

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**WORKSHEET S
PARTS I, II & III****PART I - COST REPORT STATUS**

Provider use only		1. ☒ Electronically filed cost report Date: 09/25/2018 Time: 10:50 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☒ Medicare Utilization. Enter 'F' for full or 'L' for low.	
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WEST SUBURBAN HOSP MED CTR (14-0049) {(Provider Name(s) and Number(s))} for the cost reporting period beginning 05/01/2017 and ending 04/30/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☒ I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) CAROL A. BAILEY
Chief Financial Officer or Administrator of Provider(s)

V.P. OF OPERATIONS REIMBURSEMENT
Title

09/25/2018 10:50
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII		HIT	TITLE XIX	
	TITLE V	PART A	PART B			
	1	2	3	4	5	
1	HOSPITAL	510,628	-125,180			1
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF					5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY					7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY					9
10	HEALTH CLINIC - RHC					10
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL	510,628	-125,180			200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions,

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WORKSHEET S
PARTS I, II & III

search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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

Hospital and Hospital Health Care Complex Address:

1	Street: 3 ERIE COURT	P.O. Box:			1
2	City: OAK PARK	State: IL	ZIP Code: 60302	County: COOK	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	WEST SUBURBAN HOSP MED CTR	14-0049	16974	1	07 / 01 / 1966	N	P	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF	WEST SUBURBAN SNF	14-5743	16974		12 / 28 / 1992	N	P	N	9
10	Hospital-Based NF									10
11	Hospital-Based OLTTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 05 / 01 / 2017	To: 04 / 30 / 2018		20
21	Type of control (see instructions)	4			21

Inpatient PPS Information

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,316	1,578	6		7,895	267	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid 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.							25

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

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WORKSHEET S-2
PART I

36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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

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

		1	2	3	
	Teaching Hospitals				
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
	Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65		FAMILY MEDICINE	1350		26.00		65
65.01		INTERNAL MEDICINE	1400		24.00		65.01
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
	Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67		FAMILY MEDICINE	1350				67
67.01		INTERNAL MEDICINE	1400				67.01
67.02		INTERNAL MEDICINE	1400				67.02

Inpatient Psychiatric Facility PPS

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

Inpatient Rehabilitation Facility PPS

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

Long Term Care Hospital PPS

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

TEFRA Providers

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

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PART I**

Title V and XIX Services		V	XIX	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post 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.	Y	Y	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
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 column 2 for title XIX.	Y	Y	98.06

Rural Providers

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

1

110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110
		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.			111

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	2,573,041			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121
122	Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

Transplant Center Information

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

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

127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

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

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	HB0557	140

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name: TENET HEALTHCARE CORPORATION	Contractor's Name: NOVITAS SOLUTIONS	Contractor's Number: 04011	141
142	Street: 1445 ROSS AVE., STE 1400	P.O. Box:		142
143	City: DALLAS, TX	State: TX	ZIP Code: 75202-2703	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

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

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)			168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)	9.99		169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01 / 01 / 2017	03 / 31 / 2017	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	02/28/2018	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	Y		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

		Y/N	
Bad Debts			
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	08/01/2018	Y	08/01/2018	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

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

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

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

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

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

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

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

Cost Report Preparer Contact Information			
41	First name: BETH	Last name: SLOAN	Title: DIRECTOR OF REIMBURSEMENT
42	Employer: TENET EMPLOYMENT INC.		
43	Phone number: 606.451.1228	E-mail Address: BETH1.SLOAN@TENETHEALTH.COM	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
**WORKSHEET S-3
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				
						Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	114	41,610			6,407	2,187	22,002	1
2	HMO and other (see instructions)						4,125	7,895		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		114	41,610			6,407	2,187	22,002	7
8	Intensive Care Unit	31	21	7,665			1,233	311	3,429	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						1,402	3,779	13
14	Total (see instructions)		135	49,275			7,640	3,900	29,210	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44	39	14,235			5,709		9,126	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		174							27
28	Observation Bed Days							76	1,396	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							267	413	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,652	520	7,109	1
2	HMO and other (see instructions)					886	2,458		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)	58.29	815.98			1,652	520	7,109	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		34.91						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)	58.29	850.89						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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HOSPITAL WAGE INDEX INFORMATION**WORKSHEET S-3
PARTS II-III****Part II - Wage Data**

		Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	58,556,556		58,556,556	1,769,845.00	33.09	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching			255,244	255,244	2,575.00	99.12	4.01
5	Physician-Part B							5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21	4,756,081	-255,244	4,500,837	146,666.00	30.69	7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel		4,144,359		4,144,359	118,108.00	35.09	8
9	SNF	44	2,232,130		2,232,130	72,612.00	30.74	9
10	Excluded area salaries (see instructions)		622,519	80,129	702,648	16,254.00	43.23	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		1,181,362		1,181,362	20,056.00	58.90	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		158,236		158,236	1,128.00	140.28	13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries		4,144,359		4,144,359	118,108.00	35.09	14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		10,111,265		10,111,265			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		134,966		134,966			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching		60,328		60,328			22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)		864,531		864,531			25
25.50	Home office wage-related		866,724		866,724			25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		712,749	35,007	747,756	23,214.00	32.21	26
27	Administrative & General		6,338,322	-970,156	5,368,166	137,695.00	38.99	27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		1,686,666		1,686,666	63,771.00	26.45	30
31	Laundry & Linen Service							31
32	Housekeeping		1,461,014		1,461,014	98,751.00	14.79	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		1,166,067		1,166,067	68,076.00	17.13	34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		1,148,652		1,148,652	22,248.00	51.63	38
39	Central Services and Supply		266,190		266,190	13,506.00	19.71	39
40	Pharmacy		1,501,687	66,071	1,567,758	36,614.00	42.82	40
41	Medical Records & Medical Records Library		351,412	788,949	1,140,361	38,113.00	29.92	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		49,656,116		49,656,116	1,502,496.00	33.05	1
2	Excluded area salaries (see instructions)		2,854,649	80,129	2,934,778	88,866.00	33.02	2
3	Subtotal salaries (line 1 minus line 2)		46,801,467	-80,129	46,721,338	1,413,630.00	33.05	3
4	Subtotal other wages & related costs (see instructions)		5,483,957		5,483,957	139,292.00	39.37	4

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

5	Subtotal wage-related costs (see instructions)		10,977,989		10,977,989		23.50%	5
6	Total (sum of lines 3 through 5)		63,263,413	-80,129	63,183,284	1,552,922.00	40.69	6
7	Total overhead cost (see instructions)		14,632,759	-80,129	14,552,630	501,988.00	28.99	7

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HOSPITAL WAGE RELATED COSTS**WORKSHEET S-3
PART IV****Part IV - Wage Related Cost****Part A - Core List**

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	765,749	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)	4,338,986	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	-93,603	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	819,460	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	4,003,929	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	239,970	20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances	1,564	22
23	Tuition Reimbursement	35,209	23
24	Total Wage Related cost (Sum of lines 1-23)	10,111,264	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	1,181,362	10,111,264	1
2	Hospital	1,181,362	10,111,264	2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA**WORKSHEET S-7**

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

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX	29		29	3
4	RUL	243		243	4
5	RVX				5
6	RVL	73		73	6
7	RHX				7
8	RHL	14		14	8
9	RMX				9
10	RML	7		7	10
11	RLX				11
12	RUC	348		348	12
13	RUB	501		501	13
14	RUA	3,340		3,340	14
15	RVC	59		59	15
16	RVB	46		46	16
17	RVA	760		760	17
18	RHC				18
19	RHB				19
20	RHA	21		21	20
21	RMC	18		18	21
22	RMB				22
23	RMA	50		50	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2	2		2	27
28	ES1	21		21	28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1	9		9	36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1	5		5	40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1	39		39	44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1	2		2	50
51	CB2				51
52	CB1	30		30	52
53	CA2				53
54	CA1	26		26	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA**WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
65	BB2				65
66	BB1	6		6	66
67	BA2				67
68	BA1	1		1	68
69	PE2				69
70	PE1	10		10	70
71	PD2				71
72	PD1	2		2	72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1	15		15	76
77	PA2				77
78	PA1	32		32	78
199	AAA				199
200	TOTAL	5,709		5,709	200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).	16974	16974	201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing				202
203	Recruitment				203
204	Retention of employees				204
205	Training				205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	5,369,944			207

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA**WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.142515	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	26,378,839	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid	16,925,474	5
6	Medicaid charges	308,208,372	6
7	Medicaid cost (line 1 times line 6)	43,924,316	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.	620,003	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	620,003	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	31,503,914	825,869	32,329,783	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,489,780	825,869	5,315,649	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	4,489,780	825,869	5,315,649	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	9,658,247	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	969,584	27
27.0	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,491,667	27.0
1			1
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	8,166,580	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,685,943	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	7,001,592	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,621,595	31

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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATION S	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				4,905,569	4,905,569	1,568,646	6,474,215	1
1.01	00101	CAP REL COSTS-BLDG & FIXT RIVER FOR						722,507	722,507	1.01
2	00200	Cap Rel Costs-Mvble Equip				2,944,959	2,944,959	1,101,406	4,046,365	2
4	00400	Employee Benefits Department	712,749	11,299,500	12,012,249	27,144	12,039,393	-726,306	11,313,087	4
5	00500	Administrative & General	6,338,322	19,407,552	25,745,874	-7,989,123	17,756,751	10,739,510	28,496,261	5
7	00700	Operation of Plant	1,686,666	5,288,822	6,975,488	-860,828	6,114,660	-25,056	6,089,604	7
7.01	00701	OPERATION OF PLANT-RIVER FOREST				860,438	860,438		860,438	7.01
8	00800	Laundry & Linen Service		806,115	806,115	8,821	814,936		814,936	8
9	00900	Housekeeping	1,461,014	1,095,168	2,556,182	-206,579	2,349,603	-78,951	2,270,652	9
9.01	00901	HOUSEKEEPING-RIVER FOREST				191,151	191,151		191,151	9.01
10	01000	Dietary	1,166,067	570,729	1,736,796	-22,328	1,714,468	-330,192	1,384,276	10
11	01100	Cafeteria								11
13	01300	Nursing Administration	1,148,652	16,688	1,165,340	6,313	1,171,653		1,171,653	13
14	01400	Central Services & Supply	266,190	108,873	375,063	251,747	626,810	-1,455	625,355	14
15	01500	Pharmacy	1,501,687	3,498,596	5,000,283	-2,758,609	2,241,674	-10,466	2,231,208	15
16	01600	Medical Records & Library	351,412	373,410	724,822	794,784	1,519,606	-30,788	1,488,818	16
21	02100	I&R Services-Salary & Fringes Apprvd	4,756,081		4,756,081	-255,244	4,500,837		4,500,837	21
22	02200	I&R Services-Other Prgm Costs Apprvd		1,564,660	1,564,660	255,244	1,819,904	-57,555	1,762,349	22
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	9,637,742	2,765,783	12,403,525	-233,084	12,170,441	-1,580,862	10,589,579	30
31	03100	Intensive Care Unit	2,106,886	921,490	3,028,376	-128,317	2,900,059	-83,246	2,816,813	31
43	04300	Nursery	862,801	80,610	943,411	-25,745	917,666		917,666	43
44	04400	Skilled Nursing Facility	2,232,130	354,518	2,586,648	-104,984	2,481,664	-12,041	2,469,623	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	3,308,526	4,427,533	7,736,059	-2,772,719	4,963,340	-55,599	4,907,741	50
51	05100	Recovery Room	613,050	67,810	680,860	-42,960	637,900		637,900	51
52	05200	Delivery Room & Labor Room	2,081,946	404,087	2,486,033	-180,643	2,305,390		2,305,390	52
53	05300	Anesthesiology	105,436	981,438	1,086,874	-35,134	1,051,740	-859,920	191,820	53
54	05400	Radiology-Diagnostic	2,723,842	1,522,588	4,246,430	-366,469	3,879,961	-28,272	3,851,689	54
55.01	03340	GASTRO INTESTINAL SERVICES	806,755	558,716	1,365,471	-332,307	1,033,164	-415	1,032,749	55.01
55.02	03630	ULTRA SOUND	763,544	40,818	804,362	-2,963	801,399		801,399	55.02
56	05600	Radioisotope	206,912	323,640	530,552	-249,826	280,726		280,726	56
57	05700	CT Scan	698,233	324,058	1,022,291	-16,527	1,005,764	-2,225	1,003,539	57
58	05800	MRI	267,503	202,256	469,759	-4,635	465,124	-161	464,963	58
59	05900	Cardiac Catheterization	535,252	2,046,034	2,581,286	-1,082,525	1,498,761		1,498,761	59
60	06000	Laboratory	619,902	3,935,136	4,555,038	3,051	4,558,089	-817,420	3,740,669	60
63	06300	Blood Storing, Processing & Trans.		525,268	525,268	-8,060	517,208		517,208	63
65	06500	Respiratory Therapy	1,000,115	237,287	1,237,402	-142,045	1,095,357	-4,533	1,090,824	65
66	06600	Physical Therapy	2,144,950	129,653	2,274,603	-8,068	2,266,535	-1,371	2,265,164	66
67	06700	Occupational Therapy	221,969	8,252	230,221		230,221		230,221	67
68	06800	Speech Pathology	169,965	-5,631	164,334	-682	163,652		163,652	68
69	06900	Electrocardiology	617,308	159,038	776,346	-5,044	771,302	-86,964	684,338	69
71	07100	Medical Supplies Charged to Patients				2,039,639	2,039,639		2,039,639	71
72	07200	Impl. Dev. Charged to Patients				2,474,877	2,474,877		2,474,877	72
73	07300	Drugs Charged to Patients				5,269,525	5,269,525		5,269,525	73
74	07400	Renal Dialysis		782,032	782,032	-3,661	778,371		778,371	74
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	1,771,238	1,007,761	2,778,999	-285,724	2,493,275	-381,612	2,111,663	90
90.01	04950	DIABETOLOGY	104,999	937	105,936		105,936		105,936	90.01
90.02	04951	CANCER CENTER	516,964	4,182,951	4,699,915	-1,507,955	3,191,960	-7,310	3,184,650	90.02
90.03	09001	WOUND CARE	21,262	870,064	891,326	-22,957	868,369	-6,947	861,422	90.03
91	09100	Emergency	4,405,967	3,811,094	8,217,061	-254,926	7,962,135	-2,535,123	5,427,012	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	57,934,037	74,695,334	132,629,371	122,591	132,751,962	6,407,279	139,159,241	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen		471	471		471		471	190
192	19200	Physicians' Private Offices								192
194	07950	MARKETING	159,903	373,896	533,799	3,793	537,592		537,592	194
194.0 1	07951	HOSPITALIST								194.0 1
194.0 2	07952	RETAIL PHARMACY	258,244	473,722	731,966	-203,221	528,745		528,745	194.0 2

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATION S	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
194.0 3	07953	COMMUNITY RELATIONS	72,389	71,260	143,649		143,649		143,649	194.0 3
194.0 4	07954	PHYSICIAN CLINICS	131,983	2,458	134,441	-2,074	132,367		132,367	194.0 4
194.0 5	07955	GUEST MEALS								194.0 5
194.0 6	07956	CATERING MEALS								194.0 6
194.0 7	07957	RESEARCH,RIVER FOREST NONREIMB				78,911	78,911		78,911	194.0 7
200		TOTAL (sum of lines 118-199)	58,556,556	75,617,141	134,173,697		134,173,697	6,407,279	140,580,976	200

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RECLASSIFICATIONS**WORKSHEET A-6**

		INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5
1	DEPRECIATION EXPENSE	A	Cap Rel Costs-Bldg & Fixt	1		4,166,546
2	DEPRECIATION EXPENSE	A	Cap Rel Costs-Mvble Equip	2		2,074,979
500	Total reclassifications					6,241,525
	Code Letter - A					
1	RENTS	B	Cap Rel Costs-Bldg & Fixt	1		230,754
2	RENTS	B	Cap Rel Costs-Mvble Equip	2		836,269
3	RENTS	B	Laboratory	60		8,798
4	RENTS	B				
5	RENTS	B				
6	RENTS	B				
7	RENTS	B				
8	RENTS	B				
9	RENTS	B				
10	RENTS	B				
11	RENTS	B				
12	RENTS	B				
13	RENTS	B				
14	RENTS	B				
500	Total reclassifications					1,075,821
	Code Letter - B					
1	INTEREST EXPENSE	C	Cap Rel Costs-Mvble Equip	2		33,711
500	Total reclassifications					33,711
	Code Letter - C					
1	PROPERTY TAX	D	Cap Rel Costs-Bldg & Fixt	1		485,177
500	Total reclassifications					485,177
	Code Letter - D					
1	INSURANCE	E	Cap Rel Costs-Bldg & Fixt	1		23,092
500	Total reclassifications					23,092
	Code Letter - E					
1	BILLABLE DRUGS	F	Drugs Charged to Patients	73		5,269,525
2	BILLABLE DRUGS	F	Central Services & Supply	14		6,077
3	BILLABLE DRUGS	F				
4	BILLABLE DRUGS	F				
5	BILLABLE DRUGS	F				
6	BILLABLE DRUGS	F				
7	BILLABLE DRUGS	F				
8	BILLABLE DRUGS	F				
9	BILLABLE DRUGS	F				
10	BILLABLE DRUGS	F				
11	BILLABLE DRUGS	F				
12	BILLABLE DRUGS	F				
13	BILLABLE DRUGS	F				
14	BILLABLE DRUGS	F				
15	BILLABLE DRUGS	F				
16	BILLABLE DRUGS	F				
17	BILLABLE DRUGS	F				
18	BILLABLE DRUGS	F				
19	BILLABLE DRUGS	F				
20	BILLABLE DRUGS	F				
21	BILLABLE DRUGS	F				
22	BILLABLE DRUGS	F				
23	BILLABLE DRUGS	F				
24	BILLABLE DRUGS	F				
25	BILLABLE DRUGS	F				
26	BILLABLE DRUGS	F				
27	BILLABLE DRUGS	F				
28	BILLABLE DRUGS	F				
29	BILLABLE DRUGS	F				
30	BILLABLE DRUGS	F				
31	BILLABLE DRUGS	F				
32	BILLABLE DRUGS	F				
33	BILLABLE DRUGS	F				
500	Total reclassifications					5,275,602
	Code Letter - F					

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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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RECLASSIFICATIONS**WORKSHEET A-6**

		INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5
1	LAUNDRY	G	Laundry & Linen Service	8		8,821
2	LAUNDRY	G				
3	LAUNDRY	G				
4	LAUNDRY	G				
5	LAUNDRY	G				
6	LAUNDRY	G				
7	LAUNDRY	G				
8	LAUNDRY	G				
9	LAUNDRY	G				
10	LAUNDRY	G				
11	LAUNDRY	G				
12	LAUNDRY	G				
13	LAUNDRY	G				
14	LAUNDRY	G				
15	LAUNDRY	G				
16	LAUNDRY	G				
500	Total reclassifications					8,821
	Code Letter - G					
1	BILLABLE SUPPLIES	H	Medical Supplies Charged to P	71		2,039,639
2	BILLABLE SUPPLIES	H	Employee Benefits Department	4		15
3	BILLABLE SUPPLIES	H	Nursing Administration	13		6,313
4	BILLABLE SUPPLIES	H	Central Services & Supply	14		444,932
5	BILLABLE SUPPLIES	H	Pharmacy	15		132
6	BILLABLE SUPPLIES	H	Speech Pathology	68		13
7	BILLABLE SUPPLIES	H				
8	BILLABLE SUPPLIES	H				
9	BILLABLE SUPPLIES	H				
10	BILLABLE SUPPLIES	H				
11	BILLABLE SUPPLIES	H				
12	BILLABLE SUPPLIES	H				
13	BILLABLE SUPPLIES	H				
14	BILLABLE SUPPLIES	H				
15	BILLABLE SUPPLIES	H				
16	BILLABLE SUPPLIES	H				
17	BILLABLE SUPPLIES	H				
18	BILLABLE SUPPLIES	H				
19	BILLABLE SUPPLIES	H				
20	BILLABLE SUPPLIES	H				
21	BILLABLE SUPPLIES	H				
22	BILLABLE SUPPLIES	H				
23	BILLABLE SUPPLIES	H				
24	BILLABLE SUPPLIES	H				
25	BILLABLE SUPPLIES	H				
26	BILLABLE SUPPLIES	H				
27	BILLABLE SUPPLIES	H				
28	BILLABLE SUPPLIES	H				
29	BILLABLE SUPPLIES	H				
500	Total reclassifications					2,491,044
	Code Letter - H					
1	IMPLANTABLE DEVICE	I	Impl. Dev. Charged to Patient	72		2,474,877
2	IMPLANTABLE DEVICE	I				
3	IMPLANTABLE DEVICE	I				
4	IMPLANTABLE DEVICE	I				
5	IMPLANTABLE DEVICE	I				
6	IMPLANTABLE DEVICE	I				
7	IMPLANTABLE DEVICE	I				
8	IMPLANTABLE DEVICE	I				
9	IMPLANTABLE DEVICE	I				
10	IMPLANTABLE DEVICE	I				
500	Total reclassifications					2,474,877
	Code Letter - I					
1	REGIONAL	J	Employee Benefits Department	4	35,007	2,387
2	REGIONAL	J	Pharmacy	15	66,071	278
3	REGIONAL	J	Medical Records & Library	16	788,949	5,835
4	REGIONAL	J	MARKETING	194	12,039	87
5	REGIONAL	J	RESEARCH,RIVER FOREST NONREIM	194.07	68,090	10,821
500	Total reclassifications				970,156	19,408

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5
	Code Letter - J					
1	RIVER FOREST PLT OPER AND HSKING	K	OPERATION OF PLANT-RIVER FORE	7.01	161,660	698,778
2	RIVER FOREST PLT OPER AND HSKING	K	HOUSEKEEPING-RIVER FOREST	9.01		191,151
500	Total reclassifications				161,660	889,929
	Code Letter - K					
1	TEACHING PHYSICIAN	L	I&R Services-Other Prgm Costs	22	255,244	
500	Total reclassifications				255,244	
	Code Letter - L					
	GRAND TOTAL (Increases)				1,387,060	19,019,007

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

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RECLASSIFICATIONS**WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	DEPRECIATION EXPENSE	A	Administrative & General	5		6,241,345	9	1
2	DEPRECIATION EXPENSE	A	Skilled Nursing Facility	44		180	9	2
500	Total reclassifications					6,241,525		500
	Code letter - A							
1	RENTS	B	Administrative & General	5		213,793	10	1
2	RENTS	B	Operation of Plant	7		328	10	2
3	RENTS	B	Dietary	10		75		3
4	RENTS	B	Central Services & Supply	14		199,262		4
5	RENTS	B	Pharmacy	15		192,723		5
6	RENTS	B	Adults & Pediatrics	30		43,863		6
7	RENTS	B	Intensive Care Unit	31		31,130		7
8	RENTS	B	Skilled Nursing Facility	44		69,359		8
9	RENTS	B	Operating Room	50		180,284		9
10	RENTS	B	Radiology-Diagnostic	54		35,774		10
11	RENTS	B	CT Scan	57		148		11
12	RENTS	B	Respiratory Therapy	65		76,893		12
13	RENTS	B	Clinic	90		32,066		13
14	RENTS	B	CANCER CENTER	90.02		123		14
500	Total reclassifications					1,075,821		500
	Code letter - B							
1	INTEREST EXPENSE	C	Administrative & General	5		33,711	11	1
500	Total reclassifications					33,711		500
	Code letter - C							
1	PROPERTY TAX	D	Administrative & General	5		485,177	13	1
500	Total reclassifications					485,177		500
	Code letter - D							
1	INSURANCE	E	Administrative & General	5		23,092	12	1
500	Total reclassifications					23,092		500
	Code letter - E							
1	BILLABLE DRUGS	F	Employee Benefits Department	4		10,265		1
2	BILLABLE DRUGS	F	Administrative & General	5		1,376		2
3	BILLABLE DRUGS	F	Operation of Plant	7		10		3
4	BILLABLE DRUGS	F	Housekeeping	9		45		4
5	BILLABLE DRUGS	F	Dietary	10		18,063		5
6	BILLABLE DRUGS	F	Pharmacy	15		2,632,367		6
7	BILLABLE DRUGS	F	Adults & Pediatrics	30		73,541		7
8	BILLABLE DRUGS	F	Intensive Care Unit	31		35,501		8
9	BILLABLE DRUGS	F	Nursery	43		6,930		9
10	BILLABLE DRUGS	F	Skilled Nursing Facility	44		3,588		10
11	BILLABLE DRUGS	F	Operating Room	50		50,693		11
12	BILLABLE DRUGS	F	Recovery Room	51		7,497		12
13	BILLABLE DRUGS	F	Delivery Room & Labor Room	52		52,427		13
14	BILLABLE DRUGS	F	Anesthesiology	53		24,729		14
15	BILLABLE DRUGS	F	Radiology-Diagnostic	54		13,633		15
16	BILLABLE DRUGS	F	GASTRO INTESTINAL SERVICES	55.01		32,704		16
17	BILLABLE DRUGS	F	ULTRA SOUND	55.02		81		17
18	BILLABLE DRUGS	F	Radioisotope	56		249,072		18
19	BILLABLE DRUGS	F	CT Scan	57		2,735		19
20	BILLABLE DRUGS	F	MRI	58		707		20
21	BILLABLE DRUGS	F	Cardiac Catheterization	59		4,424		21
22	BILLABLE DRUGS	F	Laboratory	60		17		22
23	BILLABLE DRUGS	F	Blood Storing, Processing & T	63		8,060		23
24	BILLABLE DRUGS	F	Respiratory Therapy	65		1,009		24
25	BILLABLE DRUGS	F	Physical Therapy	66		136		25
26	BILLABLE DRUGS	F	Electrocardiology	69		660		26
27	BILLABLE DRUGS	F	Renal Dialysis	74		2,804		27
28	BILLABLE DRUGS	F	Clinic	90		207,354		28
29	BILLABLE DRUGS	F	CANCER CENTER	90.02		1,506,592		29
30	BILLABLE DRUGS	F	WOUND CARE	90.03		11,251		30
31	BILLABLE DRUGS	F	Emergency	91		112,036		31
32	BILLABLE DRUGS	F	RETAIL PHARMACY	194.02		203,221		32
33	BILLABLE DRUGS	F	PHYSICIAN CLINICS	194.04		2,074		33
500	Total reclassifications					5,275,602		500
	Code letter - F							

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RECLASSIFICATIONS**WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	LAUNDRY	G	Housekeeping	9		107		1
2	LAUNDRY	G	Adults & Pediatrics	30		728		2
3	LAUNDRY	G	Intensive Care Unit	31		1,448		3
4	LAUNDRY	G	Nursery	43		45		4
5	LAUNDRY	G	Operating Room	50		798		5
6	LAUNDRY	G	Delivery Room & Labor Room	52		261		6
7	LAUNDRY	G	Radiology-Diagnostic	54		133		7
8	LAUNDRY	G	GASTRO INTESTINAL SERVICES	55.01		652		8
9	LAUNDRY	G	ULTRA SOUND	55.02		124		9
10	LAUNDRY	G	CT Scan	57		83		10
11	LAUNDRY	G	MRI	58		338		11
12	LAUNDRY	G	Cardiac Catheterization	59		72		12
13	LAUNDRY	G	Laboratory	60		1,161		13
14	LAUNDRY	G	Electrocardiology	69		11		14
15	LAUNDRY	G	CANCER CENTER	90.02		439		15
16	LAUNDRY	G	Emergency	91		2,421		16
500	Total reclassifications					8,821		500
	Code letter - G							
1	BILLABLE SUPPLIES	H	Administrative & General	5		1,065		1
2	BILLABLE SUPPLIES	H	Operation of Plant	7		52		2
3	BILLABLE SUPPLIES	H	Housekeeping	9		15,276		3
4	BILLABLE SUPPLIES	H	Dietary	10		4,190		4
5	BILLABLE SUPPLIES	H	Adults & Pediatrics	30		114,394		5
6	BILLABLE SUPPLIES	H	Intensive Care Unit	31		59,402		6
7	BILLABLE SUPPLIES	H	Nursery	43		18,770		7
8	BILLABLE SUPPLIES	H	Skilled Nursing Facility	44		31,857		8
9	BILLABLE SUPPLIES	H	Operating Room	50		1,230,000		9
10	BILLABLE SUPPLIES	H	Recovery Room	51		35,463		10
11	BILLABLE SUPPLIES	H	Delivery Room & Labor Room	52		127,955		11
12	BILLABLE SUPPLIES	H	Anesthesiology	53		10,405		12
13	BILLABLE SUPPLIES	H	Radiology-Diagnostic	54		156,789		13
14	BILLABLE SUPPLIES	H	GASTRO INTESTINAL SERVICES	55.01		287,191		14
15	BILLABLE SUPPLIES	H	ULTRA SOUND	55.02		2,758		15
16	BILLABLE SUPPLIES	H	Radioisotope	56		754		16
17	BILLABLE SUPPLIES	H	CT Scan	57		13,561		17
18	BILLABLE SUPPLIES	H	MRI	58		3,590		18
19	BILLABLE SUPPLIES	H	Cardiac Catheterization	59		132,785		19
20	BILLABLE SUPPLIES	H	Laboratory	60		4,569		20
21	BILLABLE SUPPLIES	H	Respiratory Therapy	65		64,143		21
22	BILLABLE SUPPLIES	H	Physical Therapy	66		7,932		22
23	BILLABLE SUPPLIES	H	Electrocardiology	69		4,373		23
24	BILLABLE SUPPLIES	H	Renal Dialysis	74		857		24
25	BILLABLE SUPPLIES	H	Clinic	90		13,608		25
26	BILLABLE SUPPLIES	H	CANCER CENTER	90.02		801		26
27	BILLABLE SUPPLIES	H	WOUND CARE	90.03		7,521		27
28	BILLABLE SUPPLIES	H	Emergency	91		132,650		28
29	BILLABLE SUPPLIES	H	MARKETING	194		8,333		29
500	Total reclassifications					2,491,044		500
	Code letter - H							
1	IMPLANTABLE DEVICE	I	Adults & Pediatrics	30		558		1
2	IMPLANTABLE DEVICE	I	Intensive Care Unit	31		836		2
3	IMPLANTABLE DEVICE	I	Operating Room	50		1,310,944		3
4	IMPLANTABLE DEVICE	I	Radiology-Diagnostic	54		160,140		4
5	IMPLANTABLE DEVICE	I	GASTRO INTESTINAL SERVICES	55.01		11,760		5
6	IMPLANTABLE DEVICE	I	Cardiac Catheterization	59		945,244		6
7	IMPLANTABLE DEVICE	I	Speech Pathology	68		695		7
8	IMPLANTABLE DEVICE	I	Clinic	90		32,696		8
9	IMPLANTABLE DEVICE	I	WOUND CARE	90.03		4,185		9
10	IMPLANTABLE DEVICE	I	Emergency	91		7,819		10
500	Total reclassifications					2,474,877		500
	Code letter - I							
1	REGIONAL	J	Administrative & General	5	970,156	19,408		1
2	REGIONAL	J						2
3	REGIONAL	J						3
4	REGIONAL	J						4

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RECLASSIFICATIONS

WORKSHEET A-6

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref. 10	
		1	6	7	8	9	10	
5	REGIONAL	J						5
500	Total reclassifications				970,156	19,408		500
	Code letter - J							
1	RIVER FOREST PLT OPER AND HSKING	K	Operation of Plant	7	161,660	698,778		1
2	RIVER FOREST PLT OPER AND HSKING	K	Housekeeping	9		191,151		2
500	Total reclassifications				161,660	889,929		500
	Code letter - K							
1	TEACHING PHYSICIAN	L	I&R Services-Salary & Fringes	21	255,244			1
500	Total reclassifications				255,244			500
	Code letter - L							
	GRAND TOTAL (Decreases)				1,387,060	19,019,007		

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

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RECONCILIATION OF CAPITAL COST CENTERS**WORKSHEET A-7
PARTS I, II & III****PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	1,930,352					1,930,352		1
2	Land Improvements	2,360,389					2,360,389		2
3	Buildings and Fixtures	157,554,587	431,193		431,193		157,985,780		3
4	Building Improvements								4
5	Fixed Equipment	20,640,059					20,640,059		5
6	Movable Equipment	105,842,631	500,032		500,032		106,342,663		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	288,328,018	931,225		931,225		289,259,243		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	288,328,018	931,225		931,225		289,259,243		10

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

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt								1
1.01	CAP REL COSTS-BLDG & FIXT RIVER FOR								1.01
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)								3

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

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
		1	2	3	4	5	6	7	8	
*										
1	Cap Rel Costs-Bldg & Fi	160,346,170		160,346,170	0.558058					1
1.01	CAP REL COSTS-BLDG & FI				0.000000					1.01
2	Cap Rel Costs-Mvble Equip	126,982,722		126,982,722	0.441942					2
3	Total (sum of lines 1-2)	287,328,892		287,328,892	1.000000					3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt	5,580,165	230,754		23,092	640,204		6,474,215	1
1.01	CAP REL COSTS-BLDG & FIXT RIVER FOR	28,198				694,309		722,507	1.01
2	Cap Rel Costs-Mvble Equip	3,176,385	836,269	33,711				4,046,365	2
3	Total (sum of lines 1-2)	8,784,748	1,067,023	33,711	23,092	1,334,513		11,243,087	3

