cost reporting period (see instruction and SNE type instruction and sole to title XV////		room dowo) ofter	0	1 1 1
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, of		room days) arter	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13
	after December 31 of the cost reporting period (if calendar	year, enter 0 on this li	ne)		
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			4, 956 1, 941	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces through December 31	of the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
	reporting period				
. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decem		ting period (line	133, 024, 110 0	21
. 00	5 x line 17)	bei 51 01 the cost repor	ting period (inte	0	
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	0	24
	7 x line 19)				
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	g period (line 8	0	25
	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		133, 024, 110	27
. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0 0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)	÷ Trhe 20)		0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	and private room cast -	ifforantial (1)	122 024 110	36
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)			133, 024, 110	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see			1, 410. 68	38
	Program general inpatient routine service cost per drem (ser			5, 003, 682	
0. 00	Medically necessary private room cost applicable to the Progr	ram (line 14 x line 35)		0	40
00	Total Program general inpatient routine service cost (line 3	7 + line 40)		5,003,682	1 41

Health Financial Systems COMPUTATION OF INPATIENT OPERA	TING COST	CENTRAL DUPAG	E HOSPITAL Provider C		eriod:	u of Form CMS-2 Worksheet D-1	
					rom 09/01/2021 o 08/31/2022	Date/Time Pre 1/28/2023 6:3	
Cost Center Descri	ption	Total Inpatient Costl	Total	e XIX Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Cost Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX	onl y)	1.00 4,401,553	<u>2.00</u> 4,956	3.00 888.13	4.00	5.00 1,723,860	42.00
Intensive Care Type Inp	atient Hospital Units				· · · ·		
43.00 I NTENSI VE CARE UNI T 44.00 CORONARY CARE UNI T		27, 495, 694 8, 223, 802	8, 731 3, 125	3, 149. 20 2, 631. 62			
45.00 BURN INTENSIVE CARE UNI	Т	0, 223, 002	5, 125	2,031.02			45.00
46.00 SURGICAL INTENSIVE CARE							46.00
47.00 NEONATAL INTENSIVE CARE Cost Center Descri		14, 717, 240	7,670	1, 918. 81	115	220, 663	47.00
	ptron					1.00	
48.00 Program inpatient ancil						0	
49.00 Total Program inpatient PASS THROUGH COST ADJUS		41 through 48)(see instructio	ons)		8, 081, 917	49.00
50.00 Pass through costs appl		atient routine	services (from	n Wkst. D, sum	of Parts I and	0	50.00
			10				E1 00
51.00 Pass through costs appl and IV)	Icable to Program inp	atient anciiiar	y services (Tr	OM WKST. D, SI	um of Parts II	0	51.00
52.00 Total Program excludabl	e cost (sum of lines	50 and 51)				0	52.00
53.00 Total Program inpatient			lated, non-phy	sician anesthe	etist, and	0	53.00
medical education costs		52)					-
54.00 Program di scharges						0	
55.00 Target amount per disch	5						55.00 56.00
56.00 Target amount (line 54 57.00 Difference between adju		ing cost and ta	rget amount (l	ine 56 minus l	ine 53)	0	
58.00 Bonus payment (see inst	ructions)	0	0		ŗ	0	58.00
59.00 Lesser of lines 53/54 c	r 55 from the cost re	porting period	ending 1996, ι	updated and cor	npounded by the	0.00	59.00
60.00 Lesser of lines 53/54 c	r 55 from prior vear	cost report. up	dated by the m	arket basket		0.00	60.00
61.00 If line 53/54 is less t	han the lower of line	s 55, 59 or 60	enter the less	er of 50% of t		0	61.00
which operating costs (amount (line 56), other			s (lines 54 x	60), or 1% of	the target		
62.00 Relief payment (see ins						0	62.00
63.00 Allowable Inpatient cos		ent (see instru	ctions)			0	63.00
64.00 Medicare swing-bed SNF		ts through Dece	mber 31 of the	e cost reportir	na period (See	0	64.00
instructions)(title XVI	II only)	Ū.					
65.00 Medicare swing-bed SNF instructions)(title XVI		ts after Decemb	er 31 of the c	cost reporting	period (See	0	65.00
66.00 Total Medicare swing-be		ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66.00
CAH (see instructions)							
67.00 Title V or XIX swing-be (line 12 x line 19)	d NF inpatient routin	e costs through	December 31 d	of the cost rep	porting period	0	67.00
68.00 Title V or XIX swing-be	d NF inpatient routin	e costs after D	ecember 31 of	the cost report	ting period	0	68.00
(line 13 x line 20)	ing had NE innationt	noutino posto (ling (7 , ling	(0)			60.00
69.00 Total title V or XIX sw PART III - SKILLED NURS	i			,		0	69.00
70.00 Skilled nursing facilit	y/other nursing facil	ity/ICF/IID rou	tine service o	cost (line 37)			70.00
71.00 Adjusted general inpati		•	ine 70 ÷ line	2)			71.00
72.00 Program routine service 73.00 Medically necessary pri	-		(line 14 x li	ne 35)			72.00
74.00 Total Program general i		0	•	,			74.00
75.00 Capital -related cost al	located to inpatient	routine service	costs (from V	lorksheet B, Pa	art II, column		75.00
26, line 45) 76.00 Per diem capital-relate	d costs (line 75 ÷ li	ne 2)					76.00
77.00 Program capital -related	•	,					77.00
78.00 Inpatient routine servi 79.00 Aggregate charges to be			rovider record	le)			78.00
80.00 Total Program routine s					us line 79)		80.00
81.00 Inpatient routine servi	ce cost per diem limi	tati on			-		81.00
82.00 Inpatient routine servi 83.00 Reasonable inpatient ro	•						82.00 83.00
84.00 Program inpatient ancil			5,				84.00
85.00 Utilization review - ph	ysician compensation	(see instructio					85.00
86.00 Total Program inpatient PART IV - COMPUTATION 0	<u> </u>		rough 85)				86.00
87.00 Total observation bed d						16, 441	87.00
88.00 Adjusted general inpati	•	•	line 2)			1, 410. 68	
89.00 Observation bed cost (1	ine 87 x line 88) (se	e instructions)				23, 192, 990	89.00

Health Financial Systems	CENTRAL DUPA	GE HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 09/01/2021	Worksheet D-1	
				To 08/31/2022	Date/Time Pre 1/28/2023 6:3	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	15, 524, 041	133, 024, 110	0. 11670	1 23, 192, 990	2, 706, 645	90.00
91.00 Nursing Program cost	0	133, 024, 110	0.00000	0 23, 192, 990	0	91.00
92.00 Allied health cost	0	133, 024, 110	0. 00000	0 23, 192, 990	0	92.00
93.00 All other Medical Education	0	133, 024, 110	0. 00000	0 23, 192, 990	0	93.00

COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 14-0242 Component CCN: 14-S242 Title XIX	Peri od: From 09/01/2021 To 08/31/2022 Subprovi der - I PF	Worksheet D-1 Date/Time Pre 1/28/2023 6:3 Cost	pared:
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS		I		
1 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	va avaluding nawharn)		0.224	1 1 00
1.00 2.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			8, 324 8, 324	1.00
3.00	Private room days (excluding swing-bed and observation bed da	J i	rivate room days,	0, 021	3.00
	do not complete this line.				
1.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	8, 324 0	4.0 5.0
00	reporting period	Som days) through becembe	er si or the cost	0	5.0
5.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.0
	reporting period (if calendar year, enter 0 on this line)		21 6 11	0	
7.00	Total swing-bed NF type inpatient days (including private roo reporting period	om days) through Decembei	r 31 of the cost	0	7.0
3.00	Total swing-bed NF type inpatient days (including private roo	om days) after December :	31 of the cost	0	8.0
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable t newborn days) (see instructions)	to the Program (excluding	g swing-bed and	550	9.0
0.00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private i	room davs)	0	10.0
	through December 31 of the cost reporting period (see instruc	ctions)	5 /	-	
1.00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) after	0	11.0
2.00	Swing-bed NF type inpatient days applicable to titles V or XI		te room davs)	0	12.0
	through December 31 of the cost reporting period	5 . 51	3 /	-	
3.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.0
4.00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.0
15.00	Total nursery days (title V or XIX only)			4, 956	
6.00	Nursery days (title V or XIX only)			1, 941	16.0
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 (of the cost	0.00	17.0
17.00	reporting period	through becember of t		0.00	17.0
18.00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18.0
19.00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0 00	19.0
	reporting period				
20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.0
21.00	reporting period Total general inpatient routine service cost (see instruction	าร)		20, 063, 352	21.0
22.00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	0	22.0
	5 x line 17)			0	
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportin	ng period (line 6	0	23.0
24.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24.0
	7 x line 19)			0	25.0
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (Tine 8	0	25.0
26.00	Total swing-bed cost (see instructions)			0	26.0
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		20, 063, 352	27.0
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ed and observation bed ch	parces)	0	28.0
29.00	Private room charges (excluding swing-bed charges)		la goo,	0	29.0
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.0
1.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
2.00 3.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instrud	ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li	, ,	ŕ	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.0
37.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	TTERENTIAL (LINE	20, 063, 352	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.				
38.00	Adjusted general inpatient routine service cost per diem (see	-		2,410.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	-		1, 325, 665 0	39.00 40.00
10.00					