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

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

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ADJUSTMENTS TO EXPENSES**WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-5,699,364				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	8,326,439				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-327,680	Dietary	10		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-30,788	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures	A	-356,452	Cap Rel Costs-Bldg & Fixt	1	9	26
27	Depreciation--movable equipment	A	1,120,314	Cap Rel Costs-Mvble Equip	2	9	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	DIRECT PHONE COSTS	A	-19,449	Administrative & General	5		33
33.01	PBX SALARY	A	-23,798	Administrative & General	5		33.01
33.02	PBX BENEFITS	A	-44,287	Employee Benefits Department	4		33.02
33.03	TELEPHONE DEPRECIATION	A	-9,301	Cap Rel Costs-Mvble Equip	2	9	33.03
33.04	TELEVISION DEPRECIATION	A	-9,607	Cap Rel Costs-Mvble Equip	2	9	33.04
33.05	TELEVISION CABLE & SATELITE	A	-23,996	Operation of Plant	7		33.05
33.06	TELEVISION CABLE & SATELITE	A	-1,455	Central Services & Supply	14		33.06
33.07	TELEVISION CABLE & SATELITE	A	-45	Skilled Nursing Facility	44		33.07
33.08	TELEVISION CABLE & SATELITE	A	-5,780	Operating Room	50		33.08
33.09	TELEVISION CABLE & SATELITE	A	-415	GASTRO INTESTINAL SERVICES	55.01		33.09
33.10	TELEVISION CABLE & SATELITE	A	-390	Electrocardiology	69		33.10
33.11	TELEVISION CABLE & SATELITE	A	-1,872	CANCER CENTER	90.02		33.11
33.12	TELEVISION CABLE & SATELITE	A	-565	Emergency	91		33.12
33.13	OTHER OPERATING REVENUE	B	-188	Employee Benefits Department	4		33.13
33.14	OTHER OPERATING REVENUE	B	-21,497	Administrative & General	5		33.14
33.15	WSPH RECEIVABLE	B	-582,061	Administrative & General	5		33.15
33.16	MEDICAL STAFF APPLICATION FEES	B	-69,680	Administrative & General	5		33.16
33.17	WELLNESS PROGRAMS	B	-428,845	Administrative & General	5		33.17
33.18	RESIDENCY PROGRAM REVENUES	B	-2,762,734	Administrative & General	5		33.18
33.19	ID BADGES	B	-1,060	Operation of Plant	7		33.19
33.20	OTHER OPERATING REVENUE	B	-2,489	Pharmacy	15		33.20
33.21	RESIDENT STIPENDS	B	-57,540	I&R Services-Other Prgm Costs Apprvd	22		33.21
33.22	MATERNAL CHILD CARE CLASSES	B	-2,879	Adults & Pediatrics	30		33.22
33.23	OTHER OPERATING REVENUE	B	-7,690	Radiology-Diagnostic	54		33.23
33.24	INTEREST PAYMENTS	B	-12,845	Clinic	90		33.24

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ADJUSTMENTS TO EXPENSES**WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
33.25	OTHER OPERATING REVENUE	B	-210	CANCER CENTER	90.02		33.25
33.26	INTEREST INCOME	B	-1,324	Administrative & General	5		33.26
33.27	ADVERTISING	A	-11,863	Administrative & General	5		33.27
33.28	OTHER EXPENSE	A	-201	Administrative & General	5		33.28
33.29	OTHER EXPENSE	A	-213	Adults & Pediatrics	30		33.29
33.30	OTHER EXPENSE	A	-53	Operating Room	50		33.30
33.31	OTHER EXPENSE	A	-5,252	Radiology-Diagnostic	54		33.31
33.32	OTHER EXPENSE	A	-771	Clinic	90		33.32
33.33	OTHER EXPENSE	A	-945	Emergency	91		33.33
33.34	PURCHASED SVCS	A	-44,868	Administrative & General	5		33.34
33.35	PURCHASED SVCS	A	-78,951	Housekeeping	9		33.35
33.36	PURCHASED SVCS	A	-2,512	Dietary	10		33.36
33.37	PURCHASED SVCS	A	-347	Radiology-Diagnostic	54		33.37
33.38	PURCHASED SVCS	A	-161	MRI	58		33.38
33.39	PURCHASED SVCS	A	-1,371	Physical Therapy	66		33.39
33.40	PHYSICIAN RELOCATION	A	-65,673	Administrative & General	5		33.40
33.41	TRAVEL	A	-917	Administrative & General	5		33.41
33.42	ALCOHOL	A	-15	I&R Services-Other Prgm Costs Apprvd	22		33.42
33.43	MEALS	A	-4,119	Administrative & General	5		33.43
33.44	DONATIONS/CONTRIBUTIONS	A	-15,063	Administrative & General	5		33.44
33.45	DUES & SUBSCRIPTION	A	-1,119	Administrative & General	5		33.45
33.46	DUES & SUBSCRIPTION	A	-2,432	Clinic	90		33.46
33.47	LOBBYING	A	-50,060	Administrative & General	5		33.47
33.48	PENALTIES	A	-6,455	Administrative & General	5		33.48
33.49	PENALTIES	A	-4,377	Pharmacy	15		33.49
33.50	PENALTIES	A	-5,228	CANCER CENTER	90.02		33.50
33.51	NON-PATIENT BAD DEBT EXPENSE	A	7,477	Administrative & General	5		33.51
33.52	TENET H.O. WORKERS COMPENSATION	A	-169,879	Employee Benefits Department	4		33.52
33.53	PERIOD 13 ADJUSTMENT	A	-511,952	Employee Benefits Department	4		33.53
33.54	PERIOD 13 ADJUSTMENT	A	7,678,887	Administrative & General	5		33.54
33.55	RIVER FOREST PROPERTY TAXES	A	694,309	CAP REL COSTS-BLDG & FIXT RIVER FOR	1.01	13	33.55
33.56	RIVER FOREST DEPRECIATION EXP	A	28,198	CAP REL COSTS-BLDG & FIXT RIVER FOR	1.01	9	33.56
33.57	PROPERTY TAX	A	155,027	Cap Rel Costs-Bldg & Fixt	1	13	33.57
34	CHIEF STRATEGY OFFICER	A	-112,289	Administrative & General	5		34
35							35
36							36
37							37
38							38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		6,407,279				50

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

(2) Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined

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

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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS**WORKSHEET A-8-1**
**A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS
OR CLAIMED HOME OFFICE COSTS:**

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	1	Cap Rel Costs-Bldg & Fixt	HOME OFFICE DIRECT CAPITAL	1,150,561		1,150,561	9	1
2	1	Cap Rel Costs-Bldg & Fixt	HOME OFFICE POOLED CAPITAL	619,510		619,510	9	2
3	5	Administrative & General	HOME OFFICE SHARED SERVICES	12,041,485		12,041,485		3
4	5	Administrative & General	PERIOD 13 ADJ - IC OVERHEAD ALLOC		4,667,697	-4,667,697		4
4.01	1	Cap Rel Costs-Bldg & Fixt	REGIONAL ALLOCATION	212,168	212,168		10	4.01
4.02	2	Cap Rel Costs-Mvble Equip	REGIONAL ALLOCATION	1,486	1,486		10	4.02
4.03	4	Employee Benefits Department	REGIONAL ALLOCATION	37,395	37,395			4.03
4.04	5	Administrative & General	REGIONAL ALLOCATION	5,871,313	5,871,313			4.04
4.05	15	Pharmacy	REGIONAL ALLOCATION	66,348	66,348			4.05
4.06	16	Medical Records & Library	REGIONAL ALLOCATION	794,784	794,784			4.06
4.07	194	MARKETING	REGIONAL ALLOCATION	12,126	12,126			4.07
4.08	194.07	RESEARCH,RIVER FOREST NONREIMB	REGIONAL ALLOCATION	57,270	57,270			4.08
4.09	60	Laboratory	GENESIS LAB	2,950,735	3,768,155	-817,420		4.09
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			23,815,181	15,488,742	8,326,439		5

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

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

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B			TENET HLTHCARE	100.00	HLTHCARE	6
7	G			GENESIS LAB	1.00	LAB	7
8							8
9							9
10							10

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	5	Administrative & Gen ADMINISTRATIVE	98,627	98,627						1
2	15	Pharmacy PHARMACY	3,600	3,600						2
3	30	Adults & Pediatrics ADULTS & PEDIAT	1,577,770	1,577,770						3
4	31	Intensive Care Unit INTENSIVE CARE	143,341	63,498	79,843	211,500	591	60,095	3,005	4
5	44	Skilled Nursing Faci SKILLED NURSING	36,400	2,800	33,600	211,500	240	24,404	1,220	5
6	50	Operating Room OPERATING ROOM	49,766	49,766						6
7	53	Anesthesiology ANESTHESIOLOGY	859,920	859,920						7
8	54	Radiology-Diagnostic RADIOLOGY - DIA	33,545	11,046	22,499	271,900	142	18,562	928	8
9	57	CT Scan CT SCAN	2,225	2,225						9
10	65	Respiratory Therapy RESPIRATORY THE	5,448	3,942	1,506	211,500	9	915	46	10
11	69	Electrocardiology ELECTRO CARDIOL	86,574	86,574						11
12	90	Clinic CLINIC	371,156	364,018	7,138	211,500	55	5,592	280	12
13	90.03	WOUND CARE WOUND CARE	16,200	2,550	13,650	211,500	91	9,253	463	13
14	91	Emergency EMERGENCY	2,533,613	2,533,613						14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	5,818,185	5,659,949	158,236		1,128	118,821	5,942	200

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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5	Administrative & Gen ADMINISTRATIVE							98,627	1
2	15	Pharmacy PHARMACY							3,600	2
3	30	Adults & Pediatrics ADULTS & PEDIAT							1,577,770	3
4	31	Intensive Care Unit INTENSIVE CARE					60,095	19,748	83,246	4
5	44	Skilled Nursing Faci SKILLED NURSING					24,404	9,196	11,996	5
6	50	Operating Room OPERATING ROOM							49,766	6
7	53	Anesthesiology ANESTHESIOLOGY							859,920	7
8	54	Radiology-Diagnostic RADIOLOGY - DIA					18,562	3,937	14,983	8
9	57	CT Scan CT SCAN							2,225	9
10	65	Respiratory Therapy RESPIRATORY THE					915	591	4,533	10
11	69	Electrocardiology ELECTRO CARDIOL							86,574	11
12	90	Clinic CLINIC					5,592	1,546	365,564	12
13	90.03	WOUND CARE WOUND CARE					9,253	4,397	6,947	13
14	91	Emergency EMERGENCY							2,533,613	14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					118,821	39,415	5,699,364	200

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COST ALLOCATION - GENERAL SERVICE COSTS
**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES		CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMEN T	SUBTOTAL (cols.0-4)	
		0	1	1.01	2	4	4A	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	6,474,215	6,474,215					1
1.01	CAP REL COSTS-BLDG & FIXT RIVER FOR	722,507		722,507				1.01
2	Cap Rel Costs-Mvble Equip	4,046,365			4,046,365			2
4	Employee Benefits Department	11,313,087				11,313,087		4
5	Administrative & General	28,496,261	420,072		250,319	1,050,539	30,217,191	5
7	Operation of Plant	6,089,604	1,675,816		998,608	298,441	9,062,469	7
7.01	OPERATION OF PLANT-RIVER FOREST	860,438		198,602	188,391	31,637	1,279,068	7.01
8	Laundry & Linen Service	814,936	21,700		12,931		849,567	8
9	Housekeeping	2,270,652	48,042		28,628	285,918	2,633,240	9
9.01	HOUSEKEEPING-RIVER FOREST	191,151					191,151	9.01
10	Dietary	1,384,276	217,284		129,479	228,197	1,959,236	10
11	Cafeteria							11
13	Nursing Administration	1,171,653	18,768		11,184	224,789	1,426,394	13
14	Central Services & Supply	625,355	78,654		46,870	52,093	802,972	14
15	Pharmacy	2,231,208	47,035		28,028	306,807	2,613,078	15
16	Medical Records & Library	1,488,818	9,205		5,485	223,166	1,726,674	16
21	I&R Services-Salary & Fringes Apprvd	4,500,837				880,805	5,381,642	21
22	I&R Services-Other Prgm Costs Apprvd	1,762,349	103,721		61,807	49,951	1,977,828	22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	10,589,579	820,280		488,802	1,886,105	13,784,766	30
31	Intensive Care Unit	2,816,813	200,786		119,648	412,313	3,549,560	31
43	Nursery	917,666	10,429		6,215	168,848	1,103,158	43
44	Skilled Nursing Facility	2,469,623	206,320		122,945	436,823	3,235,711	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,907,741	363,042		216,335	647,472	6,134,590	50
51	Recovery Room	637,900				119,973	757,873	51
52	Delivery Room & Labor Room	2,305,390	224,335		133,680	407,433	3,070,838	52
53	Anesthesiology	191,820	9,065		5,402	20,634	226,921	53
54	Radiology-Diagnostic	3,851,689	261,743	48,033	201,535	533,050	4,896,050	54
55.01	GASTRO INTESTINAL SERVICES	1,032,749	248,790		148,253	157,880	1,587,672	55.01
55.02	ULTRA SOUND	801,399				149,424	950,823	55.02
56	Radioisotope	280,726	36,694		21,866	40,492	379,778	56
57	CT Scan	1,003,539		35,033	33,232	136,643	1,208,447	57
58	MRI	464,963				52,350	517,313	58
59	Cardiac Catheterization	1,498,761	39,091		23,294	104,748	1,665,894	59
60	Laboratory	3,740,669	187,309		111,617	121,314	4,160,909	60
63	Blood Storing, Processing & Trans.	517,208	8,632		5,144		530,984	63
65	Respiratory Therapy	1,090,824	44,510		26,523	195,721	1,357,578	65
66	Physical Therapy	2,265,164	31,365	56,851	72,618	419,762	2,845,760	66
67	Occupational Therapy	230,221				43,439	273,660	67
68	Speech Pathology	163,652	19,074		11,366	33,262	227,354	68
69	Electrocardiology	684,338	35,993	39,238	58,669	120,806	939,044	69
71	Medical Supplies Charged to Patients	2,039,639					2,039,639	71
72	Impl. Dev. Charged to Patients	2,474,877					2,474,877	72
73	Drugs Charged to Patients	5,269,525					5,269,525	73
74	Renal Dialysis	778,371	6,821		4,065		789,257	74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	2,111,663	79,738		47,516	346,628	2,585,545	90
90.01	DIABETOLOGY	105,936				20,548	126,484	90.01
90.02	CANCER CENTER	3,184,650		102,625	97,349	101,169	3,485,793	90.02
90.03	WOUND CARE	861,422				4,161	865,583	90.03
91	Emergency	5,427,012	481,948		287,191	862,239	7,058,390	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	139,159,241	5,956,262	480,382	4,004,995	11,175,580	138,220,286	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	471	28,088		16,738		45,297	190
192	Physicians' Private Offices		448,530				448,530	192
194	MARKETING	537,592				33,649	571,241	194
194.0 1	HOSPITALIST							194.0 1
194.0 2	RETAIL PHARMACY	528,745		2,042		50,538	581,325	194.0 2
194.0 3	COMMUNITY RELATIONS	143,649				14,166	157,815	194.0 3

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES		CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMEN T	SUBTOTAL (cols.0-4)	
		0	1	1.01	2	4	4A	
194.0 4	PHYSICIAN CLINICS	132,367	41,335		24,632	25,829	224,163	194.0 4
194.0 5	GUEST MEALS							194.0 5
194.0 6	CATERING MEALS							194.0 6
194.0 7	RESEARCH,RIVER FOREST NONREIMB	78,911		240,083		13,325	332,319	194.0 7
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	140,580,976	6,474,215	722,507	4,046,365	11,313,087	140,580,976	202