lealth Financial Systems COMPUTATION OF INPATIENT OPERATING COST	CENTRAL DUPAGE	HOSPITAL Provider C	CN: 14-0242	Period:	worksheet D-1	
		Component	CCN: 14-S242	From 09/01/2021 To 08/31/2022		
		Ti tl	e XIX	Subprovider -	1/28/2023 6:3 Cost	30 pm
Cost Center Description	Total Inpatient CostIr	Total patient Days			Program Cost (col. 3 x col.	
	1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
2.00 NURSERY (title V & XIX only)	0	0	0. (0 00	C) 42. (
3.00 INTENSIVE CARE UNIT	0	0	0. (0 00	C	43.0
4.00 CORONARY CARE UNIT	0	0	0.0	0 00	C	
5. 00 BURN INTENSIVE CARE UNIT 6. 00 SURGICAL INTENSIVE CARE UNIT						45. 46.
7.00 NEONATAL INTENSIVE CARE UNIT	0	0	0. (0 00	C	47.
Cost Center Description					1.00	
8.00 Program inpatient ancillary service cost					C	
9.00 Total Program inpatient costs (sum of lin PASS THROUGH COST ADJUSTMENTS	<u>nes 41 through 48)(s</u>	ee instructio	ons)		1, 325, 665	49.
0.00 Pass through costs applicable to Program	inpatient routine s	ervices (from	n Wkst. D, su	m of Parts I and	C	50.
<pre>1111) 1.00 Pass through costs applicable to Program</pre>	inpatient ancillary	services (fr	om Wkst. D,	sum of Parts II	C	51.
and IV) 2.00 Total Program excludable cost (sum of lin	100 = 50 and 51				0	50
2.00 Total Program excludable cost (sum of lin 3.00 Total Program inpatient operating cost ex		ated, non-phy	vsician anest	hetist, and		
medical education costs (line 49 minus li TARGET AMOUNT AND LIMIT COMPUTATION	ne 52)					-
4.00 Program discharges					C	54.
5.00 Target amount per discharge					0.00	
6.00 Target amount (line 54 x line 55) 7.00 Difference between adjusted inpatient ope	erating cost and tar	get amount (I	ine 56 minus	line 53)		
3.00 Bonus payment (see instructions)	Ũ			ŗ	0	
9.00 Lesser of lines 53/54 or 55 from the cos market basket	t reporting period e	nding 1996, i	updated and c	ompounded by the	0.00	59.
0.00 Lesser of lines 53/54 or 55 from prior ye					0.00	
1.00 If line 53/54 is less than the lower of I which operating costs (line 53) are less					C) 61.
amount (line 56), otherwise enter zero (s	•			i the turget		
2.00 Relief payment (see instructions) 3.00 Allowable Inpatient cost plus incentive p	navment (see instruc	tions)				
PROGRAM INPATIENT ROUTINE SWING BED COST		•				
4.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs through Decem	ber 31 of the	e cost report	ing period (See	C	64.
5.00 Medicare swing-bed SNF inpatient routine	costs after Decembe	r 31 of the d	cost reportin	g period (See	0	65.
instructions)(title XVIII only) 6.00 Total Medicare swing-bed SNF inpatient ro	outine costs (line 6	4 plus line 6	5)(title XVI	ll onlv). For	l c	66.
CAH (see instructions)			, .	57		
7.00 Title V or XIX swing-bed NF inpatient rou (line 12 x line 19)	utine costs through	December 31 d	of the cost r	eporting period	C	67.
8.00 Title V or XIX swing-bed NF inpatient rou	utine costs after De	cember 31 of	the cost rep	orting period	C	68.
(line 13 x line 20) 9.00 Total title V or XIX swing-bed NF inpatio	ent routine costs (ine 67 + line	e 68)		l c	69.
PART III - SKILLED NURSING FACILITY, OTHE	R NURSING FACILITY,	AND ICF/IID	ONLY	、 、	1	
0.00 Skilled nursing facility/other nursing fa 1.00 Adjusted general inpatient routine servio	3)		70.
2.00 Program routine service cost (line 9 x li	ne 71)		ŗ			72.
3.00 Medically necessary private room cost app 4.00 Total Program general inpatient routine s	Ū	•				73.
5.00 Capital -related cost allocated to inpatie	•			Part II, column		75.
26, line 45) 6.00 Per diem capital-related costs (line 75 ·	÷line 2)					76.
7.00 Program capital-related costs (line 9 x l	ine 76)					77.
3.00 Inpatient routine service cost (line 74 m 9.00 Aggregate charges to beneficiaries for ex		ovider record	ls)			78.
0.00 Total Program routine service costs for e			· · · · · · · · · · · · · · · · · · ·	nus line 79)		80.
1.00 Inpatient routine service cost per diem I 2.00 Inpatient routine service cost limitation						81. 82.
2.00 Inpatient routine service cost limitation 3.00 Reasonable inpatient routine service cos)				82.
4.00 Program inpatient ancillary services (see	e instructions)					84.
5.00 Utilization review - physician compensati 6.00 Total Program inpatient operating costs						85. 86.
PART IV - COMPUTATION OF OBSERVATION BED	PASS THROUGH COST				1	
7.00 Total observation bed days (see instructi 8.00 Adjusted general inpatient routine cost p		line 2)) 87.) 88.
39.00 Observation bed cost (line 87 x line 88)						89.

Health Financial Systems	CENTRAL DUPA	GE HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 09/01/2021	Worksheet D-1	
		Component (To 08/31/2022	Date/Time Pre 1/28/2023 6:3	
		Ti tl	e XIX	Subprovider -	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	2, 876, 580	20, 063, 352	0. 14337	75 0	0	90.00
91.00 Nursing Program cost	0	20, 063, 352	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	20, 063, 352	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	20, 063, 352	0.00000	00 0	0	93.00

	Incial Systems CENTRAL DI VCILLARY SERVICE COST APPORTIONMENT	JPAGE HOSPITAL	CN: 14-0242	Peri od:	u of Form CMS-2 Worksheet D-3	
	VETELART SERVICE COST AFFORTIONWENT	FIOVICEI C		From 09/01/2021		
				To 08/31/2022		
		Ti +L c	e XVIII	Hospi tal	1/28/2023 6:3 PPS	su pm
	Cost Center Description	1116	Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
LUDAT			1.00	2.00	3.00	-
	I ENT ROUTI NE SERVI CE COST CENTERS		1	70 404 404		20.00
	ADULTS & PEDIATRICS INTENSIVE CARE UNIT			79, 426, 406 20, 026, 048		30.00
	CORONARY CARE UNIT			20, 020, 040		32.00
	NEONATAL INTENSIVE CARE UNIT			0		35.00
	SUBPROVIDER - IPF			0		40.00
43.00 04300	NURSERY					43.00
	LARY SERVICE COST CENTERS					
	OPERATING ROOM		0. 12296		6, 640, 259	
	RECOVERY ROOM		0. 14810		770, 644	
	DELI VERY ROOM & LABOR ROOM ANESTHESI OLOGY		0. 34205			
	RADI OLOGY-DI AGNOSTI C		0. 04290		609, 241 1, 583, 410	
	RADI OLOGY-THERAPEUTI C		0. 13255		1, 515, 580	
	RADI OI SOTOPE		0. 10208			
	CT SCAN		0. 02157		600, 847	
58.00 05800			0.06314		523, 410	
60.00 06000	LABORATORY		0. 11655		5, 716, 230	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0. 32563	7 4, 791, 068	1, 560, 149	62.00
	BLOOD CLOTTING FOR HEMOPHILIACS		0. 00000		0	
	INTRAVENOUS THERAPY		0. 02400		62, 469	
	RESPI RATORY THERAPY		0. 14029		2, 611, 268	
	PHYSI CAL THERAPY		0. 19156		735, 215	
	OCCUPATIONAL THERAPY SPEECH PATHOLOGY		0. 16631 0. 19405		446, 259	
	ELECTROCARDI OLOGY		0. 19405		501, 392 2, 559, 536	
	ELECTROENCEPHALOGRAPHY		0. 11118			
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 09314		7, 665, 841	
	IMPL. DEV. CHARGED TO PATIENTS		0. 16043		12, 893, 335	1
	DRUGS CHARGED TO PATIENTS		0. 12078			
74.00 07400	RENAL DI ALYSI S		0. 36342	7 4, 443, 367	1, 614, 840	74.00
	CARDI AC REHAB		0. 30402		1, 229	
	SLEEP LAB		0.00000		0	
	I NPATI ENT DI ALYSI S		0.00000		0	
	PAIN MANAGEMENT		0. 61458		8, 778	
	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY		0.00000		0	
	LI THOTRI PSY		0.00000		0	
	TIENT SERVICE COST CENTERS		0.00000	0 0	0	,0. //
			0. 27447	7 78, 128	21, 444	90.00
90.01 09001	PATIENT TREATMENT CENTER		0. 09474	4 3, 378, 832	320, 124	90.01
90.02 09002	REHAB SERVI CES-BLOOMI NGDALE		0.00000		0	90.02
	CANTERA		0.00000		0	
	MENTAL HEALTH O/P		0. 17026		41, 518	
	WOMENS CLINIC		0.00000		0	
	WOUND CARE		0. 11248		2, 205	
	EMERGENCY		0. 13771		3, 212, 596	
92.00 09200 200.00	OBSERVATION BEDS (NON-DISTINCT PART Total (sum of lines 50 through 94 and 96 through 9	8)	0. 43836	7 6, 020, 652 565, 433, 267	2, 639, 255 67, 746, 552	
	Less PBP Clinic Laboratory Services-Program only c			003, 433, 207	07,740,002	200.00
201.00						

Health Financial Systems	CENTRAL DUPAGE HOSPITAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 14-0242	Period:	Worksheet D-3	
	Component	CCN: 14-S242	From 09/01/2021 To 08/31/2022	Date/Time Pre 1/28/2023 6:3	
	Ti tl	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	- · · ·	Ratio of Cos		I npati ent	
· ·		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
32. 00 03200 CORONARY CARE UNIT					32.00
35. 00 02060 NEONATAL NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - PF			E 220 120		35.00 40.00
40. 00 04000 SUBPROVIDER - TPP 43. 00 04300 NURSERY			5, 329, 139		40.00
ANCI LLARY SERVICE COST CENTERS					10.00
50. 00 05000 OPERATI NG ROOM		0. 12290	58 12, 262	1, 508	50.00
51.00 05100 RECOVERY ROOM		0. 14810	02 158, 517	23, 477	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 34205			
53.00 05300 ANESTHESI OLOGY		0. 04290			
54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY-THERAPEUTI C		0. 1325			1
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI 0I SOTOPE		0. 12299			55.00 56.00
57. 00 05700 CT SCAN		0. 0215			
58. 00 05800 MRI		0. 06314			
60. 00 06000 LABORATORY		0. 1165			1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 32563		0	•
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		-	
64.00 06400 I NTRAVENOUS THERAPY		0. 02400			
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 14029			•
67. 00 06700 OCCUPATI ONAL THERAPY		0. 1915			•
68. 00 06800 SPEECH PATHOLOGY		0. 19405			
69.00 06900 ELECTROCARDI OLOGY		0.06414			
70.00 07000 ELECTROENCEPHALOGRAPHY		0. 11118	31 0	0	70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 09314			•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 16043		0	
73. 00 07300 DRUGS CHARGED TO PATI ENTS		0. 12078			•
74. 00 07400 RENAL DI ALYSI S 75. 01 07501 CARDI AC REHAB		0.36342			
75. 02 07502 SLEEP LAB		0. 00000			
75.03 07503 INPATIENT DIALYSIS		0. 00000			
75.04 07504 PAIN MANAGEMENT		0. 61458	38 0	0	75.04
76. 97 07697 CARDI AC REHABI LI TATI ON		0.0000			
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.0000			
76. 99 07699 LI THOTRI PSY		0.0000	00 0	0	76.99
0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLINI C		0. 2744	77 0	0	90.00
90. 01 09001 PATIENT TREATMENT CENTER		0. 09474	-		
90. 02 09002 REHAB SERVI CES-BLOOMI NGDALE		0.0000			1
90. 03 09003 CANTERA		0. 00000	00 0	0	•
90. 04 09004 MENTAL HEALTH 0/P		0. 17020			
90. 05 09005 WOMENS CLINIC		0.0000		0	•
90. 06 09006 WOUND CARE 91. 00 09100 EMERGENCY		0. 11248		0 51, 809	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 1377		51,809	
200.00 Total (sum of lines 50 through 94 and 9	96 through 98)	0. 43030	2, 302, 900		
201.00 Less PBP Clinic Laboratory Services-Pro	5 ,		,, ,, 0		201.00
202.00 Net charges (line 200 minus line 201)			2, 302, 900		202.00

CALCUL	Financial Systems CENTRAL DUPAGE ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0242	Period: From 09/01/2021	u of Form CMS-2 Worksheet E Part A			
			To 08/31/2022				
		Title XVIII	Hospi tal	PPS			
				1.00			
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS						
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurrinstructions)	ing prior to October 1	(see	0 5, 958, 413			
1. 02	,						
1. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	or di scharges occurri ng	prior to October	0	1.0		
1.04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	or discharges occurring	on or after	0	1.0		
2.00 2.01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.0		
2.01	Outlier payment for discharges for Model 4 BPCI (see instruct)	i ons)		0	2.0		
2. 03	Outlier payments for discharges occurring prior to October 1	-		523, 769	2.0		
2.04	Outlier payments for discharges occurring on or after October	1 (see instructions)		4,037,980			
3.00	Managed Care Simulated Payments			34, 213, 658			
4.00	Bed days available divided by number of days in the cost report Indirect Medical Education Adjustment	rting period (see instr	uctions)	301.04	4.0		
5. 00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5.0		
5. 00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)	he criteria for an add-	on to the cap for	0.00	6.0		
7.00 7.01	MMA Section 422 reduction amount to the LME cap as specified ACA \S 5503 reduction amount to the LME cap as specified under		0.00 0.00	7.0 7.0			
8.00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa	thic and osteonathic nr	ograms for	0.00	8.0		
5.00				0.00	0.0		
8. 01	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost						
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slo			0.00			
9.00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8, 8,01 and 8,02)	(see	0.00	9.0		
10.00	instructions) FTE count for allopathic and osteopathic programs in the curre	ent year from your reco	rds	0.00	10.0		
11.00	FTE count for residents in dental and podiatric programs.				11.0		
12.00	Current year allowable FTE (see instructions)			0.00			
13.00 14.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year	ar ended on or after Se	ptember 30 1997	0.00	13.0 14.0		
	otherwise enter zero.			0.00			
	Sum of lines 12 through 14 divided by 3.				15.0		
	Adjustment for residents in initial years of the program				16.0		
	Adjustment for residents displaced by program or hospital clos	sure		0.00			
	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4)	`		0.00	18.0		
	Prior year resident to bed ratio (see instructions)).		0.000000			
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000			
22.00	IME payment adjustment (see instructions)			0			
22.01	IME payment adjustment - Managed Care (see instructions)	0 - C + L - MUA		0	22.0		
23.00	Indirect Medical Education Adjustment for the Add-on for § 42 Number of additional allopathic and osteopathic IME FTE reside (F2(1)(i))(C)		CFR 412.105	0.00	23.0		
24.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00	24.0		
	If the amount on line 24 is greater than -0-, then enter the linstructions)	lower of line 23 or lin	e 24 (see		25.0		
	Resident to bed ratio (divide line 25 by line 4)			0. 000000	1		
	IME payments adjustment factor. (see instructions)			0. 000000	1		
	IME add-on adjustment amount (see instructions)	\		0			
28.01 29.00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28))		0			
	Total IME payment (sum of Tines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0)	1)		0			
	Disproportionate Share Adjustment						
	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instru	ctions)	1.31			
31.00	Percentage of Medicaid patient days (see instructions)			16.93			
	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions))		18.24	32.0 33.0		
33.00		,					

ALCULATION C	F REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0242	Period: From 09/01/2021	Worksheet E Part A	
			To 08/31/2022		pare
		Title XVIII	Hospi tal	PPS	<u>o piii</u>
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	ensated Care Adjustment				
	uncompensated care amount (see instructions) 3 (see instructions)		0. 00000000		
	al uncompensated care payment (If line 34 is zero, e	enter zero on this line) (se			
	ctions)				
	ta share of the hospital uncompensated care payment uncompensated care (sum of columns 1 and 2 on line 3		923, 539 11, 914, 283		35. 36.
	onal payment for high percentage of ESRD beneficiary				30.
0.00 Total	Medicare discharges (see instructions)		0		40.
			Before 1/1 1.00	0n/After 1/1 1.01	
1.00 Total	ESRD Medicare discharges (see instructions)		0		41.
	ESRD Medicare covered and paid discharges (see instr		0		
1	line 41 by line 40 (if less than 10%, you do not qu Medicare ESRD inpatient days (see instructions)	ualify for adjustment)	0.00		42
	of average length of stay to one week (line 43 divid	led by line 41 divided by 7	0. 000000		43
days)					
	e weekly cost for dialysis treatments (see instructi additional payment (line 45 times line 44 times line		0.00	0.00	45 46
	al (see instructions)		92, 572, 814		40
	al specific payments (to be completed by SCH and MDH	l, small rural hospitals	0		48
only. (see instructions)			Amount	
				1.00	
	payment for inpatient operating costs (see instructi	-		92, 572, 814	
	t for inpatient program capital (from Wkst. L, Pt. I ion payment for inpatient program capital (Wkst. L,)	6, 624, 367 0	50 51
	graduate medical education payment (from Wkst. E-4,			0	
	g and Allied Health Managed Care payment			0	53
	l add-on payments for new technologies isolation add-on payment			988, 424	
	gan acquisition cost (Wkst. D-4 Pt. III, col. 1, lin	ne 69)		0	
.00 Cost o	f physicians' services in a teaching hospital (see i	ntructions)		0	
	e service other pass through costs (from Wkst. D, Pt		through 35).	0	57 58
	ary service other pass through costs from Wkst. D, P (sum of amounts on lines 49 through 58)	rt. TV, cor. TI TTHE 200)		100, 185, 605	
	y payer payments			33, 361	
	amount payable for program beneficiaries (line 59 mi	nus line 60)		100, 152, 244	
	ibles billed to program beneficiaries rance billed to program beneficiaries			6, 503, 748 297, 644	
	ble bad debts (see instructions)			1, 048, 393	
-	ed reimbursable bad debts (see instructions)			681, 455	
	ble bad debts for dual eligible beneficiaries (see i al (line 61 plus line 65 minus lines 62 and 63)	nstructions)		637, 782 94, 032, 307	66 67
	s received from manufacturers for replaced devices f	or applicable to MS-DRGs (s	see instructions)		
	r payments reconciliation (sum of lines 93, 95 and 9	96) (For SCH see instruction	ns)	0	
	ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) ADJUSTMENT PER PS&R			0	
	TRATION ADJUSTMENT			0	
. 50 Rural	Community Hospital Demonstration Project (§410A Demo	, ,	instructions)	0	70
1	tration payment adjustment amount before sequestrati			0	
	MDH volume decrease adjustment (contractor use only r ACO demonstration payment adjustment amount (see i			0	70 70
	nus payment HVBP adjustment amount (see instructions			0	
	nus payment HRR adjustment amount (see instructions)			0	
	d Model 1 discount amount (see instructions) ayment adjustment amount (see instructions)			-4, 536	
	justment amount (see instructions)			-4, 536	
	ry of accelerated depreciation				70