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COST ALLOCATION - GENERAL SERVICE COSTS
**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT		LAUNDRY & LINEN SERVICE	HOUSE- KEEPING		
		5	7	7.01	8	9	9.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-BLDG & FIXT RIVER FOR							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General	30,217,191						5
7	Operation of Plant	2,481,268	11,543,737					7
7.01	OPERATION OF PLANT-RIVER FOREST	350,204		1,629,272				7.01
8	Laundry & Linen Service	232,608	57,214		1,139,389			8
9	Housekeeping	720,971	126,665			3,480,876		9
9.01	HOUSEKEEPING-RIVER FOREST	52,336					243,487	9.01
10	Dietary	536,431	572,884			175,543		10
11	Cafeteria							11
13	Nursing Administration	390,541	49,483			15,162		13
14	Central Services & Supply	219,851	207,377		926	63,544		14
15	Pharmacy	715,450	124,009			37,999		15
16	Medical Records & Library	472,756	24,271			7,437		16
21	I&R Services-Salary & Fringes Apprvd	1,473,472						21
22	I&R Services-Other Prgm Costs Apprvd	541,521	273,466			83,795		22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,774,243	2,162,719		508,874	662,698		30
31	Intensive Care Unit	971,855	529,385		108,830	162,214		31
43	Nursery	302,040	27,498			8,426		43
44	Skilled Nursing Facility	885,925	543,974		131,128	166,684		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,679,626	957,182		122,012	293,299		50
51	Recovery Room	207,503						51
52	Delivery Room & Labor Room	840,783	591,474		5,506	181,239		52
53	Anesthesiology	62,130	23,901			7,324		53
54	Radiology-Diagnostic	1,340,519	690,103	149,375	62,716	211,461	22,323	54
55.01	GASTRO INTESTINAL SERVICES	434,698	655,949		18,454	200,995		55.01
55.02	ULTRA SOUND	260,332						55.02
56	Radioisotope	103,982	96,747			29,645		56
57	CT Scan	330,868		108,949			16,282	57
58	MRI	141,638						58
59	Cardiac Catheterization	456,115	103,067		2,100	31,582		59
60	Laboratory	1,139,240	493,853			151,326		60
63	Blood Storing, Processing & Trans.	145,381	22,758			6,973		63
65	Respiratory Therapy	371,699	117,353		1,932	35,959		65
66	Physical Therapy	779,158	82,695	176,799	5,884	25,339	26,422	66
67	Occupational Therapy	74,927						67
68	Speech Pathology	62,249	50,290			15,410		68
69	Electrocardiology	257,106	94,898	122,025	913	29,079	18,236	69
71	Medical Supplies Charged to Patients	558,445						71
72	Impl. Dev. Charged to Patients	677,611						72
73	Drugs Charged to Patients	1,442,775						73
74	Renal Dialysis	216,095	17,985		1,914	5,511		74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	707,912	210,235		4,968	64,420		90
90.01	DIABETOLOGY	34,631						90.01
90.02	CANCER CENTER	954,396		319,149			47,695	90.02
90.03	WOUND CARE	236,993						90.03
91	Emergency	1,932,559	1,270,685		163,232	389,362		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	29,570,843	10,178,120	876,297	1,139,389	3,062,426	130,958	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	12,402	74,056			22,692		190
192	Physicians' Private Offices	122,806	1,182,578			362,364		192
194	MARKETING	156,404						194
194.0	HOSPITALIST							194.0
1								1
194.0	RETAIL PHARMACY	159,164		6,352			949	194.0
2								2
194.0	COMMUNITY RELATIONS	43,209						194.0
3								3
194.0	PHYSICIAN CLINICS	61,375	108,983			33,394		194.0
4								4

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT		LAUNDRY & LINEN SERVICE	HOUSE- KEEPING		
		5	7	7.01	8	9	9.01	
194.0 5	GUEST MEALS							194.0 5
194.0 6	CATERING MEALS							194.0 6
194.0 7	RESEARCH,RIVER FOREST NONREIMB	90,988		746,623			111,580	194.0 7
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	30,217,191	11,543,737	1,629,272	1,139,389	3,480,876	243,487	202

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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COST ALLOCATION - GENERAL SERVICE COSTS
**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10	11	13	14	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-BLDG & FIXT RIVER FOR							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
7.01	OPERATION OF PLANT-RIVER FOREST							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
9.01	HOUSEKEEPING-RIVER FOREST							9.01
10	Dietary	3,244,094						10
11	Cafeteria	1,583,741	1,583,741					11
13	Nursing Administration		37,800	1,919,380				13
14	Central Services & Supply		8,760		1,303,430			14
15	Pharmacy		51,592			3,542,128		15
16	Medical Records & Library		37,527				2,268,665	16
21	I&R Services-Salary & Fringes Apprvd		148,114					21
22	I&R Services-Other Prgm Costs Apprvd		8,400					22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	829,282	317,139	707,109			249,400	30
31	Intensive Care Unit	126,846	69,333	151,916			49,213	31
43	Nursery		28,393	46,884			37,194	43
44	Skilled Nursing Facility	337,638	73,455	174,861			13,930	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		108,877	224,206			190,601	50
51	Recovery Room		20,174	29,577			40,029	51
52	Delivery Room & Labor Room		68,513	124,887			46,270	52
53	Anesthesiology		3,470	10,251			28,148	53
54	Radiology-Diagnostic		89,636				127,465	54
55.01	GASTRO INTESTINAL SERVICES		26,549	53,401			85,437	55.01
55.02	ULTRA SOUND		25,127				46,705	55.02
56	Radioisotope		6,809				15,437	56
57	CT Scan		22,977				154,115	57
58	MRI		8,803				35,856	58
59	Cardiac Catheterization		17,614	25,057			56,898	59
60	Laboratory		20,400				231,736	60
63	Blood Storing, Processing & Trans.						13,875	63
65	Respiratory Therapy		32,912				55,659	65
66	Physical Therapy		70,586				61,297	66
67	Occupational Therapy		7,305				10,636	67
68	Speech Pathology		5,593				4,254	68
69	Electrocardiology		20,314	46,099			49,549	69
71	Medical Supplies Charged to Patients				586,544		79,178	71
72	Impl. Dev. Charged to Patients				716,886		47,636	72
73	Drugs Charged to Patients					3,542,128	230,026	73
74	Renal Dialysis						4,890	74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		58,288				17,888	90
90.01	DIABETOLOGY		3,455				208	90.01
90.02	CANCER CENTER		17,012				4,986	90.02
90.03	WOUND CARE		700				17,128	90.03
91	Emergency		144,992	325,132			263,021	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,877,507	1,560,619	1,919,380	1,303,430	3,542,128	2,268,665	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	366,587						192
194	MARKETING		5,658					194
194.0	HOSPITALIST							194.0
1								1
194.0	RETAIL PHARMACY		8,498					194.0
2								2
194.0	COMMUNITY RELATIONS		2,382					194.0
3								3
194.0	PHYSICIAN CLINICS		4,343					194.0
4								4

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10	11	13	14	15	16	
194.0 5	GUEST MEALS							194.0 5
194.0 6	CATERING MEALS							194.0 6
194.0 7	RESEARCH,RIVER FOREST NONREIMB		2,241					194.0 7
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,244,094	1,583,741	1,919,380	1,303,430	3,542,128	2,268,665	202

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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COST ALLOCATION - GENERAL SERVICE COSTS**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	I&R SALARY & FRINGES 21	I&R PROGRAM COSTS 22	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-BLDG & FIXT RIVER FOR							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
7.01	OPERATION OF PLANT-RIVER FOREST							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
9.01	HOUSEKEEPING-RIVER FOREST							9.01
10	Dietary							10
11	Cafeteria							11
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
21	I&R Services-Salary & Fringes Apprvd	7,003,228						21
22	I&R Services-Other Prgm Costs Apprvd		2,885,010					22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,973,192	2,872,636	32,842,058	-9,845,828	22,996,230		30
31	Intensive Care Unit			5,719,152		5,719,152		31
43	Nursery			1,553,593		1,553,593		43
44	Skilled Nursing Facility			5,563,306		5,563,306		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			9,710,393		9,710,393		50
51	Recovery Room			1,055,156		1,055,156		51
52	Delivery Room & Labor Room			4,929,510		4,929,510		52
53	Anesthesiology			362,145		362,145		53
54	Radiology-Diagnostic			7,589,648		7,589,648		54
55.01	GASTRO INTESTINAL SERVICES			3,063,155		3,063,155		55.01
55.02	ULTRA SOUND			1,282,987		1,282,987		55.02
56	Radioisotope			632,398		632,398		56
57	CT Scan			1,841,638		1,841,638		57
58	MRI			703,610		703,610		58
59	Cardiac Catheterization			2,358,327		2,358,327		59
60	Laboratory			6,197,464		6,197,464		60
63	Blood Storing, Processing & Trans.			719,971		719,971		63
65	Respiratory Therapy			1,973,092		1,973,092		65
66	Physical Therapy			4,073,940		4,073,940		66
67	Occupational Therapy			366,528		366,528		67
68	Speech Pathology			365,150		365,150		68
69	Electrocardiology			1,577,263		1,577,263		69
71	Medical Supplies Charged to Patients			3,263,806		3,263,806		71
72	Impl. Dev. Charged to Patients			3,917,010		3,917,010		72
73	Drugs Charged to Patients			10,484,454		10,484,454		73
74	Renal Dialysis			1,035,652		1,035,652		74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			3,649,256		3,649,256		90
90.01	DIABETOLOGY			164,778		164,778		90.01
90.02	CANCER CENTER			4,829,031		4,829,031		90.02
90.03	WOUND CARE			1,120,404		1,120,404		90.03
91	Emergency	30,036	12,374	11,589,783	-42,410	11,547,373		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	7,003,228	2,885,010	134,534,658	-9,888,238	124,646,420		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			154,447		154,447		190
192	Physicians' Private Offices			2,482,865		2,482,865		192
194	MARKETING			733,303		733,303		194
194.0	HOSPITALIST							194.0
1								1
194.0	RETAIL PHARMACY			756,288		756,288		194.0
2								2
194.0	COMMUNITY RELATIONS			203,406		203,406		194.0
3								3
194.0	PHYSICIAN CLINICS			432,258		432,258		194.0
4								4

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	I&R SALARY & FRINGES 21	I&R PROGRAM COSTS 22	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26		
194.0 5	GUEST MEALS							194.0 5
194.0 6	CATERING MEALS							194.0 6
194.0 7	RESEARCH,RIVER FOREST NONREIMB			1,283,751		1,283,751		194.0 7
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	7,003,228	2,885,010	140,580,976	-9,888,238	130,692,738		202

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES		CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	
		0	1	1.01	2	2A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-BLDG & FIXT RIVER FOR							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		420,072		250,319	670,391	670,391	5
7	Operation of Plant		1,675,816		998,608	2,674,424	55,045	7
7.01	OPERATION OF PLANT-RIVER FOREST			198,602	188,391	386,993	7,769	7.01
8	Laundry & Linen Service		21,700		12,931	34,631	5,160	8
9	Housekeeping		48,042		28,628	76,670	15,994	9
9.01	HOUSEKEEPING-RIVER FOREST						1,161	9.01
10	Dietary		217,284		129,479	346,763	11,900	10
11	Cafeteria							11
13	Nursing Administration		18,768		11,184	29,952	8,664	13
14	Central Services & Supply		78,654		46,870	125,524	4,877	14
15	Pharmacy		47,035		28,028	75,063	15,872	15
16	Medical Records & Library		9,205		5,485	14,690	10,488	16
21	I&R Services-Salary & Fringes Apprvd						32,688	21
22	I&R Services-Other Prgm Costs Apprvd		103,721		61,807	165,528	12,013	22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		820,280		488,802	1,309,082	83,770	30
31	Intensive Care Unit		200,786		119,648	320,434	21,560	31
43	Nursery		10,429		6,215	16,644	6,701	43
44	Skilled Nursing Facility		206,320		122,945	329,265	19,654	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		363,042		216,335	579,377	37,261	50
51	Recovery Room						4,603	51
52	Delivery Room & Labor Room		224,335		133,680	358,015	18,652	52
53	Anesthesiology		9,065		5,402	14,467	1,378	53
54	Radiology-Diagnostic		261,743	48,033	201,535	511,311	29,739	54
55.01	GASTRO INTESTINAL SERVICES		248,790		148,253	397,043	9,644	55.01
55.02	ULTRA SOUND						5,775	55.02
56	Radioisotope		36,694		21,866	58,560	2,307	56
57	CT Scan			35,033	33,232	68,265	7,340	57
58	MRI						3,142	58
59	Cardiac Catheterization		39,091		23,294	62,385	10,119	59
60	Laboratory		187,309		111,617	298,926	25,273	60
63	Blood Storing, Processing & Trans.		8,632		5,144	13,776	3,225	63
65	Respiratory Therapy		44,510		26,523	71,033	8,246	65
66	Physical Therapy		31,365	56,851	72,618	160,834	17,285	66
67	Occupational Therapy						1,662	67
68	Speech Pathology		19,074		11,366	30,440	1,381	68
69	Electrocardiology		35,993	39,238	58,669	133,900	5,704	69
71	Medical Supplies Charged to Patients						12,389	71
72	Impl. Dev. Charged to Patients						15,032	72
73	Drugs Charged to Patients						32,007	73
74	Renal Dialysis		6,821		4,065	10,886	4,794	74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		79,738		47,516	127,254	15,705	90
90.01	DIABETOLOGY						768	90.01
90.02	CANCER CENTER			102,625	97,349	199,974	21,173	90.02
90.03	WOUND CARE						5,258	90.03
91	Emergency		481,948		287,191	769,139	42,873	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		5,956,262	480,382	4,004,995	10,441,639	656,051	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		28,088		16,738	44,826	275	190
192	Physicians' Private Offices		448,530			448,530	2,724	192
194	MARKETING						3,470	194
194.0	HOSPITALIST							194.0
1								1
194.0	RETAIL PHARMACY			2,042		2,042	3,531	194.0
2								2
194.0	COMMUNITY RELATIONS						959	194.0
3								3
194.0	PHYSICIAN CLINICS		41,335		24,632	65,967	1,362	194.0
4								4

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES		CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	
		0	1	1.01	2	2A	5	
194.0 5	GUEST MEALS							194.0 5
194.0 6	CATERING MEALS							194.0 6
194.0 7	RESEARCH,RIVER FOREST NONREIMB			240,083		240,083	2,019	194.0 7
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		6,474,215	722,507	4,046,365	11,243,087	670,391	202

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT		LAUNDRY & LINEN SERVICE	HOUSE- KEEPING		DIETARY	
		7	7.01	8	9	9.01	10	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-BLDG & FIXT RIVER FOR							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant	2,729,469						7
7.01	OPERATION OF PLANT-RIVER FOREST		394,762					7.01
8	Laundry & Linen Service	13,528		53,319				8
9	Housekeeping	29,949			122,613			9
9.01	HOUSEKEEPING-RIVER FOREST					1,161		9.01
10	Dietary	135,456			6,183		500,302	10
11	Cafeteria						244,244	11
13	Nursing Administration	11,700			534			13
14	Central Services & Supply	49,033		43	2,238			14
15	Pharmacy	29,322			1,338			15
16	Medical Records & Library	5,739			262			16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	64,660			2,952			22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	511,368		23,813	23,346		127,891	30
31	Intensive Care Unit	125,171		5,093	5,714		19,562	31
43	Nursery	6,502			297			43
44	Skilled Nursing Facility	128,620		6,136	5,871		52,070	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	226,322		5,710	10,331			50
51	Recovery Room							51
52	Delivery Room & Labor Room	139,851		258	6,384			52
53	Anesthesiology	5,651			258			53
54	Radiology-Diagnostic	163,172	36,193	2,935	7,449	106		54
55.01	GASTRO INTESTINAL SERVICES	155,096		864	7,080			55.01
55.02	ULTRA SOUND							55.02
56	Radioisotope	22,875			1,044			56
57	CT Scan		26,398			78		57
58	MRI							58
59	Cardiac Catheterization	24,370		98	1,112			59
60	Laboratory	116,769			5,330			60
63	Blood Storing, Processing & Trans.	5,381			246			63
65	Respiratory Therapy	27,748		90	1,267			65
66	Physical Therapy	19,553	42,837	275	893	126		66
67	Occupational Therapy							67
68	Speech Pathology	11,891			543			68
69	Electrocardiology	22,438	29,566	43	1,024	87		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	4,252		90	194			74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	49,709		232	2,269			90
90.01	DIABETOLOGY							90.01
90.02	CANCER CENTER		77,328			227		90.02
90.03	WOUND CARE							90.03
91	Emergency	300,448		7,639	13,715			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,406,574	212,322	53,319	107,874	624	443,767	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	17,510			799			190
192	Physicians' Private Offices	279,616			12,764		56,535	192
194	MARKETING							194
194.0	HOSPITALIST							194.0
1								1
194.0	RETAIL PHARMACY		1,539			5		194.0
2								2
194.0	COMMUNITY RELATIONS							194.0
3								3
194.0	PHYSICIAN CLINICS	25,769			1,176			194.0
4								4

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT		LAUNDRY & LINEN SERVICE	HOUSE- KEEPING		DIETARY	
		7	7.01	8	9	9.01	10	
194.0 5	GUEST MEALS							194.0 5
194.0 6	CATERING MEALS							194.0 6
194.0 7	RESEARCH,RIVER FOREST NONREIMB		180,901			532		194.0 7
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,729,469	394,762	53,319	122,613	1,161	500,302	202