alth Financial Systems CENTRAL DUPAGE H LCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	N· 14-0242	Peri od:	u of Form CMS-2 Worksheet E	
			From 09/01/2021 To 08/31/2022	Part A Date/Time Prej 1/28/2023 6:30	
	Title	XVIII	Hospi tal	PPS	
			(уууу)	Amount	
			0	1.00	
.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n column O		0	0	70
.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or after the period ending on or			0	0	70
.98 Low Volume Payment-3				0	70
.99 HAC adjustment amount (see instructions)				0	70
.00 Amount due provider (line 67 minus lines 68 plus/minus lines 6	69 & 70)			94, 021, 754	71
.01 Sequestration adjustment (see instructions)				554, 728	71
.02 Demonstration payment adjustment amount after sequestration				0	71
.03 Sequestration adjustment-PARHM pass-throughs					71
.00 Interim payments				93, 232, 082	72
.01 Interim payments-PARHM					72
.00 Tentative settlement (for contractor use only)				0	73
.01 Tentative settlement-PARHM (for contractor use only)					73
.00 Balance due provider/program (line 71 minus lines 71.01, 71.02 73)	2, 72, and			234, 944	74
.01 Balance due provider/program-PARHM (see instructions)					74
.00 Protested amounts (nonallowable cost report items) in accordar	nce with			2, 192, 478	
CMS Pub. 15-2, chapter 1, §115.2				2, 172, 170	,,,
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum o	of 2.03			4, 028, 618	90
plus 2.04 (see instructions) .00 Capital outlier from Wkst. L, Pt. I, line 2				762, 245	91
.00 Operating outlier reconciliation adjustment amount (see instru	(ctions)			/02, 245	92
.00 Capital outlier reconciliation adjustment amount (see instruct				0	93
.00 The rate used to calculate the time value of money (see instruct				0.00	
.00 Time value of money for operating expenses (see instructions)				0.00	95
.00 Time value of money for capital related expenses (see instructions)	tions)			0	
			Prior to 10/1		
HSP Bonus Payment Amount			1.00	2.00	
0.00 HSP bonus amount (see instructions)			0	0	100
HVBP Adjustment for HSP Bonus Payment					100
1.00 HVBP adjustment factor (see instructions)			0.000000000	0. 000000000	101
			0		102
2.00HVBP adjustment amount for HSP bonus payment (see instructions	5)				
	5)				
HRR Adjustment for HSP Bonus Payment	5)		0.0000	0.0000	103
HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions)					
HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions))	Istment	0. 0000		
HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 0. 00 Is this the first year of the current 5-year demonstration per) ration) Adju		0. 0000	0	104
HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 0.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.) ration) Adju		0. 0000	0	104
 HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 0. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement) ration) Adju riod under 1		0. 0000	0	104 200
HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 0. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line) ration) Adju riod under 1		0. 0000	0	104 200 201
HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 0. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2. 00 Medicare discharges (see instructions)) ration) Adju riod under 1		0. 0000	0	104 200 201 202
HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Cost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2. 00 Case-mix adjustment factor (see instructions)) ration) Adju riod under 1 e 49)	he 21st	0.0000	0	104 200 201 202
 HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 0. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2. 00 Medicare discharges (see instructions) 3. 00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)) ration) Adju riod under 1 e 49)	he 21st	0.0000	0	104 200 201 202
HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 0. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2. 00 Medicare discharges (see instructions) 3. 00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 4. 00 Medicare target amount) ration) Adju riod under 1 e 49)	he 21st	0.0000	0 trati on	104 200 201 202 203
HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 1. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 0. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement) ration) Adju riod under 1 e 49)	he 21st	0.0000	0 trati on	104 200 201 202 203 204
HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 0. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement) ration) Adju riod under 1 e 49)	he 21st	0.0000	0 trati on	104 200 201 202 203 204 204
HRR Adj ustment for HSP Bonus Payment 3. 00 HRR adj ustment factor (see instructions) 4. 00 HRR adj ustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 0. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2. 00 Medicare discharges (see instructions) 3. 00 Case-mix adj ustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 4. 00 Medicare target amount 5. 00 Case-mix adj usted target amount (line 203 times line 204) 6. 00 Medicare inpatient routine cost cap (line 202 times line 205) Adj ustment to Medicare Part A Inpatient Reimbursement) ration) Adju riod under 1 e 49) first year	he 21st	0.0000	0 trati on	104 200 201 202 203 204 205 206
HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 0. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 00 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2. 00 Medicare discharges (see instructions) 3. 00 Case-mix adjustment factor (see instructions) 3. 00 Case-mix adjustment factor (see instructions) 4. 00 Medicare target amount 5. 00 Case-mix adjusted target amount (line 203 times line 204) 5. 00 Medicare to Medicare Part A Inpatient Reimbursement 7. 00 Program reimbursement under the §410A Demonstration (see instruction)) ration) Adju riod under 1 e 49) first year	he 21st	0.0000	0 trati on	104 200 201 202 203 204 205 206 207
 HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 0. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2. 00 Medicare discharges (see instructions) 3. 00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 4. 00 Medicare target amount 5. 00 Case-mix adjusted target amount (line 203 times line 204) 6. 00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7. 00 Program reimbursement under the §410A Demonstration (see instruction See instruction See instructions)) ration) Adju riod under 1 e 49) first year	he 21st	0.0000	0 trati on	104 200 201 202 203 204 205 206 207 208
 HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2. 00 Medicare discharges (see instructions) 3. 00 Case-mix adjustment factor (see instructions) 4. 00 Medicare target amount 5. 00 Case-mix adjusted target amount (line 203 times line 204) 6. 00 Medicare inpatient service costs cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7. 00 Program reimbursement under the §410A Demonstration (see instructions) 8. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 9. 00 Adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under 1 e 49) first year	he 21st	0.0000	0 trati on	104 200 201 202 203 204 205 206 207 208 207
 HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 0. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2. 00 Medicare discharges (see instructions) 3. 00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 4. 00 Medicare target amount 5. 00 Case-mix adjusted target amount (line 203 times line 204) 6. 00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7. 00 Program reimbursement under the §410A Demonstration (see instructions) 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 9. 00 Adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under 1 e 49) first year	he 21st	0.0000	0 tration	104 200 201 202 203 204 205 206 207 208 209 210
 HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2. 00 Medicare discharges (see instructions) 3. 00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 4. 00 Medicare inpatient routine cost cap (line 202 times line 204) 6. 00 Medicare inpatient number of the service costs (from Wkst. E, Pt. A, 9, 00 Adjustment to Medicare IPPS payments (see instructions) 0. 00 Reserved for future use 1. 00 Program reimbursement to Medicare IPPS payments (see instructions)) ration) Adju riod under 1 e 49) first year	he 21st	0.0000	0 tration	104 200 201 202 203 204 205 206 207 208
HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 0. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 0 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2. 00 Medicare discharges (see instructions) 3. 00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 4. 00 Medicare target amount 5. 00 Case-mix adjusted target amount (line 203 times line 204) 6. 00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7. 00 Program reimbursement under the §410A Demonstration (see instructions) 0. 00 Reserved for future use 1. 00 Total adjustment to Medicare IPPS payments (see instructions) 0. 00 Total adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under 1 e 49) first year ructions) line 59)	he 21st	0.0000	0 trati on	104 200 201 202 203 204 205 206 207 208 209 210 211
 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 0.00 Reserved for future use 0.01 Otal adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 2.00 Total adjustment to Medicare Part A IPPS payments (from line 2) ration) Adju riod under 1 e 49) first year ructions) line 59)	he 21st	0.0000	0 trati on	104 200 201 202 203 204 205 206 207 208 209 210 211 212
HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 0. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 0 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2. 00 Medicare discharges (see instructions) 3. 00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 4. 00 Medicare target amount 5. 00 Case-mix adjusted target amount (line 203 times line 204) 6. 00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7. 00 Program reimbursement under the §410A Demonstration (see instructions) 0. 00 Reserved for future use 1. 00 Total adjustment to Medicare IPPS payments (see instructions) 0. 00 Total adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under 1 e 49) first year ructions) line 59)	of the currer	0.0000	0 trati on	104 200 201 202 203 204 205 206 207 208 209 210 211

-	Financial Systems CENTRAL DUPAGE ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 14-0242	In Lie Period: From 09/01/2021 To 08/31/2022		pared:
		Title XVIII	Hospi tal	1/28/2023 6: 3 PPS	0 pm
			nooprea		
				1.00	
1.00 2.00 3.00 4.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct OPPS payments Outlier payment (see instructions)	ctions)		32, 091 86, 556, 321 75, 629, 026 426, 427	1.00 2.00 3.00 4.00
4.01 5.00 6.00 7.00 8.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6	uctions)		0 0.000 0 0.00 0	5.00 6.00 7.00
9.00 10.00 11.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES	IV, col. 13, line 200		0 0 32, 091	9.00 10.00
	Reasonable charges				
12.00 13.00 14.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I Total reasonable charges (sum of lines 12 and 13) Customary charges	ine 69)		228, 778 0 228, 778	13.00
15. 00 16. 00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(or payment for services o	0	0 0	
17. 00 18. 00 19. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on		ne 11) (see	0. 000000 228, 778 196, 687	18.00
20.00	instructions) Excess of reasonable cost over customary charges (complete on instructions)	-		0	20.00
21.00 22.00 23.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	tructions)		32, 091 0	1
24.00	Total prospective payment (sum of lines 3, 4, 4,01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			76, 055, 453	24.00
25.00 26.00 27.00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lin Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	ne 24 (for CAH, see instr		0 12, 107, 289 63, 980, 255	26.00
28.00 29.00 30.00 31.00	Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments			0 0 63, 980, 255 1, 374	29.00 30.00
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. 1-5, line 11)	CES)		63, 978, 881	32.00
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			968, 129 629, 284	34.00 35.00
	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			503, 559 64, 608, 165 0 0	37.00 38.00 39.00
39.50 39.97 39.98 39.99	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION		ctions)	0 0 0	
40.00 40.01 40.02 40.03	Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			64, 608, 165 381, 188 0	40. 01
	Interim payments Interim payments-PARHM Tentative settlement (for contractors use only)			64, 156, 524 0	41.00 41.01
42.01 43.00 43.01	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			70, 453	43.01
44.00	Protested amounts (nonallowable cost report items) in accorda §115.2 TO BE COMPLETED BY CONTRACTOR	ance with CMS Pub. 15-2,	chapter 1,	0	44.00
91.00 92.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			871, 221 0 0. 00	91.00 92.00
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0 0	1

Health Financial Systems	CENTRAL DUPAGE	HOSPI TAL	In Lieu	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0242	Period: From 09/01/2021	Worksheet E	
				Date/Time Pre	
				1/28/2023 6:3	0 pm
		Title XVIII	Hospi tal	PPS	
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200.00
				0	200. 00

-	Financial Systems CENTRAL DUPAGE ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0242	Period:	u of Form CMS-2 Worksheet E	2552-10
		Component CCN: 14-S242	From 09/01/2021 To 08/31/2022		
		Title XVIII	Subprovider -	1/28/2023 6: 3 PPS	U pm
			IPF	1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instru	uctions)		0 1, 956	
3.00	OPPS payments	,		2, 435	3.00
4.00 4.01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	
5.00 6.00	Enter the hospital specific payment to cost ratio (see instr Line 2 times line 5	ructions)		0. 000 0	•
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		0	
10.00	Organ acqui si ti ons	10, 0011 10, 1110 200		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			0	11.00
12.00	Reasonable charges Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.00
15.00	Aggregate amount actually collected from patients liable for			0	
16.00	Amounts that would have been realized from patients liable f had such payment been made in accordance with 42 CFR §413.13	1 3	on a chargebasis	0	16.00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000	
19.00	Excess of customary charges over reasonable cost (complete o	nly if line 18 exceeds l	ine 11) (see	0	
20.00	instructions) Excess of reasonable cost over customary charges (complete o	nlyifline 11 exceeds l	ine 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			0	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00 24.00	Cost of physicians' services in a teaching hospital (see ins Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 2, 435	20.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on li		ructions)	12	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 2	2 and 23] (see	2, 423	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4,			0	
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36 Subtotal (sum of lines 27 through 29)))		0 2, 423	
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			0 2, 423	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV	I CES)			
33.00 34.00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	
35.00	Adjusted reimbursable bad debts (see instructions)			0	35.00
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (see instructions)	structions)		0 2, 423	
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39.00 39.50	Pioneer ACO demonstration payment adjustment (see instructio	ins)		0	39.50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repl		ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			2, 423 14	
	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			2, 400	40.03 41.00
41.01 42.00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01 42.00
42.01	Tentative settlement-PARHM (for contractor use only)				42.01
43.00 43.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			9	43.00 43.01
44.00	Protested amounts (nonallowable cost report items) in accord §115.2	ance with CMS Pub. 15-2,	chapter 1,	0	
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90.00 91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00

Health Financial Systems	CENTRAL DUPAGE HO	OSPI TAL	In Lieu	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Ę	Provider CCN: 14-0242	Period: From 09/01/2021	Worksheet E Part B	
	(Component CCN: 14-S242	To 08/31/2022		
		Title XVIII	Subprovider -	PPS	
			I PF		
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200.00

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C		To ()9/01/2021)8/31/2022	Worksheet E-1 Part I Date/Time Prep 1/28/2023 6:30	
			XVIII	Но	spi tal	PPS	
		Inpatien	t Part A		Par	t B	
		mm/dd/yyyy	Amount	mm	/dd/yyyy	Amount	
		1.00	2.00		3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		93, 242, 2	243 0		64, 213, 284 0	1. (2. (
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider						3.0
01	ADJUSTMENTS TO PROVIDER			0		0	3. (
02				0		0	3.0
03				0		0	3.0
04 05				0		0	3. (3. (
	Provider to Program	I	I	-		-	
50	ADJUSTMENTS TO PROGRAM	05/11/2022	10, 1		/11/2022	56, 760	3.
51 52				0		0	3. 3.
53				0		0	3.
54				0		0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-10, 1	61		-56, 760	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		93, 232, C	082		64, 156, 524	4.
	TO BE COMPLETED BY CONTRACTOR	1					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.
01	Program to Provi der TENTATI VE TO PROVI DER			0		0	5.
01				0		0	э. 5.
03				0		0	5.
EO	Provider to Program TENTATIVE TO PROGRAM			0		0	5.
50 51				0		0	5. 5.
52				0		0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0		0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)						6.
01	SETTLEMENT TO PROVIDER		234, 9			70, 453	6.
02 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		93, 467, 0	0		0 64, 226, 977	6. 7.
00	Trotal medicale program frability (see fistructions)		73,407,0		ntractor	NPR Date	7.
					lumber	(Mo/Day/Yr)	
0.0				150	1.00	2.00	-
00	Name of Contractor	NATIONAL GOVER	NWENT SERVIC	E2	06101		8

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Concernent (CN: 14-0242 CCN: 14-S242	Period: From 09/01/202 To 08/31/202		pare
		Title	e XVIII	Subprovider -		<u>o pin</u>
		I npati en	it Part A		art B	
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	1.00	1, 097, 6		2,400	1. 2. 3.
	Program to Provider					
D1 D2 D3 D4 D5	ADJUSTMENTS TO PROVIDER			0 0 0 0		3 3 3 3
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3
50 51 52 53 54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0 0 0 0		3333
0	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 097, 6	86	2, 400	4
0	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
)1)2)3	Program to Provi der TENTATI VE TO PROVI DER			0 0 0	000000000000000000000000000000000000000	5 5 5
0	Provider to Program TENTATIVE TO PROGRAM		1	0	0	5
50 51 52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0 0 0	0	
)0)1	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER		57, 7	74	9	6
)2)0	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		1, 155, 4	0	0 2, 409	6
,0)	Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	
00		NATIONAL GOVER	-		2.00	8

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0242	Period:	Worksheet E-3	
		Component CCN: 14-S242	From 09/01/2021 To 08/31/2022	Part II Date/Time Pre 1/28/2023 6:30	
		Title XVIII	Subprovider -	PPS	o piii
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS				
. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, ar	nd medical education payments))	1, 164, 192	1.
. 00 . 00	Net IPF PPS Outlier Payments Net IPF PPS ECT Payments			72, 302 20, 658	2. 3.
. 00	Unweighted intern and resident FTE count in the most rec	cent cost report filed on or b	pefore November	0.00	4.
	15, 2004. (see instructions)			01 00	
. 01	Cap increases for the unweighted intern and resident FTE	E count for residents that we	re displaced by	0.00	4.
	program or hospital closure, that would not be counted w		tment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions))			_
. 00	New Teaching program adjustment. (see instructions)			0.00	5.
. 00	Current year's unweighted FTE count of I&R excluding FTE teaching program" (see instuctions)	s in the new program growth p	period of a "new	0.00	6.
. 00	Current year's unweighted I&R FTE count for residents wi	thin the new program growth a	period of a "new	0.00	7.
. 00	teaching program" (see instuctions)			0.00	
. 00	Intern and resident count for IPF PPS medical education	adjustment (see instructions))	0.00	8.
. 00	Average Daily Census (see instructions)			22.805479	9.
0.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raise	ed to the power of .5150 -1}.		0.000000	
1.00	Teaching Adjustment (line 1 multiplied by line 10).			0	11
2.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and			1, 257, 152	
3.00 4.00	Nursing and Allied Health Managed Care payment (see inst Organ acquisition (DO NOT USE THIS LINE)	(ruction)		0	13 14
	Cost of physicians' services in a teaching hospital (see	instructions)		0	
5.00	Subtotal (see instructions)			1, 257, 152	
7.00	Primary payer payments			0	17
3.00	Subtotal (line 16 less line 17).			1, 257, 152	18
9.00	Deducti bl es			131, 512	19
D. 00	Subtotal (line 18 minus line 19)			1, 125, 640	
1.00	Coi nsurance			22, 472	
	Subtotal (line 20 minus line 21)	convisor) (coo instructions)		1, 103, 168	
3.00	Allowable bad debts (exclude bad debts for professional Adjusted reimbursable bad debts (see instructions)	services) (see instructions)		91, 000 59, 150	
5.00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		49, 288	
	Subtotal (sum of lines 22 and 24)			1, 162, 318	
7.00	Direct graduate medical education payments (see instruct	tions)		0	27
3.00	Other pass through costs (see instructions)	-		0	28
9.00	Outlier payments reconciliation			0	29
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30
D. 50	Pioneer ACO demonstration payment adjustment (see instru	uctions)		0	30
). 98). 99	Recovery of accelerated depreciation. Demonstration payment adjustment amount before sequestra	ation		0	30 30
1.00	Total amount payable to the provider (see instructions)			1, 162, 318	
1.01	Sequestration adjustment (see instructions)			6, 858	
	Demonstration payment adjustment amount after sequestrat	tion		0	
2.00	Interim payments			1, 097, 686	
3.00	Tentative settlement (for contractor use only)			0	33
1.00	Balance due provider/program (line 31 minus lines 31.01,			57, 774	
5.00	Protested amounts (nonallowable cost report items) in ac §115.2	ccordance with CMS Pub. 15-2,	chapter 1,	0	35.
	TO BE COMPLETED BY CONTRACTOR				
0.00	Original outlier amount from Worksheet E-3, Part II, lir			72, 302	
1.00	Outlier reconciliation adjustment amount (see instruction	ons)		0	51
2.00	The rate used to calculate the Time Value of Money			0.00	
3.00	Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 202			0 0 DHF	53