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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I&R SALARY & FRINGES	
		11	13	14	15	16	21	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-BLDG & FIXT RIVER FOR							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
7.01	OPERATION OF PLANT-RIVER FOREST							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
9.01	HOUSEKEEPING-RIVER FOREST							9.01
10	Dietary							10
11	Cafeteria	244,244						11
13	Nursing Administration	5,829	56,679					13
14	Central Services & Supply	1,351		183,066				14
15	Pharmacy	7,956			129,551			15
16	Medical Records & Library	5,787				36,966		16
21	I&R Services-Salary & Fringes Apprvd	22,842					55,530	21
22	I&R Services-Other Prgm Costs Apprvd	1,295						22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	48,911	20,881			4,038		30
31	Intensive Care Unit	10,692	4,486			797		31
43	Nursery	4,379	1,384			602		43
44	Skilled Nursing Facility	11,328	5,164			226		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	16,791	6,621			3,086		50
51	Recovery Room	3,111	873			648		51
52	Delivery Room & Labor Room	10,566	3,688			749		52
53	Anesthesiology	535	303			456		53
54	Radiology-Diagnostic	13,823				2,064		54
55.01	GASTRO INTESTINAL SERVICES	4,094	1,577			1,383		55.01
55.02	ULTRA SOUND	3,875				756		55.02
56	Radioisotope	1,050				250		56
57	CT Scan	3,544				2,495		57
58	MRI	1,358				581		58
59	Cardiac Catheterization	2,716	740			921		59
60	Laboratory	3,146				3,752		60
63	Blood Storing, Processing & Trans.					225		63
65	Respiratory Therapy	5,076				901		65
66	Physical Therapy	10,886				992		66
67	Occupational Therapy	1,126				172		67
68	Speech Pathology	863				69		68
69	Electrocardiology	3,133	1,361			802		69
71	Medical Supplies Charged to Patients			82,380		1,282		71
72	Impl. Dev. Charged to Patients			100,686		771		72
73	Drugs Charged to Patients				129,551	3,724		73
74	Renal Dialysis					79		74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	8,989				290		90
90.01	DIABETOLOGY	533				3		90.01
90.02	CANCER CENTER	2,624				81		90.02
90.03	WOUND CARE	108				277		90.03
91	Emergency	22,360	9,601			4,494		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	240,677	56,679	183,066	129,551	36,966		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	MARKETING	873						194
194.0	HOSPITALIST							194.0
1								1
194.0	RETAIL PHARMACY	1,311						194.0
2								2
194.0	COMMUNITY RELATIONS	367						194.0
3								3
194.0	PHYSICIAN CLINICS	670						194.0
4								4

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I&R SALARY & FRINGES	
		11	13	14	15	16	21	
194.0 5	GUEST MEALS							194.0 5
194.0 6	CATERING MEALS							194.0 6
194.0 7	RESEARCH,RIVER FOREST NONREIMB	346						194.0 7
200	Cross Foot Adjustments						55,530	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	244,244	56,679	183,066	129,551	36,966	55,530	202

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ALLOCATION OF CAPITAL-RELATED COSTS**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	I&R PROGRAM COSTS 22	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-BLDG & FIXT RIVER FOR							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
7.01	OPERATION OF PLANT-RIVER FOREST							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
9.01	HOUSEKEEPING-RIVER FOREST							9.01
10	Dietary							10
11	Cafeteria							11
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	246,448						22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		2,153,100		2,153,100			30
31	Intensive Care Unit		513,509		513,509			31
43	Nursery		36,509		36,509			43
44	Skilled Nursing Facility		558,334		558,334			44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		885,499		885,499			50
51	Recovery Room		9,235		9,235			51
52	Delivery Room & Labor Room		538,163		538,163			52
53	Anesthesiology		23,048		23,048			53
54	Radiology-Diagnostic		766,792		766,792			54
55.01	GASTRO INTESTINAL SERVICES		576,781		576,781			55.01
55.02	ULTRA SOUND		10,406		10,406			55.02
56	Radioisotope		86,086		86,086			56
57	CT Scan		108,120		108,120			57
58	MRI		5,081		5,081			58
59	Cardiac Catheterization		102,461		102,461			59
60	Laboratory		453,196		453,196			60
63	Blood Storing, Processing & Trans.		22,853		22,853			63
65	Respiratory Therapy		114,361		114,361			65
66	Physical Therapy		253,681		253,681			66
67	Occupational Therapy		2,960		2,960			67
68	Speech Pathology		45,187		45,187			68
69	Electrocardiology		198,058		198,058			69
71	Medical Supplies Charged to Patients		96,051		96,051			71
72	Impl. Dev. Charged to Patients		116,489		116,489			72
73	Drugs Charged to Patients		165,282		165,282			73
74	Renal Dialysis		20,295		20,295			74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		204,448		204,448			90
90.01	DIABETOLOGY		1,304		1,304			90.01
90.02	CANCER CENTER		301,407		301,407			90.02
90.03	WOUND CARE		5,643		5,643			90.03
91	Emergency		1,170,269		1,170,269			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		9,544,608		9,544,608			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		63,410		63,410			190
192	Physicians' Private Offices		800,169		800,169			192
194	MARKETING		4,343		4,343			194
194.0	HOSPITALIST							194.0
1								1
194.0	RETAIL PHARMACY		8,428		8,428			194.0
2								2
194.0	COMMUNITY RELATIONS		1,326		1,326			194.0
3								3
194.0	PHYSICIAN CLINICS		94,944		94,944			194.0
4								4

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		22	24	25	26			
194.0 5	GUEST MEALS							194.0 5
194.0 6	CATERING MEALS							194.0 6
194.0 7	RESEARCH,RIVER FOREST NONREIMB		423,881		423,881			194.0 7
200	Cross Foot Adjustments	246,448	301,978		301,978			200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	246,448	11,243,087		11,243,087			202

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COST ALLOCATION - STATISTICAL BASIS
WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMEN T GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
		1	1.01	2	4	5A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	507,784						1
1.01	CAP REL COSTS-BLDG & FIXT RIVER FOR		90,207					1.01
2	Cap Rel Costs-Mvble Equip			532,582				2
4	Employee Benefits Department				57,808,800			4
5	Administrative & General	32,947		32,947	5,368,166	-30,217,191	110,363,785	5
7	Operation of Plant	131,437		131,437	1,525,006		9,062,469	7
7.01	OPERATION OF PLANT-RIVER FOREST		24,796	24,796	161,660		1,279,068	7.01
8	Laundry & Linen Service	1,702		1,702			849,567	8
9	Housekeeping	3,768		3,768	1,461,014		2,633,240	9
9.01	HOUSEKEEPING-RIVER FOREST						191,151	9.01
10	Dietary	17,042		17,042	1,166,067		1,959,236	10
11	Cafeteria							11
13	Nursing Administration	1,472		1,472	1,148,652		1,426,394	13
14	Central Services & Supply	6,169		6,169	266,190		802,972	14
15	Pharmacy	3,689		3,689	1,567,758		2,613,078	15
16	Medical Records & Library	722		722	1,140,361		1,726,674	16
21	I&R Services-Salary & Fringes Apprvd				4,500,837		5,381,642	21
22	I&R Services-Other Prgm Costs Apprvd	8,135		8,135	255,244		1,977,828	22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	64,336		64,336	9,637,742		13,784,766	30
31	Intensive Care Unit	15,748		15,748	2,106,886		3,549,560	31
43	Nursery	818		818	862,801		1,103,158	43
44	Skilled Nursing Facility	16,182		16,182	2,232,130		3,235,711	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	28,474		28,474	3,308,526		6,134,590	50
51	Recovery Room				613,050		757,873	51
52	Delivery Room & Labor Room	17,595		17,595	2,081,946		3,070,838	52
53	Anesthesiology	711		711	105,436		226,921	53
54	Radiology-Diagnostic	20,529	5,997	26,526	2,723,842		4,896,050	54
55.01	GASTRO INTESTINAL SERVICES	19,513		19,513	806,755		1,587,672	55.01
55.02	ULTRA SOUND				763,544		950,823	55.02
56	Radioisotope	2,878		2,878	206,912		379,778	56
57	CT Scan		4,374	4,374	698,233		1,208,447	57
58	MRI				267,503		517,313	58
59	Cardiac Catheterization	3,066		3,066	535,252		1,665,894	59
60	Laboratory	14,691		14,691	619,902		4,160,909	60
63	Blood Storing, Processing & Trans.	677		677			530,984	63
65	Respiratory Therapy	3,491		3,491	1,000,115		1,357,578	65
66	Physical Therapy	2,460	7,098	9,558	2,144,950		2,845,760	66
67	Occupational Therapy				221,969		273,660	67
68	Speech Pathology	1,496		1,496	169,965		227,354	68
69	Electrocardiology	2,823	4,899	7,722	617,308		939,044	69
71	Medical Supplies Charged to Patients						2,039,639	71
72	Impl. Dev. Charged to Patients						2,474,877	72
73	Drugs Charged to Patients						5,269,525	73
74	Renal Dialysis	535		535			789,257	74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	6,254		6,254	1,771,238		2,585,545	90
90.01	DIABETOLOGY				104,999		126,484	90.01
90.02	CANCER CENTER		12,813	12,813	516,964		3,485,793	90.02
90.03	WOUND CARE				21,262		865,583	90.03
91	Emergency	37,800		37,800	4,405,967		7,058,390	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	467,160	59,977	527,137	57,106,152	-30,217,191	108,003,095	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	2,203		2,203			45,297	190
192	Physicians' Private Offices	35,179					448,530	192
194	MARKETING				171,942		571,241	194
194.0 1	HOSPITALIST							194.0 1
194.0 2	RETAIL PHARMACY		255		258,244		581,325	194.0 2
194.0 3	COMMUNITY RELATIONS				72,389		157,815	194.0 3

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COST ALLOCATION - STATISTICAL BASIS**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMEN T GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
		1	1.01	2	4	5A	5	
194.0 4	PHYSICIAN CLINICS	3,242		3,242	131,983		224,163	194.0 4
194.0 5	GUEST MEALS							194.0 5
194.0 6	CATERING MEALS							194.0 6
194.0 7	RESEARCH,RIVER FOREST NONREIMB		29,975		68,090		332,319	194.0 7
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	6,474,215	722,507	4,046,365	11,313,087		30,217,191	202
203	Unit Cost Multiplier (Wkst. B, Part I)	12.749939	8.009434	7.597638	0.195698		0.273796	203
204	Cost to be allocated (Per Wkst. B, Part II)						670,391	204
205	Unit Cost Multiplier (Wkst. B, Part II)						0.006074	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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COST ALLOCATION - STATISTICAL BASIS
WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING SQUARE FEET	SQUARE FEET	DIETARY MEALS SERVED	
		7	7.01	8	9	9.01	10	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-BLDG & FIXT RIVER FOR							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant	343,400						7
7.01	OPERATION OF PLANT-RIVER FOREST		65,411					7.01
8	Laundry & Linen Service	1,702		1,194,949				8
9	Housekeeping	3,768			337,930			9
9.01	HOUSEKEEPING-RIVER FOREST					65,411		9.01
10	Dietary	17,042			17,042		391,553	10
11	Cafeteria						191,153	11
13	Nursing Administration	1,472			1,472			13
14	Central Services & Supply	6,169		971	6,169			14
15	Pharmacy	3,689			3,689			15
16	Medical Records & Library	722			722			16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	8,135			8,135			22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	64,336		533,689	64,336		100,092	30
31	Intensive Care Unit	15,748		114,137	15,748		15,310	31
43	Nursery	818			818			43
44	Skilled Nursing Facility	16,182		137,522	16,182		40,752	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	28,474		127,962	28,474			50
51	Recovery Room							51
52	Delivery Room & Labor Room	17,595		5,775	17,595			52
53	Anesthesiology	711			711			53
54	Radiology-Diagnostic	20,529	5,997	65,774	20,529	5,997		54
55.01	GASTRO INTESTINAL SERVICES	19,513		19,354	19,513			55.01
55.02	ULTRA SOUND							55.02
56	Radioisotope	2,878			2,878			56
57	CT Scan		4,374			4,374		57
58	MRI							58
59	Cardiac Catheterization	3,066		2,202	3,066			59
60	Laboratory	14,691			14,691			60
63	Blood Storing, Processing & Trans.	677			677			63
65	Respiratory Therapy	3,491		2,026	3,491			65
66	Physical Therapy	2,460	7,098	6,171	2,460	7,098		66
67	Occupational Therapy							67
68	Speech Pathology	1,496			1,496			68
69	Electrocardiology	2,823	4,899	957	2,823	4,899		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	535		2,007	535			74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	6,254		5,210	6,254			90
90.01	DIABETOLOGY							90.01
90.02	CANCER CENTER		12,813			12,813		90.02
90.03	WOUND CARE							90.03
91	Emergency	37,800		171,192	37,800			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	302,776	35,181	1,194,949	297,306	35,181	347,307	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	2,203			2,203			190
192	Physicians' Private Offices	35,179			35,179		44,246	192
194	MARKETING							194
194.0 1	HOSPITALIST							194.0 1
194.0 2	RETAIL PHARMACY		255			255		194.0 2
194.0 3	COMMUNITY RELATIONS							194.0 3

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COST ALLOCATION - STATISTICAL BASIS**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING SQUARE FEET	SQUARE FEET	DIETARY MEALS SERVED	
		7	7.01	8	9	9.01	10	
194.0 4	PHYSICIAN CLINICS	3,242			3,242			194.0 4
194.0 5	GUEST MEALS							194.0 5
194.0 6	CATERING MEALS							194.0 6
194.0 7	RESEARCH,RIVER FOREST NONREIMB		29,975			29,975		194.0 7
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	11,543,737	1,629,272	1,139,389	3,480,876	243,487	3,244,094	202
203	Unit Cost Multiplier (Wkst. B, Part I)	33.616008	24.908226	0.953504	10.300583	3.722417	8.285198	203
204	Cost to be allocated (Per Wkst. B, Part II)	2,729,469	394,762	53,319	122,613	1,161	500,302	204
205	Unit Cost Multiplier (Wkst. B, Part II)	7.948366	6.035101	0.044620	0.362835	0.017749	1.277738	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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COST ALLOCATION - STATISTICAL BASIS**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAFETERIA GROSS SALARIES	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS CHAR GES	I&R SALARY & FRINGES ASSIGNED TIME	
		11	13	14	15	16	21	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-BLDG & FIXT RIVER FOR							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
7.01	OPERATION OF PLANT-RIVER FOREST							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
9.01	HOUSEKEEPING-RIVER FOREST							9.01
10	Dietary							10
11	Cafeteria	48,126,887						11
13	Nursing Administration	1,148,652	797,035					13
14	Central Services & Supply	266,190		100				14
15	Pharmacy	1,567,758			100			15
16	Medical Records & Library	1,140,361				874,619,668		16
21	I&R Services-Salary & Fringes Apprvd	4,500,837					5,829	21
22	I&R Services-Other Prgm Costs Apprvd	255,244						22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,637,742	293,632			96,145,099	5,804	30
31	Intensive Care Unit	2,106,886	63,084			18,971,706		31
43	Nursery	862,801	19,469			14,338,662		43
44	Skilled Nursing Facility	2,232,130	72,612			5,369,944		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,308,526	93,103			73,477,555		50
51	Recovery Room	613,050	12,282			15,431,560		51
52	Delivery Room & Labor Room	2,081,946	51,860			17,837,280		52
53	Anesthesiology	105,436	4,257			10,851,028		53
54	Radiology-Diagnostic	2,723,842				49,138,492		54
55.01	GASTRO INTESTINAL SERVICES	806,755	22,175			32,936,505		55.01
55.02	ULTRA SOUND	763,544				18,004,916		55.02
56	Radioisotope	206,912				5,950,896		56
57	CT Scan	698,233				59,412,071		57
58	MRI	267,503				13,822,629		58
59	Cardiac Catheterization	535,252	10,405			21,934,607		59
60	Laboratory	619,902				89,335,527		60
63	Blood Storing, Processing & Trans.					5,348,771		63
65	Respiratory Therapy	1,000,115				21,456,975		65
66	Physical Therapy	2,144,950				23,630,266		66
67	Occupational Therapy	221,969				4,100,316		67
68	Speech Pathology	169,965				1,640,115		68
69	Electrocardiology	617,308	19,143			19,101,391		69
71	Medical Supplies Charged to Patients			45		30,523,551		71
72	Impl. Dev. Charged to Patients			55		18,363,833		72
73	Drugs Charged to Patients				100	88,676,297		73
74	Renal Dialysis					1,885,161		74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,771,238				6,895,993		90
90.01	DIABETOLOGY	104,999				80,356		90.01
90.02	CANCER CENTER	516,964				1,922,044		90.02
90.03	WOUND CARE	21,262				6,603,109		90.03
91	Emergency	4,405,967	135,013			101,433,013	25	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	47,424,239	797,035	100	100	874,619,668	5,829	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	MARKETING	171,942						194
194.0 1	HOSPITALIST							194.0 1
194.0 2	RETAIL PHARMACY	258,244						194.0 2
194.0 3	COMMUNITY RELATIONS	72,389						194.0 3