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0242	Period:	Worksheet E-3	3
			From 09/01/2021 To 08/31/2022	Part VII Date/Time Pre 1/28/2023 6:3	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	ERVICES FOR TITLES V OR 2	(IX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
. 00	Inpatient hospital/SNF/NF services		8, 081, 917		1.00
. 00	Medical and other services			0	
. 00	Organ acquisition (certified transplant centers only)		0		3.00
. 00	Subtotal (sum of lines 1, 2 and 3)		8, 081, 917	0	
. 00	Inpatient primary payer payments		0	_	5.00
. 00	Outpatient primary payer payments			0	
. 00	Subtotal (line 4 less sum of lines 5 and 6)		8, 081, 917	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
	Reasonable Charges				0.00
. 00	Routine service charges		0	0	8.00
00	Ancillary service charges		0	0	
0.00	Organ acquisition charges, net of revenue		-		10.00
1.00	Incentive from target amount computation		0	0	11.00
2.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
3.00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for	or sorvices on a charge	0	0	13.00
3.00	basis	or services on a charge	0	0	13.00
4.00	Amounts that would have been realized from patients liable for		on 0	0	14.00
E 00	a charge basis had such payment been made in accordance with Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CFR 9413.13(e)	0. 000000	0. 000000	15 00
5.00 6.00	Total customary charges (see instructions)		0.000000	0.000000	
7.00	Excess of customary charges over reasonable cost (complete or	nly if line 16 exceeds	0	0	
7.00	line 4) (see instructions)	III y II IIIle 16 exceeds	0	0	17.00
8.00	Excess of reasonable cost over customary charges (complete or	nlvifline 4 exceeds li	ne 8, 081, 917	0	18.00
0.00	16) (see instructions)		0,001,717	0	10.00
9.00	Interns and Residents (see instructions)		0	0	19.00
0.00	Cost of physicians' services in a teaching hospital (see inst	tructions)	0	0	
1.00	Cost of covered services (enter the lesser of line 4 or line		0	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		ders.		
2.00	Other than outlier payments		0	0	22.00
3.00	Outlier payments		0	0	23.00
4.00	Program capital payments		0		24.00
5.00	Capital exception payments (see instructions)		0		25.00
6.00	Routine and Ancillary service other pass through costs		0	0	26.00
7.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
8.00	Customary charges (title V or XIX PPS covered services only)		0	0	
9.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
0.00	Excess of reasonable cost (from line 18)		8, 081, 917	0	
1.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	6)	0	0	
2.00	Deductibles		0	0	
3.00	Coinsurance		0	0	
4.00	Allowable bad debts (see instructions)		0	0	34.00
5.00	Utilization review		0	_	35.00
6.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 minus sum of line	na 33)	0	0	
7.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
8.00	Subtotal (line 36 ± line 37)		0	0	
9.00	Direct graduate medical education payments (from Wkst. E-4)	、 、	0	-	39.00
0.00	Total amount payable to the provider (sum of lines 38 and 39))	0	0	
1.00	Interim payments		0	0	
2 00			()	()	1 47 00
2.00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accorda	anco with CMS Dub 15 0	0	0	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0242 Component CCN: 14-S242	Period: From 09/01/2021 To 08/31/2022	Worksheet E-3 Part VII Date/Time Pre	
				1/28/2023 6:3	раг 10 р
		Title XIX	Subprovider - IPF	Cost	
			Inpatient	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR >	1.00	2.00	-
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		1, 325, 665		1 -
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		1, 325, 665	0	
00	Inpatient primary payer payments		0	0	
00 00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		1, 325, 665	0	
00	COMPUTATION OF LESSER OF COST OR CHARGES		1, 325, 005	0	1
	Reasonable Charges				1
00	Routine service charges		0		18
00	Ancillary service charges		0	0	0
. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		0	0	12
00	CUSTOMARY CHARGES				1.
. 00	Amount actually collected from patients liable for payment for basis	or services on a charge	0	0	1:
. 00	Amounts that would have been realized from patients liable fo	n navment for services (on O	0	14
. 00	a charge basis had such payment been made in accordance with			0	'
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	1
. 00	Total customary charges (see instructions)		0	0	
. 00	Excess of customary charges over reasonable cost (complete or	ly if line 16 exceeds	0	0	1
	line 4) (see instructions)				
. 00	Excess of reasonable cost over customary charges (complete or	nly if line 4 exceeds lir	ne 1, 325, 665	0	18
. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	10
. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		0	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				1
. 00	Other than outlier payments		0	0	22
. 00	Outlier payments		0	0	23
. 00	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		2
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00 . 00	Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		0	0	
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		V	0	2
. 00	Excess of reasonable cost (from line 18)		1, 325, 665	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	
. 00	Deducti bl es		0	0	32
. 00	Coinsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	-
. 00	Utilization review		0	-	3
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 ar	ia 33)	0	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
. 00 . 00	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4)		0	0	30
. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
. 00	Interim payments		0	0	
. 00	Balance due provider/program (line 40 minus line 41)		0	0	
. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2,	0	0	
	chapter 1, §115.2		0	0	1

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	_	F	Period: From 09/01/2021 Fo 08/31/2022	Worksheet G Date/Time Pre 1/28/2023 6:3	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	1, 506, 776, 890	C	0	0	1.0
00	Temporary investments	0	C		0	1
00	Notes receivable	0	0	-	0	
00 00	Accounts receivable Other receivable	92, 412, 910 3, 957, 610		-	0	
00	Allowances for uncollectible notes and accounts receivable			, i	0	6.0
00	Inventory	12, 551, 580	C	0	0	7.
00	Prepaid expenses	0	C	, v	0	
00	Other current assets	31, 884, 930	0		0	
	Due from other funds	43, 580, 350		-	0	10. 11.
. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	1, 691, 164, 270	(<u> </u>	0	'''
2. 00	Land	35, 273, 260	C	0 0	0	12.0
8.00	Land improvements	0	C	0 0	0	13. (
	Accumulated depreciation	0	C	-	0	14.
	Buildings	655, 200, 710		-	0	
	Accumulated depreciation Leasehold improvements	-197, 278, 048 16, 124, 340		-	0	
	Accumulated depreciation	0		-	0	18.
	Fixed equipment	173, 193, 710	C	0 0	0	19.
	Accumulated depreciation	-116, 080, 612	C	, v	0	20.
	Automobiles and trucks	0	C	, i	0	21.
	Accumulated depreciation	0	0	, i	0	22.
	Major movable equipment Accumulated depreciation			-	0	23.
	Minor equipment depreciable	0		-	0	
	Accumulated depreciation	0	C	0 0	0	26.
	HIT designated Assets	0	C	-	0	27.
	Accumulated depreciation	0	C	-	0	28.
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	0 566, 433, 360		-	0	29.
. 00	OTHER ASSETS	500, 433, 300		<u> </u>	0	30.
. 00	Investments	300, 600, 190	C	0 0	0	31.
2.00	Deposits on Leases	0	C	0 0	0	32.
	Due from owners/officers	0	C	-	0	33.
	Other assets Total other assets (sum of lines 31-34)	82, 539, 830 383, 140, 020			0	34. 35.
	Total assets (sum of lines 11, 30, and 35)	2, 640, 737, 650		-	0	
	CURRENT LIABILITIES	2,010,101,000		<u> </u>		
	Accounts payable	10, 618, 190	C	0 0	0	37.
3.00	Salaries, wages, and fees payable	29, 081, 550	C		0	
	Payroll taxes payable Notes and Loans payable (short term)	0	0	0	0	1
	Deferred income				0	
	Accel erated payments	0			0	42.
8.00	Due to other funds	746, 970	C	0 0	0	
	Other current liabilities	248, 035, 290	C	-	0	
5.00	Total current liabilities (sum of lines 37 thru 44)	288, 482, 000		0 0	0	45.
. 00	LONG TERM LIABILITIES Mortgage payable	0	C	0 0	0	46.
	Notes payable	0			0	
8.00	Unsecured Loans	0	C	0 0	0	48.
	Other long term liabilities	164, 911, 650	C	-	0	
	Total long term liabilities (sum of lines 46 thru 49)	164, 911, 650	0		0	50.
. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	453, 393, 650		0 0	0	51.
2.00	General fund balance	2, 187, 344, 000				52.
8.00	Specific purpose fund	, . , ,	C	b		53.
. 00	Donor created - endowment fund balance - restricted			0		54.
	Donor created - endowment fund balance - unrestricted			0		55.
. 00	Governing body created - endowment fund balance			0	0	56.
. 00 . 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
. 00	replacement, and expansion				0	30.
. 00	Total fund balances (sum of lines 52 thru 58)	2, 187, 344, 000	C	0 0	0	59.
. 00	Total liabilities and fund balances (sum of lines 51 and	2, 640, 737, 650	C	0 0	0	60.

Health Financial Systems	CENTRAL DUPAGE	HOSPITAL		In L	eu of Form CMS-	<u> 2552-10</u>
STATEMENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 14-0242	Period: From 09/01/202 To 08/31/202		epared:
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
<pre>1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify) 5.00 NET ASSETS RELEASED 6.00 7.00 8.00 9.00 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 NET EQUITY TRANSFERS 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)</pre>	0 0 0 0 0 0 17, 955, 251 0 0 0 0 0 0 0	2,00 1,981,705,690 223,593,561 2,205,299,251 0 2,205,299,251 17,955,251 17,955,251 2,187,344,000	3.00	4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
	Endowment Fund	PI ant	Fund	_	1	
	6.00	7.00	8.00			
 Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) O Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) NET ASSETS RELEASED NO NO O0 O0 O0 O0 	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 NET EQUITY TRANSFERS 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance 	000	0 0 0 0 0 0		0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

Cost Center DescriptionInpatientOutpatientPART 1 - PATIENT REVENUES General Inpatient Routine Services1.00Hospital283,143,1552.00SUBPROVIDER - IPF45,022,4173.00SUBPROVIDER - IRF45,022,4174.00SUBPROVIDER05.00Swing bed - SNF06.00Swing bed - NF07.00SKILLED NURSING FACILITY08.00NURSING FACILITY09.00OTHER LONG TERM CARE010.00Total general inpatient care services (sum of lines 1-9)328,165,57211.00INTENSIVE CARE UNIT65,603,97212.00CORONARY CARE UNIT21,870,62413.00BURN INTENSIVE CARE UNIT67,109,36614.00SURGICAL INTENSIVE CARE UNIT67,109,366	Total 3.00 283, 143, 155 45, 022, 417 0 0 328, 165, 572 65, 603, 972 21, 870, 624	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
PART I - PATIENT REVENUES General Inpatient Routine Services1.00Hospital283, 143, 1552.00SUBPROVIDER - IPF45, 022, 4173.00SUBPROVIDER - IRF04.00SUBPROVIDER05.00Swing bed - SNF06.00Swing bed - NF07.00SKILLED NURSING FACILITY08.00NURSING FACILITY09.00OTHER LONG TERM CARE010.00Total general inpatient care services (sum of lines 1-9)328, 165, 57211.00INTENSI VE CARE UNIT65, 603, 97212.00CORONARY CARE UNIT21, 870, 62413.00BURN INTENSI VE CARE UNIT67, 109, 366	283, 143, 155 45, 022, 417 0 0 328, 165, 572 65, 603, 972	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
General Inpatient Routine Services 1.00 Hospital 283, 143, 155 2.00 SUBPROVIDER - IPF 45, 022, 417 3.00 SUBPROVIDER - IRF 45, 022, 417 4.00 SUBPROVIDER 0 5.00 Swing bed - SNF 0 6.00 Swing bed - NF 0 7.00 SKILLED NURSING FACILITY 0 8.00 NURSING FACILITY 0 9.00 OTHER LONG TERM CARE 0 10.00 Total general inpatient care services (sum of lines 1-9) 328, 165, 572 11.00 INTENSI VE CARE UNI T 65, 603, 972 12.00 CORONARY CARE UNI T 21, 870, 624 13.00 BURN INTENSI VE CARE UNI T 21, 870, 624 14.00 SURGI CAL INTENSI VE CARE UNI T 67, 109, 366	45, 022, 417 0 0 328, 165, 572 65, 603, 972	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
1.00 Hospital 283, 143, 155 2.00 SUBPROVI DER - IPF 45, 022, 417 3.00 SUBPROVI DER - IRF 0 4.00 SUBPROVI DER 0 5.00 Swing bed - SNF 0 6.00 Swing bed - NF 0 7.00 SKI LLED NURSI NG FACI LI TY 0 8.00 NURSI NG FACI LI TY 0 9.00 OTHER LONG TERM CARE 0 10.00 Total general inpatient care services (sum of lines 1-9) 328, 165, 572 Intensi ve Care Type Inpatient Hospital Services 65, 603, 972 11.00 INTENSI VE CARE UNI T 21, 870, 624 13.00 BURN INTENSI VE CARE UNI T 67, 109, 366	45, 022, 417 0 0 328, 165, 572 65, 603, 972	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
2.00 SUBPROVIDER - IPF 45,022,417 3.00 SUBPROVIDER - IRF 45,022,417 4.00 SUBPROVIDER 0 5.00 Swing bed - SNF 0 6.00 Swing bed - NF 0 7.00 SKILLED NURSING FACILITY 0 8.00 NURSING FACILITY 0 9.00 OTHER LONG TERM CARE 0 10.00 Total general inpatient care services (sum of lines 1-9) 328, 165, 572 11.00 INTENSI VE CARE UNIT 65, 603, 972 12.00 CORONARY CARE UNIT 21, 870, 624 13.00 BURN INTENSI VE CARE UNIT 67, 109, 366	45, 022, 417 0 0 328, 165, 572 65, 603, 972	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
3.00SUBPROVIDER - IRF4.00SUBPROVIDER5.00Swing bed - SNF00Swing bed - NF00SKILLED NURSING FACILITY00SKILLED NURSING FACILITY00OTHER LONG TERM CARE10.00Total general inpatient care services (sum of lines 1-9)328, 165, 57211.00INTENSIVE CARE UNIT12.00CORONARY CARE UNIT13.00BURN INTENSIVE CARE UNIT14.00SURGICAL INTENSIVE CARE UNIT15.00NEONATAL INTENSIVE CARE UNIT15.00KONATAL INTENSIVE CARE UNIT15.00ACTION, 36	0 0 328, 165, 572 65, 603, 972	3.00 4.00 5.00 6.00 7.00 8.00 9.00
4.00SUBPROVIDER5.00Swing bed - SNF06.00Swing bed - NF07.00SKILLED NURSING FACILITY8.00NURSING FACILITY9.00OTHER LONG TERM CARE10.00Total general inpatient care services (sum of lines 1-9)328, 165, 57211.00INTENSI VE CARE UNIT12.00CORONARY CARE UNIT13.00BURN INTENSI VE CARE UNIT14.00SURGICAL INTENSI VE CARE UNIT15.00NEONATAL INTENSI VE CARE UNIT15.0067, 109, 366	0 328, 165, 572 65, 603, 972	4.00 5.00 6.00 7.00 8.00 9.00
5.00Swing bed - SNF06.00Swing bed - NF07.00SKI LLED NURSI NG FACI LI TY8.00NURSI NG FACI LI TY9.00OTHER LONG TERM CARE10.00Total general inpatient care services (sum of lines 1-9)328, 165, 57211.00Intensi ve Care Type Inpatient Hospital Services12.00CORONARY CARE UNIT65, 603, 97212.00SURGI CAL INTENSI VE CARE UNIT14.00SURGI CAL INTENSI VE CARE UNIT15.00NEONATAL INTENSI VE CARE UNIT67, 109, 366	0 328, 165, 572 65, 603, 972	5.00 6.00 7.00 8.00 9.00
6.00 Swing bed - NF 0 7.00 SKILLED NURSING FACILITY 0 8.00 NURSING FACILITY 0 9.00 OTHER LONG TERM CARE 1 10.00 Total general inpatient care services (sum of lines 1-9) 328, 165, 572 Intensive Care Type Inpatient Hospital Services 65, 603, 972 12.00 CORONARY CARE UNIT 21, 870, 624 13.00 BURN INTENSIVE CARE UNIT 21, 870, 624 14.00 SURGICAL INTENSIVE CARE UNIT 67, 109, 366	0 328, 165, 572 65, 603, 972	6.00 7.00 8.00 9.00
7.00 SKILLED NURSING FACILITY 8.00 NURSING FACILITY 9.00 OTHER LONG TERM CARE 10.00 Total general inpatient care services (sum of lines 1-9) 328, 165, 572 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 65, 603, 972 21, 870, 624 13.00 BURN INTENSIVE CARE UNIT 14.00 SURGICAL INTENSIVE CARE UNIT 15.00 NEONATAL INTENSIVE CARE UNIT 67, 109, 366	328, 165, 572 65, 603, 972	7.00 8.00 9.00
8.00 NURSI NG FACILITY 0THER LONG TERM CARE 9.00 OTHER LONG TERM CARE 328, 165, 572 10.00 Total general inpatient care services (sum of lines 1-9) 328, 165, 572 11.00 INTENSI VE CARE UNIT 65, 603, 972 12.00 CORONARY CARE UNIT 21, 870, 624 13.00 BURN INTENSI VE CARE UNIT 14.00 SURGI CAL INTENSI VE CARE UNIT 67, 109, 366	65, 603, 972	8.00 9.00
9.00 OTHER LONG TERM CARE 328, 165, 572 10.00 Total general inpatient care services (sum of lines 1-9) 328, 165, 572 Intensive Care Type Inpatient Hospital Services 56, 603, 972 11.00 INTENSI VE CARE UNIT 65, 603, 972 12.00 CORONARY CARE UNIT 21, 870, 624 13.00 BURN INTENSI VE CARE UNIT 14.00 SURGI CAL INTENSI VE CARE UNIT 67, 109, 366	65, 603, 972	9.00
10.00Total general inpatient care services (sum of lines 1-9)328, 165, 572Intensive Care Type Inpatient Hospital Services11.00INTENSI VE CARE UNIT65, 603, 97212.00CORONARY CARE UNIT13.00BURN INTENSI VE CARE UNIT14.00SURGI CAL INTENSI VE CARE UNIT15.00NEONATAL INTENSI VE CARE UNIT67, 109, 366	65, 603, 972	
Intensive Care Type Inpatient Hospital Services11.00INTENSI VE CARE UNI T12.00CORONARY CARE UNI T13.00BURN INTENSI VE CARE UNI T14.00SURGI CAL INTENSI VE CARE UNI T15.00NEONATAL INTENSI VE CARE UNI T67, 109, 366		1
12.00 CORONARY CARE UNIT 21,870,624 13.00 BURN I NTENSI VE CARE UNIT 14.00 SURGI CAL INTENSI VE CARE UNIT 67,109,366		1
13.00BURN I NTENSI VE CARE UNI T14.00SURGI CAL I NTENSI VE CARE UNI T15.00NEONATAL I NTENSI VE CARE UNI T67, 109, 366	21, 870, 624	11.00
14.00 SURGI CAL I NTENSI VE CARE UNI T 15.00 NEONATAL I NTENSI VE CARE UNI T 67, 109, 366	I	12.00
15. 00 NEONATAL INTENSIVE CARE UNIT 67, 109, 366		13.00
		14.00
	67, 109, 366	
16.00 Total intensive care type inpatient hospital services (sum of lines 154, 583, 962	154, 583, 962	16.00
	400 740 504	17.00
17.00 Total inpatient routine care services (sum of lines 10 and 16) 482, 749, 534 10.00 Assillant 111, 00, 007	482, 749, 534	17.00
18.00 Ancillary services 1,185,384,906 3,111,600,087 4 10.00 Output 200,001 100,001 100,000		
19.00 Outpatient services 396, 865, 394 1, 086, 269, 185 1 20.00 RURAL HEALTH CLINIC 0 0 0 0	1, 483, 134, 579 0	19.00 20.00
21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0	0	20.00
22.00 HOME HEALTH GENCY	U	21.00
23.00 AMBULANCE SERVICES		23.00
24. 00 CMHC		24.00
24.10 COFF 0 0	0	24.10
24. 20 OUTPATI ENT PHYSI CAL THERAPY 0 0	0	24.20
24.30 OUTPATIENT OCCUPATIONAL THERAPY 0 0	0	24.30
24.40 OUTPATIENT SPEECH PATHOLOGY 0 0	0	24.40
25.00 AMBULATORY SURGICAL CENTER (D.P.)		25.00
26.00 HOSPICE		26.00
27.00 OTHER (SPECIFY) 0 0	0	27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 2,064,999,834 4,197,869,272 6	5, 262, 869, 106	28.00
G-3, line 1)		
PART II - OPERATING EXPENSES		20.00
29.00 Operating expenses (per Wkst. A, column 3, line 200) 1,011,522,677 30.00 BAD DEBTS 0		29.00
30.00 BAD DEBTS 0 31.00 0		30.00 31.00
32.00		32.00
33.00		33.00
34.00		34.00
35.00		35.00
36.00 Total additions (sum of lines 30-35)		36.00
37.00 DEDUCT (SPECI FY) 0		37.00
38.00		38.00
39.00		39.00
40.00 0		40.00
41.00 0		41.00
42.00 Total deductions (sum of lines 37-41) 0		42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 1,011,522,677		43.00
to Wkst. G-3, line 4)		