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COST ALLOCATION - STATISTICAL BASIS**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAFETERIA GROSS SALARIES	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS CHAR GES	I&R SALARY & FRINGES ASSIGNED TIME	
		11	13	14	15	16	21	
194.0 4	PHYSICIAN CLINICS	131,983						194.0 4
194.0 5	GUEST MEALS							194.0 5
194.0 6	CATERING MEALS							194.0 6
194.0 7	RESEARCH,RIVER FOREST NONREIMB	68,090						194.0 7
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,583,741	1,919,380	1,303,430	3,542,128	2,268,665	7,003,228	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.032908	2.408150	13,034.300000	35,421.280000	0.002594	1,201.445874	203
204	Cost to be allocated (Per Wkst. B, Part II)	244,244	56,679	183,066	129,551	36,966	55,530	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.005075	0.071112	1,830.660000	1,295.510000	0.000042	9.526505	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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COST ALLOCATION - STATISTICAL BASIS**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	I&R PROGRAM COSTS ASSIGNED TIME						
		22						

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-BLDG & FIXT RIVER FOR							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
7.01	OPERATION OF PLANT-RIVER FOREST							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
9.01	HOUSEKEEPING-RIVER FOREST							9.01
10	Dietary							10
11	Cafeteria							11
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	5,829						22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,804						30
31	Intensive Care Unit							31
43	Nursery							43
44	Skilled Nursing Facility							44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
55.01	GASTRO INTESTINAL SERVICES							55.01
55.02	ULTRA SOUND							55.02
56	Radioisotope							56
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
63	Blood Storing, Processing & Trans.							63
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	DIABETOLOGY							90.01
90.02	CANCER CENTER							90.02
90.03	WOUND CARE							90.03
91	Emergency	25						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,829						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	MARKETING							194
194.0	HOSPITALIST							194.0
1								1
194.0	RETAIL PHARMACY							194.0
2								2

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	I&R PROGRAM COSTS ASSIGNED TIME						
		22						
194.0 3	COMMUNITY RELATIONS							194.0 3
194.0 4	PHYSICIAN CLINICS							194.0 4
194.0 5	GUEST MEALS							194.0 5
194.0 6	CATERING MEALS							194.0 6
194.0 7	RESEARCH,RIVER FOREST NONREIMB							194.0 7
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,885,010						202
203	Unit Cost Multiplier (Wkst. B, Part I)	494.940813						203
204	Cost to be allocated (Per Wkst. B, Part II)	246,448						204
205	Unit Cost Multiplier (Wkst. B, Part II)	42.279636						205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

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COMPUTATION OF RATIO OF COST TO CHARGES**WORKSHEET C
PART I**

		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	22,996,230		22,996,230		22,996,230	30
31	Intensive Care Unit	5,719,152		5,719,152	19,748	5,738,900	31
43	Nursery	1,553,593		1,553,593		1,553,593	43
44	Skilled Nursing Facility	5,563,306		5,563,306	9,196	5,572,502	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	9,710,393		9,710,393		9,710,393	50
51	Recovery Room	1,055,156		1,055,156		1,055,156	51
52	Delivery Room & Labor Room	4,929,510		4,929,510		4,929,510	52
53	Anesthesiology	362,145		362,145		362,145	53
54	Radiology-Diagnostic	7,589,648		7,589,648	3,937	7,593,585	54
55.01	GASTRO INTESTINAL SERVICES	3,063,155		3,063,155		3,063,155	55.01
55.02	ULTRA SOUND	1,282,987		1,282,987		1,282,987	55.02
56	Radioisotope	632,398		632,398		632,398	56
57	CT Scan	1,841,638		1,841,638		1,841,638	57
58	MRI	703,610		703,610		703,610	58
59	Cardiac Catheterization	2,358,327		2,358,327		2,358,327	59
60	Laboratory	6,197,464		6,197,464		6,197,464	60
63	Blood Storing, Processing & Trans.	719,971		719,971		719,971	63
65	Respiratory Therapy	1,973,092		1,973,092	591	1,973,683	65
66	Physical Therapy	4,073,940		4,073,940		4,073,940	66
67	Occupational Therapy	366,528		366,528		366,528	67
68	Speech Pathology	365,150		365,150		365,150	68
69	Electrocardiology	1,577,263		1,577,263		1,577,263	69
71	Medical Supplies Charged to Patients	3,263,806		3,263,806		3,263,806	71
72	Impl. Dev. Charged to Patients	3,917,010		3,917,010		3,917,010	72
73	Drugs Charged to Patients	10,484,454		10,484,454		10,484,454	73
74	Renal Dialysis	1,035,652		1,035,652		1,035,652	74
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	3,649,256		3,649,256	1,546	3,650,802	90
90.01	DIABETOLOGY	164,778		164,778		164,778	90.01
90.02	CANCER CENTER	4,829,031		4,829,031		4,829,031	90.02
90.03	WOUND CARE	1,120,404		1,120,404	4,397	1,124,801	90.03
91	Emergency	11,547,373		11,547,373		11,547,373	91
92	Observation Beds (Non-Distinct Part)	1,372,031		1,372,031		1,372,031	92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	126,018,451		126,018,451	39,415	126,057,866	200
201	Less Observation Beds	1,372,031		1,372,031		1,372,031	201
202	Total (line 200 minus line 201)	124,646,420		124,646,420		124,685,835	202

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COMPUTATION OF RATIO OF COST TO CHARGES**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	91,418,089		91,418,089				30
31	Intensive Care Unit	18,971,706		18,971,706				31
43	Nursery	14,338,662		14,338,662				43
44	Skilled Nursing Facility	5,369,944		5,369,944				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	29,713,294	43,764,261	73,477,555	0.132155	0.132155	0.132155	50
51	Recovery Room	6,660,691	8,770,869	15,431,560	0.068376	0.068376	0.068376	51
52	Delivery Room & Labor Room	17,307,391	529,889	17,837,280	0.276360	0.276360	0.276360	52
53	Anesthesiology	3,482,705	7,368,323	10,851,028	0.033374	0.033374	0.033374	53
54	Radiology-Diagnostic	8,060,374	41,078,118	49,138,492	0.154454	0.154454	0.154534	54
55.01	GASTRO INTESTINAL SERVICES	4,819,480	28,117,025	32,936,505	0.093002	0.093002	0.093002	55.01
55.02	ULTRA SOUND	3,108,648	14,896,268	18,004,916	0.071258	0.071258	0.071258	55.02
56	Radioisotope	2,686,734	3,264,162	5,950,896	0.106269	0.106269	0.106269	56
57	CT Scan	19,109,633	40,302,438	59,412,071	0.030998	0.030998	0.030998	57
58	MRI	2,509,317	11,313,312	13,822,629	0.050903	0.050903	0.050903	58
59	Cardiac Catheterization	12,197,274	9,737,333	21,934,607	0.107516	0.107516	0.107516	59
60	Laboratory	54,283,026	35,052,501	89,335,527	0.069373	0.069373	0.069373	60
63	Blood Storing, Processing & Trans.	4,478,164	870,607	5,348,771	0.134605	0.134605	0.134605	63
65	Respiratory Therapy	18,398,984	3,057,991	21,456,975	0.091956	0.091956	0.091983	65
66	Physical Therapy	15,515,018	8,115,248	23,630,266	0.172403	0.172403	0.172403	66
67	Occupational Therapy	3,922,195	178,121	4,100,316	0.089390	0.089390	0.089390	67
68	Speech Pathology	1,564,927	75,188	1,640,115	0.222637	0.222637	0.222637	68
69	Electrocardiology	9,520,789	9,580,602	19,101,391	0.082573	0.082573	0.082573	69
71	Medical Supplies Charged to Patients	14,084,083	16,439,468	30,523,551	0.106927	0.106927	0.106927	71
72	Impl. Dev. Charged to Patients	10,129,193	8,234,640	18,363,833	0.213300	0.213300	0.213300	72
73	Drugs Charged to Patients	35,766,024	52,910,273	88,676,297	0.118233	0.118233	0.118233	73
74	Renal Dialysis	1,810,300	74,861	1,885,161	0.549371	0.549371	0.549371	74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	145,713	6,750,280	6,895,993	0.529185	0.529185	0.529409	90
90.01	DIABETOLOGY		80,356	80,356	2.050600	2.050600	2.050600	90.01
90.02	CANCER CENTER		1,922,044	1,922,044	2.512446	2.512446	2.512446	90.02
90.03	WOUND CARE	7,055	6,596,054	6,603,109	0.169678	0.169678	0.170344	90.03
91	Emergency	19,779,926	81,653,087	101,433,013	0.113842	0.113842	0.113842	91
92	Observation Beds (Non-Distinct Part)	395,391	4,331,619	4,727,010	0.290253	0.290253	0.290253	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	429,554,730	445,064,938	874,619,668				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	429,554,730	445,064,938	874,619,668				202

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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
31	Intensive Care Unit						31
43	Nursery						43
44	Skilled Nursing Facility						44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
51	Recovery Room						51
52	Delivery Room & Labor Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
55.01	GASTRO INTESTINAL SERVICES						55.01
55.02	ULTRA SOUND						55.02
56	Radioisotope						56
57	CT Scan						57
58	MRI						58
59	Cardiac Catheterization						59
60	Laboratory						60
63	Blood Storing, Processing & Trans.						63
65	Respiratory Therapy						65
66	Physical Therapy						66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology						69
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
90.01	DIABETOLOGY						90.01
90.02	CANCER CENTER						90.02
90.03	WOUND CARE						90.03
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)						200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)						202

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	91,418,089		91,418,089				30
31	Intensive Care Unit	18,971,706		18,971,706				31
43	Nursery	14,338,662		14,338,662				43
44	Skilled Nursing Facility	5,369,944		5,369,944				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	29,713,294	43,764,261	73,477,555				50
51	Recovery Room	6,660,691	8,770,869	15,431,560				51
52	Delivery Room & Labor Room	17,307,391	529,889	17,837,280				52
53	Anesthesiology	3,482,705	7,368,323	10,851,028				53
54	Radiology-Diagnostic	8,060,374	41,078,118	49,138,492				54
55.01	GASTRO INTESTINAL SERVICES	4,819,480	28,117,025	32,936,505				55.01
55.02	ULTRA SOUND	3,108,648	14,896,268	18,004,916				55.02
56	Radioisotope	2,686,734	3,264,162	5,950,896				56
57	CT Scan	19,109,633	40,302,438	59,412,071				57
58	MRI	2,509,317	11,313,312	13,822,629				58
59	Cardiac Catheterization	12,197,274	9,737,333	21,934,607				59
60	Laboratory	54,283,026	35,052,501	89,335,527				60
63	Blood Storing, Processing & Trans.	4,478,164	870,607	5,348,771				63
65	Respiratory Therapy	18,398,984	3,057,991	21,456,975				65
66	Physical Therapy	15,515,018	8,115,248	23,630,266				66
67	Occupational Therapy	3,922,195	178,121	4,100,316				67
68	Speech Pathology	1,564,927	75,188	1,640,115				68
69	Electrocardiology	9,520,789	9,580,602	19,101,391				69
71	Medical Supplies Charged to Patients	14,084,083	16,439,468	30,523,551				71
72	Impl. Dev. Charged to Patients	10,129,193	8,234,640	18,363,833				72
73	Drugs Charged to Patients	35,766,024	52,910,273	88,676,297				73
74	Renal Dialysis	1,810,300	74,861	1,885,161				74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	145,713	6,750,280	6,895,993				90
90.01	DIABETOLOGY		80,356	80,356				90.01
90.02	CANCER CENTER		1,922,044	1,922,044				90.02
90.03	WOUND CARE	7,055	6,596,054	6,603,109				90.03
91	Emergency	19,779,926	81,653,087	101,433,013				91
92	Observation Beds (Non-Distinct Part)	395,391	4,331,619	4,727,010				92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	429,554,730	445,064,938	874,619,668				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	429,554,730	445,064,938	874,619,668				202

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)**WORKSHEET C
PART I**

		Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	22,996,230		22,996,230		22,996,230	30
31	Intensive Care Unit	5,719,152		5,719,152	19,748	5,738,900	31
43	Nursery	1,553,593		1,553,593		1,553,593	43
44	Skilled Nursing Facility	5,563,306		5,563,306	9,196	5,572,502	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	9,710,393		9,710,393		9,710,393	50
51	Recovery Room	1,055,156		1,055,156		1,055,156	51
52	Delivery Room & Labor Room	4,929,510		4,929,510		4,929,510	52
53	Anesthesiology	362,145		362,145		362,145	53
54	Radiology-Diagnostic	7,589,648		7,589,648	3,937	7,593,585	54
55.01	GASTRO INTESTINAL SERVICES	3,063,155		3,063,155		3,063,155	55.01
55.02	ULTRA SOUND	1,282,987		1,282,987		1,282,987	55.02
56	Radioisotope	632,398		632,398		632,398	56
57	CT Scan	1,841,638		1,841,638		1,841,638	57
58	MRI	703,610		703,610		703,610	58
59	Cardiac Catheterization	2,358,327		2,358,327		2,358,327	59
60	Laboratory	6,197,464		6,197,464		6,197,464	60
63	Blood Storing, Processing & Trans.	719,971		719,971		719,971	63
65	Respiratory Therapy	1,973,092		1,973,092	591	1,973,683	65
66	Physical Therapy	4,073,940		4,073,940		4,073,940	66
67	Occupational Therapy	366,528		366,528		366,528	67
68	Speech Pathology	365,150		365,150		365,150	68
69	Electrocardiology	1,577,263		1,577,263		1,577,263	69
71	Medical Supplies Charged to Patients	3,263,806		3,263,806		3,263,806	71
72	Impl. Dev. Charged to Patients	3,917,010		3,917,010		3,917,010	72
73	Drugs Charged to Patients	10,484,454		10,484,454		10,484,454	73
74	Renal Dialysis	1,035,652		1,035,652		1,035,652	74
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	3,649,256		3,649,256	1,546	3,650,802	90
90.01	DIABETOLOGY	164,778		164,778		164,778	90.01
90.02	CANCER CENTER	4,829,031		4,829,031		4,829,031	90.02
90.03	WOUND CARE	1,120,404		1,120,404	4,397	1,124,801	90.03
91	Emergency	11,547,373		11,547,373		11,547,373	91
92	Observation Beds (Non-Distinct Part)	1,372,031		1,372,031		1,372,031	92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	126,018,451		126,018,451	39,415	126,057,866	200
201	Less Observation Beds	1,372,031		1,372,031		1,372,031	201
202	Total (line 200 minus line 201)	124,646,420		124,646,420	39,415	124,685,835	202

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	91,418,089		91,418,089				30
31	Intensive Care Unit	18,971,706		18,971,706				31
43	Nursery	14,338,662		14,338,662				43
44	Skilled Nursing Facility	5,369,944		5,369,944				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	29,713,294	43,764,261	73,477,555	0.132155	0.132155	0.132155	50
51	Recovery Room	6,660,691	8,770,869	15,431,560	0.068376	0.068376	0.068376	51
52	Delivery Room & Labor Room	17,307,391	529,889	17,837,280	0.276360	0.276360	0.276360	52
53	Anesthesiology	3,482,705	7,368,323	10,851,028	0.033374	0.033374	0.033374	53
54	Radiology-Diagnostic	8,060,374	41,078,118	49,138,492	0.154454	0.154454	0.154534	54
55.01	GASTRO INTESTINAL SERVICES	4,819,480	28,117,025	32,936,505	0.093002	0.093002	0.093002	55.01
55.02	ULTRA SOUND	3,108,648	14,896,268	18,004,916	0.071258	0.071258	0.071258	55.02
56	Radioisotope	2,686,734	3,264,162	5,950,896	0.106269	0.106269	0.106269	56
57	CT Scan	19,109,633	40,302,438	59,412,071	0.030998	0.030998	0.030998	57
58	MRI	2,509,317	11,313,312	13,822,629	0.050903	0.050903	0.050903	58
59	Cardiac Catheterization	12,197,274	9,737,333	21,934,607	0.107516	0.107516	0.107516	59
60	Laboratory	54,283,026	35,052,501	89,335,527	0.069373	0.069373	0.069373	60
63	Blood Storing, Processing & Trans.	4,478,164	870,607	5,348,771	0.134605	0.134605	0.134605	63
65	Respiratory Therapy	18,398,984	3,057,991	21,456,975	0.091956	0.091956	0.091983	65
66	Physical Therapy	15,515,018	8,115,248	23,630,266	0.172403	0.172403	0.172403	66
67	Occupational Therapy	3,922,195	178,121	4,100,316	0.089390	0.089390	0.089390	67
68	Speech Pathology	1,564,927	75,188	1,640,115	0.222637	0.222637	0.222637	68
69	Electrocardiology	9,520,789	9,580,602	19,101,391	0.082573	0.082573	0.082573	69
71	Medical Supplies Charged to Patients	14,084,083	16,439,468	30,523,551	0.106927	0.106927	0.106927	71
72	Impl. Dev. Charged to Patients	10,129,193	8,234,640	18,363,833	0.213300	0.213300	0.213300	72
73	Drugs Charged to Patients	35,766,024	52,910,273	88,676,297	0.118233	0.118233	0.118233	73
74	Renal Dialysis	1,810,300	74,861	1,885,161	0.549371	0.549371	0.549371	74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	145,713	6,750,280	6,895,993	0.529185	0.529185	0.529409	90
90.01	DIABETOLOGY		80,356	80,356	2.050600	2.050600	2.050600	90.01
90.02	CANCER CENTER		1,922,044	1,922,044	2.512446	2.512446	2.512446	90.02
90.03	WOUND CARE	7,055	6,596,054	6,603,109	0.169678	0.169678	0.170344	90.03
91	Emergency	19,779,926	81,653,087	101,433,013	0.113842	0.113842	0.113842	91
92	Observation Beds (Non-Distinct Part)	395,391	4,331,619	4,727,010	0.290253	0.290253	0.290253	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	429,554,730	445,064,938	874,619,668				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	429,554,730	445,064,938	874,619,668				202

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY**WORKSHEET C
PART II**

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	9,710,393	885,499	8,824,894		50
51	Recovery Room	1,055,156	9,235	1,045,921		51
52	Delivery Room & Labor Room	4,929,510	538,163	4,391,347		52
53	Anesthesiology	362,145	23,048	339,097		53
54	Radiology-Diagnostic	7,589,648	766,792	6,822,856		54
55.01	GASTRO INTESTINAL SERVICES	3,063,155	576,781	2,486,374		55.01
55.02	ULTRA SOUND	1,282,987	10,406	1,272,581		55.02
56	Radioisotope	632,398	86,086	546,312		56
57	CT Scan	1,841,638	108,120	1,733,518		57
58	MRI	703,610	5,081	698,529		58
59	Cardiac Catheterization	2,358,327	102,461	2,255,866		59
60	Laboratory	6,197,464	453,196	5,744,268		60
63	Blood Storing, Processing & Trans.	719,971	22,853	697,118		63
65	Respiratory Therapy	1,973,092	114,361	1,858,731		65
66	Physical Therapy	4,073,940	253,681	3,820,259		66
67	Occupational Therapy	366,528	2,960	363,568		67
68	Speech Pathology	365,150	45,187	319,963		68
69	Electrocardiology	1,577,263	198,058	1,379,205		69
71	Medical Supplies Charged to Patients	3,263,806	96,051	3,167,755		71
72	Impl. Dev. Charged to Patients	3,917,010	116,489	3,800,521		72
73	Drugs Charged to Patients	10,484,454	165,282	10,319,172		73
74	Renal Dialysis	1,035,652	20,295	1,015,357		74
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic	3,649,256	204,448	3,444,808		90
90.01	DIABETOLOGY	164,778	1,304	163,474		90.01
90.02	CANCER CENTER	4,829,031	301,407	4,527,624		90.02
90.03	WOUND CARE	1,120,404	5,643	1,114,761		90.03
91	Emergency	11,547,373	1,170,269	10,377,104		91
92	Observation Beds (Non-Distinct Part)	1,372,031	128,461	1,243,570		92
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal	90,186,170	6,411,617	83,774,553		200
201	Less Observation Beds	1,372,031	128,461	1,243,570		201
202	Total	88,814,139	6,283,156	82,530,983		202

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY**WORKSHEET C
PART II**

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		9,710,393	73,477,555	0.132155	50
51	Recovery Room		1,055,156	15,431,560	0.068376	51
52	Delivery Room & Labor Room		4,929,510	17,837,280	0.276360	52
53	Anesthesiology		362,145	10,851,028	0.033374	53
54	Radiology-Diagnostic		7,589,648	49,138,492	0.154454	54
55.01	GASTRO INTESTINAL SERVICES		3,063,155	32,936,505	0.093002	55.01
55.02	ULTRA SOUND		1,282,987	18,004,916	0.071258	55.02
56	Radioisotope		632,398	5,950,896	0.106269	56
57	CT Scan		1,841,638	59,412,071	0.030998	57
58	MRI		703,610	13,822,629	0.050903	58
59	Cardiac Catheterization		2,358,327	21,934,607	0.107516	59
60	Laboratory		6,197,464	89,335,527	0.069373	60
63	Blood Storing, Processing & Trans.		719,971	5,348,771	0.134605	63
65	Respiratory Therapy		1,973,092	21,456,975	0.091956	65
66	Physical Therapy		4,073,940	23,630,266	0.172403	66
67	Occupational Therapy		366,528	4,100,316	0.089390	67
68	Speech Pathology		365,150	1,640,115	0.222637	68
69	Electrocardiology		1,577,263	19,101,391	0.082573	69
71	Medical Supplies Charged to Patients		3,263,806	30,523,551	0.106927	71
72	Impl. Dev. Charged to Patients		3,917,010	18,363,833	0.213300	72
73	Drugs Charged to Patients		10,484,454	88,676,297	0.118233	73
74	Renal Dialysis		1,035,652	1,885,161	0.549371	74
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic		3,649,256	6,895,993	0.529185	90
90.01	DIABETOLOGY		164,778	80,356	2.050600	90.01
90.02	CANCER CENTER		4,829,031	1,922,044	2.512446	90.02
90.03	WOUND CARE		1,120,404	6,603,109	0.169678	90.03
91	Emergency		11,547,373	101,433,013	0.113842	91
92	Observation Beds (Non-Distinct Part)		1,372,031	4,727,010	0.290253	92
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal		90,186,170	744,521,267		200
201	Less Observation Beds		1,372,031	4,727,010		201
202	Total		88,814,139	739,794,257		202

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	2,153,100		2,153,100	23,398	92.02	6,407	589,572	30
31	Intensive Care Unit	513,509		513,509	3,429	149.75	1,233	184,642	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	36,509		36,509	3,779	9.66			43
44	Skilled Nursing Facility	558,334		558,334	9,126	61.18	5,709	349,277	44
45	Nursing Facility								45
200	Total (lines 30-199)	3,261,452		3,261,452	39,732		13,349	1,123,491	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**COMPONENT CCN: 14-0049****WORKSHEET D
PART II**

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	885,499	73,477,555	0.012051	11,773,226	141,879	50
51	Recovery Room	9,235	15,431,560	0.000598	1,890,559	1,131	51
52	Delivery Room & Labor Room	538,163	17,837,280	0.030171	40,889	1,234	52
53	Anesthesiology	23,048	10,851,028	0.002124	1,052,843	2,236	53
54	Radiology-Diagnostic	766,792	49,138,492	0.015605	2,393,962	37,358	54
55.01	GASTRO INTESTINAL SERVICES	576,781	32,936,505	0.017512	1,499,747	26,264	55.01
55.02	ULTRA SOUND	10,406	18,004,916	0.000578	353,797	204	55.02
56	Radioisotope	86,086	5,950,896	0.014466	1,023,385	14,804	56
57	CT Scan	108,120	59,412,071	0.001820	5,634,288	10,254	57
58	MRI	5,081	13,822,629	0.000368	824,825	304	58
59	Cardiac Catheterization	102,461	21,934,607	0.004671	3,076,404	14,370	59
60	Laboratory	453,196	89,335,527	0.005073	16,321,496	82,799	60
63	Blood Storing, Processing & Tra	22,853	5,348,771	0.004273	775,928	3,316	63
65	Respiratory Therapy	114,361	21,456,975	0.005330	5,531,977	29,485	65
66	Physical Therapy	253,681	23,630,266	0.010735	2,157,377	23,159	66
67	Occupational Therapy	2,960	4,100,316	0.000722	1,510,734	1,091	67
68	Speech Pathology	45,187	1,640,115	0.027551	387,139	10,666	68
69	Electrocardiology	198,058	19,101,391	0.010369	3,321,543	34,441	69
71	Medical Supplies Charged to Pat	96,051	30,523,551	0.003147	2,828,181	8,900	71
72	Impl. Dev. Charged to Patients	116,489	18,363,833	0.006343	5,302,517	33,634	72
73	Drugs Charged to Patients	165,282	88,676,297	0.001864	8,492,203	15,829	73
74	Renal Dialysis	20,295	1,885,161	0.010766	971,457	10,459	74
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	204,448	6,895,993	0.029647	1,228	36	90
90.01	DIABETOLOGY	1,304	80,356	0.016228			90.01
90.02	CANCER CENTER	301,407	1,922,044	0.156816			90.02
90.03	WOUND CARE	5,643	6,603,109	0.000855			90.03
91	Emergency	1,170,269	101,433,013	0.011537	5,390,790	62,194	91
92	Observation Beds (Non-Distinct	128,461	4,727,010	0.027176	137,083	3,725	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	6,411,617	744,521,267		82,693,578	569,772	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	23,398		6,407		30
31	Intensive Care Unit	3,429		1,233		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	3,779				43
44	Skilled Nursing Facility	9,126		5,709		44
45	Nursing Facility					45
200	Total (lines 30-199)	39,732		13,349		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0049

WORKSHEET D PART IV

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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
55.01	GASTRO INTESTINAL SERVICES									55.01
55.02	ULTRA SOUND									55.02
56	Radioisotope									56
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
63	Blood Storing, Processing & Tra									63
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
	OUTPATIENT SERVICE COST CENTERS									
90	Clinic									90
90.01	DIABETOLOGY									90.01
90.02	CANCER CENTER									90.02
90.03	WOUND CARE									90.03
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**
COMPONENT CCN: 14-0049
**WORKSHEET D
PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	73,477,555			11,773,226		15,362,978		50
51	Recovery Room	15,431,560			1,890,559		2,248,365		51
52	Delivery Room & Labor Room	17,837,280			40,889		2,497		52
53	Anesthesiology	10,851,028			1,052,843		1,343,939		53
54	Radiology-Diagnostic	49,138,492			2,393,962		2,487,295		54
55.01	GASTRO INTESTINAL SERVICES	32,936,505			1,499,747		4,876,887		55.01
55.02	ULTRA SOUND	18,004,916			353,797		800,924		55.02
56	Radioisotope	5,950,896			1,023,385		799,959		56
57	CT Scan	59,412,071			5,634,288		6,780,858		57
58	MRI	13,822,629			824,825		1,955,565		58
59	Cardiac Catheterization	21,934,607			3,076,404		2,733,928		59
60	Laboratory	89,335,527			16,321,496		4,988,267		60
63	Blood Storing, Processing & Tra	5,348,771			775,928		51,413		63
65	Respiratory Therapy	21,456,975			5,531,977		346,496		65
66	Physical Therapy	23,630,266			2,157,377		49,408		66
67	Occupational Therapy	4,100,316			1,510,734		39,262		67
68	Speech Pathology	1,640,115			387,139		3,636		68
69	Electrocardiology	19,101,391			3,321,543		2,616,112		69
71	Medical Supplies Charged to Pat	30,523,551			2,828,181		3,407,967		71
72	Impl. Dev. Charged to Patients	18,363,833			5,302,517		2,935,233		72
73	Drugs Charged to Patients	88,676,297			8,492,203		15,796,945		73
74	Renal Dialysis	1,885,161			971,457		41,119		74
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	6,895,993			1,228		374,227		90
90.01	DIABETOLOGY	80,356					104		90.01
90.02	CANCER CENTER	1,922,044							90.02
90.03	WOUND CARE	6,603,109					370,026		90.03
91	Emergency	101,433,013			5,390,790		8,171,231		91
92	Observation Beds (Non-Distinct	4,727,010			137,083		842,492		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	744,521,267			82,693,578		79,427,133		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS
COMPONENT CCN: 14-0049
**WORKSHEET D
PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.132155	15,362,978			2,030,294			50
51	Recovery Room	0.068376	2,248,365			153,734			51
52	Delivery Room & Labor Room	0.276360	2,497			690			52
53	Anesthesiology	0.033374	1,343,939			44,853			53
54	Radiology-Diagnostic	0.154454	2,487,295			384,173			54
55.01	GASTRO INTESTINAL SERVICES	0.093002	4,876,887			453,560			55.01
55.02	ULTRA SOUND	0.071258	800,924			57,072			55.02
56	Radioisotope	0.106269	799,959			85,011			56
57	CT Scan	0.030998	6,780,858			210,193			57
58	MRI	0.050903	1,955,565			99,544			58
59	Cardiac Catheterization	0.107516	2,733,928			293,941			59
60	Laboratory	0.069373	4,988,267		30	346,051		2	60
63	Blood Storing, Processing & Tra	0.134605	51,413			6,920			63
65	Respiratory Therapy	0.091956	346,496			31,862			65
66	Physical Therapy	0.172403	49,408			8,518			66
67	Occupational Therapy	0.089390	39,262			3,510			67
68	Speech Pathology	0.222637	3,636			810			68
69	Electrocardiology	0.082573	2,616,112			216,020			69
71	Medical Supplies Charged to Pat	0.106927	3,407,967			364,404			71
72	Impl. Dev. Charged to Patients	0.213300	2,935,233			626,085			72
73	Drugs Charged to Patients	0.118233	15,796,945		49,070	1,867,720		5,802	73
74	Renal Dialysis	0.549371	41,119			22,590			74
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.529185	374,227			198,035			90
90.01	DIABETOLOGY	2.050600	104			213			90.01
90.02	CANCER CENTER	2.512446							90.02
90.03	WOUND CARE	0.169678	370,026			62,785			90.03
91	Emergency	0.113842	8,171,231			930,229			91
92	Observation Beds (Non-Distinct	0.290253	842,492			244,536			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		79,427,133		49,100	8,743,353		5,804	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		79,427,133		49,100	8,743,353		5,804	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-5743

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☐ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☒ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
55.01	GASTRO INTESTINAL SERVICES									55.01
55.02	ULTRA SOUND									55.02
56	Radioisotope									56
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
63	Blood Storing, Processing & Tra									63
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
	OUTPATIENT SERVICE COST CENTERS									
90	Clinic									90
90.01	DIABETOLOGY									90.01
90.02	CANCER CENTER									90.02
90.03	WOUND CARE									90.03
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**
COMPONENT CCN: 14-5743
**WORKSHEET D
PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	73,477,555			10,179				50
51	Recovery Room	15,431,560							51
52	Delivery Room & Labor Room	17,837,280							52
53	Anesthesiology	10,851,028							53
54	Radiology-Diagnostic	49,138,492			90,295				54
55.01	GASTRO INTESTINAL SERVICES	32,936,505							55.01
55.02	ULTRA SOUND	18,004,916			7,362				55.02
56	Radioisotope	5,950,896			9,105				56
57	CT Scan	59,412,071			33,717				57
58	MRI	13,822,629							58
59	Cardiac Catheterization	21,934,607							59
60	Laboratory	89,335,527			2,160,040				60
63	Blood Storing, Processing & Tra	5,348,771			34,265				63
65	Respiratory Therapy	21,456,975			475,709				65
66	Physical Therapy	23,630,266			6,122,707				66
67	Occupational Therapy	4,100,316							67
68	Speech Pathology	1,640,115			400,802				68
69	Electrocardiology	19,101,391			53,280				69
71	Medical Supplies Charged to Pat	30,523,551			441,270				71
72	Impl. Dev. Charged to Patients	18,363,833							72
73	Drugs Charged to Patients	88,676,297			2,257,279				73
74	Renal Dialysis	1,885,161							74
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	6,895,993							90
90.01	DIABETOLOGY	80,356							90.01
90.02	CANCER CENTER	1,922,044							90.02
90.03	WOUND CARE	6,603,109							90.03
91	Emergency	101,433,013							91
92	Observation Beds (Non-Distinct	4,727,010							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	744,521,267			12,096,010				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-5743

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P

☒ Title XVIII, Part B

☐ Title XIX - O/P

☐ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☒ SNF

☐ NF

☐ Swing Bed SNF

☐ Swing Bed NF

☐ ICF/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.132155							50
51	Recovery Room	0.068376							51
52	Delivery Room & Labor Room	0.276360							52
53	Anesthesiology	0.033374							53
54	Radiology-Diagnostic	0.154454							54
55.01	GASTRO INTESTINAL SERVICES	0.093002							55.01
55.02	ULTRA SOUND	0.071258							55.02
56	Radioisotope	0.106269							56
57	CT Scan	0.030998							57
58	MRI	0.050903							58
59	Cardiac Catheterization	0.107516							59
60	Laboratory	0.069373							60
63	Blood Storing, Processing & Tra	0.134605							63
65	Respiratory Therapy	0.091956							65
66	Physical Therapy	0.172403							66
67	Occupational Therapy	0.089390							67
68	Speech Pathology	0.222637							68
69	Electrocardiology	0.082573							69
71	Medical Supplies Charged to Pat	0.106927							71
72	Impl. Dev. Charged to Patients	0.213300							72
73	Drugs Charged to Patients	0.118233							73
74	Renal Dialysis	0.549371							74
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.529185							90
90.01	DIABETOLOGY	2.050600							90.01
90.02	CANCER CENTER	2.512446							90.02
90.03	WOUND CARE	0.169678							90.03
91	Emergency	0.113842							91
92	Observation Beds (Non-Distinct	0.290253							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check [] Title V
Applicable [] Title XVIII, Part A
Boxes: [XX] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	2,153,100		2,153,100	23,398	92.02	2,187	201,248	30
31	Intensive Care Unit	513,509		513,509	3,429	149.75	311	46,572	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	36,509		36,509	3,779	9.66	1,402	13,543	43
44	Skilled Nursing Facility	558,334		558,334	9,126	61.18			44
45	Nursing Facility								45
200	Total (lines 30-199)	3,261,452		3,261,452	39,732		3,900	261,363	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0049