		SE HOSPITAL		u of Form CMS-	
STATEN	IENT OF REVENUES AND EXPENSES	Provider CCN: 14-0242	Period: From 09/01/2021	Worksheet G-3	5
			To 08/31/2022	Date/Time Pre 1/28/2023 6:3	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, I			6, 262, 869, 106	
2.00	Less contractual allowances and discounts on patients' acco	ounts		5,079,132,260	
3.00 4.00	Net patient revenues (line 1 minus line 2) Less total operating expenses (from Wkst. G-2, Part II, lin	12)		1, 183, 736, 846 1, 011, 522, 677	
4.00 5.00	Net income from service to patients (line 3 minus line 4) OTHER INCOME			172, 214, 169	
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communicati	on services		0	
9.00 10.00	Revenue from television and radio service Purchase discounts			0	
11.00	Rebates and refunds of expenses			0	
12.00	Parking lot receipts			0	1
13.00	Revenue from Laundry and Linen service			0	1
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	
17.00	Revenue from sale of drugs to other than patients			0	
18.00 19.00	Revenue from sale of medical records and abstracts Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	
21.00	Rental of vending machines			0	
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	TRAINING PROGRAM			81, 864	
24.01	WORKSHOPS CONFERENCES ETC			0	
24.02 24.03	NON-GOVT GRANT REVENUE FEDERAL GRANT REVENUE			383, 844 14, 394	
24.03	STATE GRANT REVENUE			14, 374	
24.05	NET ASSETS REL FR RESTR - OP			1, 621, 694	
24.06	DI ETARY GUEST TRAYS			0	24.06
24.07	FEINBERG CAFETERIA REVENUE			0	
24.08	CDH CAFETERIA REVENUE			2, 401, 668	
24.09 24.10	BUILDING RENT NON NMFF/NU INTERCOMPANY RENT INCOME			3, 672, 199 16, 023, 450	
24.10	IC CORP REVENUE			6, 167, 890	
24.12	CORPORATE BILLING ADJUSTMENT			11, 455, 291	
24.13	SHARED SERVICES INCOME ELOO4			171, 675	
24.15	INSTYMEDS REVENUE			0	24.15
	OTHER SERVICE REVENUE			454, 543	
24.18	RECOVERY LIVING REVENUE			0	
24.19	NON-PATIENT MEDICAL SUPPLIES GIFT SHOP SALES - BED TOWER			23, 615 310, 178	
24.20	GIFT SHOP SALES - BED TOWER GIFT SHOP SALES - MOTHER/BABY			310, 178	
	AUXI LI ARY - BABY PHOTOS			0	
24.23	GIFT SHOP SALES			0	1
24.25	COST OF CONSIGNMENT SALE			0	
24.26	NEWSPAPER			0	
	OTHER OPERATING INCOME			3, 548, 626	
24.50	COVID-19 PHE Funding Total other income (sum of lines 6-24)			7, 538, 226 53, 869, 157	
	Total (line 5 plus line 25)			226, 083, 326	
27.00	NON OPERATING			2, 489, 765	
	Total other expenses (sum of line 27 and subscripts)			2, 489, 765	
29 00	Net income (or loss) for the period (line 26 minus line 28)	1		223, 593, 561	29.00

ealth Financial Systems ALCULATION OF CAPITAL PAYMENT	Provi der CCN: 14-0242 Peri od:	eu of Form CMS-2 Worksheet L	
	From 09/01/202 To 08/31/2022		parec
	Title XVIII Hospital	PPS	o piii
PART I - FULLY PROSPECTIVE METHOD		1.00	
CAPITAL FEDERAL AMOUNT			
00 Capital DRG other than outlier		5, 729, 916	1 1.
01 Model 4 BPCI Capital DRG other than outlier		0	1.
00 Capital DRG outlier payments		679, 006	2.
01 Model 4 BPCI Capital DRG outlier payments		0	2.
00 Total inpatient days divided by number of day	Total inpatient days divided by number of days in the cost reporting period (see instructions)		
Number of interns & residents (see instructions)			4.
Indirect medical education percentage (see instructions)			5.
1.01) (see instructions)	ly line 5 by the sum of lines 1 and 1.01, columns 1 and	0	6.
00 Percentage of SSI recipient patient days to M 30) (see instructions)	1. 31	7.	
Percentage of Medicaid patient days to total days (see instructions)			8.
) Sum of lines 7 and 8			9.
00 Allowable disproportionate share percentage (see instructions)			10.
00 Disproportionate share adjustment (see instructions)			11.
.00 Total prospective capital payments (see instr	ructions)	6, 624, 367	12.
		1.00	
PART II - PAYMENT UNDER REASONABLE COST			
00 Program inpatient routine capital cost (see i		0	
D Program inpatient ancillary capital cost (see instructions)		0	
0 Total inpatient program capital cost (line 1 plus line 2)		0	
00 Capital cost payment factor (see instructions		0	
00 Total inpatient program capital cost (line 3	x line 4)	0	5.
		1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS 00 Program inpatient capital costs (see instruct	i ons)	0	1 1
00 Program inpatient capital costs (see instruct 00 Program inpatient capital costs for extraordi		0	
00 Net program inpatient capital costs for extraordi	5	0	
00 Applicable exception percentage (see instruct		0.00	-
00 Capital cost for comparison to payments (line		0.00	
00 Percentage adjustment for extraordinary circu		0.00	-
	For extraordinary circumstances (line 2 x line 6)	0.00	
00 Capital minimum payment level (line 5 plus li	5	0	
00 Current year capital payments (from Part I, I		0	-
	iyment level to capital payments (line 8 less line 9)	0	
	ent level over capital payment (from prior year	0	
. 00 Net comparison of capital minimum payment lev	el to capital payments (line 10 plus line 11)	0	12.
.00 Current year exception payment (if line 12 is		0	
.00 Carryover of accumulated capital minimum paym	nent level over capital payment for the following period	0	
(if line 12 is negative, enter the amount on			
(if line 12 is negative, enter the amount on 0.00 Current year allowable operating and capital		0	15
	payment (see instructions)	0	