WORKSHEET D PART II

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	885,499	73,477,555	0.012051			50
51	Recovery Room	9,235	15,431,560	0.000598			51
52	Delivery Room & Labor Room	538,163	17,837,280	0.030171			52
53	Anesthesiology	23,048	10,851,028	0.002124			53
54	Radiology-Diagnostic	766,792	49,138,492	0.015605			54
55.01	GASTRO INTESTINAL SERVICES	576,781	32,936,505	0.017512			55.01
55.02	ULTRA SOUND	10,406	18,004,916	0.000578			55.02
56	Radioisotope	86,086	5,950,896	0.014466			56
57	CT Scan	108,120	59,412,071	0.001820			57
58	MRI	5,081	13,822,629	0.000368			58
59	Cardiac Catheterization	102,461	21,934,607	0.004671			59
60	Laboratory	453,196	89,335,527	0.005073			60
63	Blood Storing, Processing & Tra	22,853	5,348,771	0.004273			63
65	Respiratory Therapy	114,361	21,456,975	0.005330			65
66	Physical Therapy	253,681	23,630,266	0.010735			66
67	Occupational Therapy	2,960	4,100,316	0.000722			67
68	Speech Pathology	45,187	1,640,115	0.027551			68
69	Electrocardiology	198,058	19,101,391	0.010369			69
71	Medical Supplies Charged to Pat	96,051	30,523,551	0.003147			71
72	Impl. Dev. Charged to Patients	116,489	18,363,833	0.006343			72
73	Drugs Charged to Patients	165,282	88,676,297	0.001864			73
74	Renal Dialysis	20,295	1,885,161	0.010766			74
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	204,448	6,895,993	0.029647			90
90.01	DIABETOLOGY	1,304	80,356	0.016228			90.01
90.02	CANCER CENTER	301,407	1,922,044	0.156816			90.02
90.03	WOUND CARE	5,643	6,603,109	0.000855			90.03
91	Emergency	1,170,269	101,433,013	0.011537			91
92	Observation Beds (Non-Distinct	128,461	4,727,010	0.027176			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	6,411,617	744,521,267				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ PPS
☐ TEFRA
☒ Other

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ PPS
☐ TEFRA
☒ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	23,398		2,187		30
31	Intensive Care Unit	3,429		311		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	3,779		1,402		43
44	Skilled Nursing Facility	9,126				44
45	Nursing Facility					45
200	Total (lines 30-199)	39,732		3,900		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**
COMPONENT CCN: 14-0049
**WORKSHEET D
PART IV**

Check ☐ Title V
 Applicable ☐ Title XVIII, Part A
 Boxes: ☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID
☐ PPS
☐ TEFRA
☒ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
55.01	GASTRO INTESTINAL SERVICES									55.01
55.02	ULTRA SOUND									55.02
56	Radioisotope									56
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
63	Blood Storing, Processing & Tra									63
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
	OUTPATIENT SERVICE COST CENTERS									
90	Clinic									90
90.01	DIABETOLOGY									90.01
90.02	CANCER CENTER									90.02
90.03	WOUND CARE									90.03
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**
COMPONENT CCN: 14-0049
**WORKSHEET D
PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	73,477,555							50
51	Recovery Room	15,431,560							51
52	Delivery Room & Labor Room	17,837,280							52
53	Anesthesiology	10,851,028							53
54	Radiology-Diagnostic	49,138,492							54
55.01	GASTRO INTESTINAL SERVICES	32,936,505							55.01
55.02	ULTRA SOUND	18,004,916							55.02
56	Radioisotope	5,950,896							56
57	CT Scan	59,412,071							57
58	MRI	13,822,629							58
59	Cardiac Catheterization	21,934,607							59
60	Laboratory	89,335,527							60
63	Blood Storing, Processing & Tra	5,348,771							63
65	Respiratory Therapy	21,456,975							65
66	Physical Therapy	23,630,266							66
67	Occupational Therapy	4,100,316							67
68	Speech Pathology	1,640,115							68
69	Electrocardiology	19,101,391							69
71	Medical Supplies Charged to Pat	30,523,551							71
72	Impl. Dev. Charged to Patients	18,363,833							72
73	Drugs Charged to Patients	88,676,297							73
74	Renal Dialysis	1,885,161							74
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	6,895,993							90
90.01	DIABETOLOGY	80,356							90.01
90.02	CANCER CENTER	1,922,044							90.02
90.03	WOUND CARE	6,603,109							90.03
91	Emergency	101,433,013							91
92	Observation Beds (Non-Distinct	4,727,010							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	744,521,267							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0049

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P

☐ Title XVIII, Part B

☒ Title XIX - O/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ Swing Bed SNF

☐ Swing Bed NF

☐ ICF/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.132155							50
51	Recovery Room	0.068376							51
52	Delivery Room & Labor Room	0.276360							52
53	Anesthesiology	0.033374							53
54	Radiology-Diagnostic	0.154454							54
55.01	GASTRO INTESTINAL SERVICES	0.093002							55.01
55.02	ULTRA SOUND	0.071258							55.02
56	Radioisotope	0.106269							56
57	CT Scan	0.030998							57
58	MRI	0.050903							58
59	Cardiac Catheterization	0.107516							59
60	Laboratory	0.069373							60
63	Blood Storing, Processing & Tra	0.134605							63
65	Respiratory Therapy	0.091956							65
66	Physical Therapy	0.172403							66
67	Occupational Therapy	0.089390							67
68	Speech Pathology	0.222637							68
69	Electrocardiology	0.082573							69
71	Medical Supplies Charged to Pat	0.106927							71
72	Impl. Dev. Charged to Patients	0.213300							72
73	Drugs Charged to Patients	0.118233							73
74	Renal Dialysis	0.549371							74
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.529185							90
90.01	DIABETOLOGY	2.050600							90.01
90.02	CANCER CENTER	2.512446							90.02
90.03	WOUND CARE	0.169678							90.03
91	Emergency	0.113842							91
92	Observation Beds (Non-Distinct	0.290253							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0049****WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	23,398	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	23,398	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	22,002	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	6,407	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	22,996,230	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	22,996,230	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	22,996,230	37

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0049****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1
38	Adjusted general inpatient routine service cost per diem (see instructions)					982.83	38
39	Program general inpatient routine service cost (line 9 x line 38)					6,296,992	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					6,296,992	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	5,738,900	3,429	1,673.64	1,233	2,063,598	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					9,160,721	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					17,521,311	49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					774,214	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					569,772	51
52	Total Program excludable cost (sum of lines 50 and 51)					1,343,986	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					16,177,325	53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0049

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,396	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					982.83	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,372,031	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	2,153,100	22,996,230	0.093628	1,372,031	128,461	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-5743****WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,126	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,126	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	9,126	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,709	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	5,572,502	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,572,502	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,572,502	37

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-5743****WORKSHEET D-1
PARTS III & IV**

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

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

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	5,572,502	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	610.62	71
72	Program routine service cost (line 9 x line 71)	3,486,030	72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)	3,486,030	74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)	3,486,030	83
84	Program inpatient ancillary services (see instructions)	1,679,307	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	5,165,337	86

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0049****WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	23,398	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	23,398	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	22,002	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,187	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	3,779	15
16	Nursery days (title V or XIX only)	1,402	16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	22,996,230	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	22,996,230	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	22,996,230	37

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0049****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						982.83	38
39	Program general inpatient routine service cost (line 9 x line 38)						2,149,449	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)							40
41	Total Program general inpatient routine service cost (line 39 + line 40)						2,149,449	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
42	Nursery (Titles V and XIX only)	1,553,593	3,779	411.11	1,402	576,376		42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	5,719,152	3,429	1,667.88	311	518,711		43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47
							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)							48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						3,244,536	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						261,363	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							51
52	Total Program excludable cost (sum of lines 50 and 51)						261,363	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)							53
TARGET AMOUNT AND LIMIT COMPUTATION								
54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63
PROGRAM INPATIENT ROUTINE SWING BED COST								
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0049

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☐ Title XVIII, Part A

☒ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,396	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT**COMPONENT CCN: 14-0049****WORKSHEET D-3**

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		28,225,465		30
31	Intensive Care Unit		6,718,815		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.132155	11,773,226	1,555,891	50
51	Recovery Room	0.068376	1,890,559	129,269	51
52	Delivery Room & Labor Room	0.276360	40,889	11,300	52
53	Anesthesiology	0.033374	1,052,843	35,138	53
54	Radiology-Diagnostic	0.154534	2,393,962	369,949	54
55.01	GASTRO INTESTINAL SERVICES	0.093002	1,499,747	139,479	55.01
55.02	ULTRA SOUND	0.071258	353,797	25,211	55.02
56	Radioisotope	0.106269	1,023,385	108,754	56
57	CT Scan	0.030998	5,634,288	174,652	57
58	MRI	0.050903	824,825	41,986	58
59	Cardiac Catheterization	0.107516	3,076,404	330,763	59
60	Laboratory	0.069373	16,321,496	1,132,271	60
63	Blood Storing, Processing & Trans.	0.134605	775,928	104,444	63
65	Respiratory Therapy	0.091983	5,531,977	508,848	65
66	Physical Therapy	0.172403	2,157,377	371,938	66
67	Occupational Therapy	0.089390	1,510,734	135,045	67
68	Speech Pathology	0.222637	387,139	86,191	68
69	Electrocardiology	0.082573	3,321,543	274,270	69
71	Medical Supplies Charged to Patients	0.106927	2,828,181	302,409	71
72	Impl. Dev. Charged to Patients	0.213300	5,302,517	1,131,027	72
73	Drugs Charged to Patients	0.118233	8,492,203	1,004,059	73
74	Renal Dialysis	0.549371	971,457	533,690	74
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.529409	1,228	650	90
90.01	DIABETOLOGY	2.050600			90.01
90.02	CANCER CENTER	2.512446			90.02
90.03	WOUND CARE	0.170344			90.03
91	Emergency	0.113842	5,390,790	613,698	91
92	Observation Beds (Non-Distinct Part)	0.290253	137,083	39,789	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		82,693,578	9,160,721	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		82,693,578		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT**COMPONENT CCN: 14-5743****WORKSHEET D-3**

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.132155	10,179	1,345	50
51	Recovery Room	0.068376			51
52	Delivery Room & Labor Room	0.276360			52
53	Anesthesiology	0.033374			53
54	Radiology-Diagnostic	0.154454	90,295	13,946	54
55.01	GASTRO INTESTINAL SERVICES	0.093002			55.01
55.02	ULTRA SOUND	0.071258	7,362	525	55.02
56	Radioisotope	0.106269	9,105	968	56
57	CT Scan	0.030998	33,717	1,045	57
58	MRI	0.050903			58
59	Cardiac Catheterization	0.107516			59
60	Laboratory	0.069373	2,160,040	149,848	60
63	Blood Storing, Processing & Trans.	0.134605	34,265	4,612	63
65	Respiratory Therapy	0.091956	475,709	43,744	65
66	Physical Therapy	0.172403	6,122,707	1,055,573	66
67	Occupational Therapy	0.089390			67
68	Speech Pathology	0.222637	400,802	89,233	68
69	Electrocardiology	0.082573	53,280	4,399	69
71	Medical Supplies Charged to Patients	0.106927	441,270	47,184	71
72	Impl. Dev. Charged to Patients	0.213300			72
73	Drugs Charged to Patients	0.118233	2,257,279	266,885	73
74	Renal Dialysis	0.549371			74
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.529185			90
90.01	DIABETOLOGY	2.050600			90.01
90.02	CANCER CENTER	2.512446			90.02
90.03	WOUND CARE	0.169678			90.03
91	Emergency	0.113842			91
92	Observation Beds (Non-Distinct Part)	0.290253			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		12,096,010	1,679,307	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		12,096,010		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT**COMPONENT CCN: 14-0049****WORKSHEET D-3**

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.132155			50
51	Recovery Room	0.068376			51
52	Delivery Room & Labor Room	0.276360			52
53	Anesthesiology	0.033374			53
54	Radiology-Diagnostic	0.154454			54
55.01	GASTRO INTESTINAL SERVICES	0.093002			55.01
55.02	ULTRA SOUND	0.071258			55.02
56	Radioisotope	0.106269			56
57	CT Scan	0.030998			57
58	MRI	0.050903			58
59	Cardiac Catheterization	0.107516			59
60	Laboratory	0.069373			60
63	Blood Storing, Processing & Trans.	0.134605			63
65	Respiratory Therapy	0.091956			65
66	Physical Therapy	0.172403			66
67	Occupational Therapy	0.089390			67
68	Speech Pathology	0.222637			68
69	Electrocardiology	0.082573			69
71	Medical Supplies Charged to Patients	0.106927			71
72	Impl. Dev. Charged to Patients	0.213300			72
73	Drugs Charged to Patients	0.118233			73
74	Renal Dialysis	0.549371			74
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.529185			90
90.01	DIABETOLOGY	2.050600			90.01
90.02	CANCER CENTER	2.512446			90.02
90.03	WOUND CARE	0.169678			90.03
91	Emergency	0.113842			91
92	Observation Beds (Non-Distinct Part)	0.290253			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E
PART A****PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,908,415			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	9,053,802			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	125,135			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments	7,294,387			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	131.18			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)	55.47			5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)	55.47			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	58.29			10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)	55.47			12
13	Total allowable FTE count for the prior year	55.47			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	55.47			14
15	Sum of lines 12 through 14 divided by 3	55.47			15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count	55.47			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.422854			19
20	Prior year resident to bed ratio (see instructions)	0.426168			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.422854			21
22	IME payment adjustment (see instructions)	3,101,219			22
22.01	IME payment adjustment - Managed Care (see instructions)	1,511,908			22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)	2.82			24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)	3,101,219			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	1,511,908			29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.1159			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.4072			31
32	Sum of lines 30 and 31	0.5231			32
33	Allowable disproportionate share percentage (see instructions)	0.3237			33
34	Disproportionate share adjustment (see instructions)	1,210,818			34
		Prior to		On or after	
	Uncompensated Care Adjustment	October 1 (1.00)	(1.01)	October 1 (2.00)	
35	Total uncompensated care amount (see instructions)			6,766,695,164	35
35.01	Factor 3 (see instructions)	0.000000000		0.000289184	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,393,938		1,956,820	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,003,486		1,136,564	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,140,050			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40

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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E
PART A****PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46
47	Subtotal (see instructions)	21,539,439			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	23,051,347			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,665,139			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)	2,567,455			52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies	2,071			54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	27,286,012			59
60	Primary payer payments	14,261			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	27,271,751			61
62	Deductibles billed to program beneficiaries	1,441,500			62
63	Coinsurance billed to program beneficiaries	67,328			63
64	Allowable bad debts (see instructions)	935,726			64
65	Adjusted reimbursable bad debts (see instructions)	608,222			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	542,411			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	26,371,145			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	57,009			70.93
70.94	HRR adjustment amount (see instructions)	-87,233			70.94
71	Amount due provider (see instructions)	26,340,921			71
71.01	Sequestration adjustment (see instructions)	526,818			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	25,303,475			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	510,628			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	248,416			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

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

HSP Bonus Payment Amount**Prior to 10/1****On or After
10/1**

100	HSP bonus amount (see instructions)				100
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HVBP Adjustment for HSP Bonus Payment**Prior to 10/1****On or After
10/1**

101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

HRR Adjustment for HSP Bonus Payment**Prior to 10/1****On or After
10/1**

103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-0049****WORKSHEET E
PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	5,804			1
2	Medical and other services reimbursed under OPPS (see instructions)	8,743,353			2
3	OPPS payments	9,423,482			3
4	Outlier payment (see instructions)	37,941			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	5,804			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	49,100			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	49,100			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	49,100			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	43,296			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	5,804			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	9,461,423			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,771,006			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	7,696,221			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	931,379			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	8,627,600			30
31	Primary payer payments	7,928			31
32	Subtotal (line 30 minus line 31)	8,619,672			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	555,941			34
35	Adjusted reimbursable bad debts (see instructions)	361,362			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	314,035			36
37	Subtotal (see instructions)	8,981,034			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	8,981,034			40
40.01	Sequestration adjustment (see instructions)	179,621			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	8,926,593			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-125,180			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-5743****WORKSHEET E
PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED**COMPONENT CCN: 14-0049****WORKSHEET E-1
PART I**

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

			INPATIENT PART A		PART B		
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider			25,524,810		8,919,054	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero						2
3	List separately each retroactive lump sum adjustment	.01	12/07/2017	306,673	04/05/2018	7,539	3.01
	amount based on subsequent revision of the interim	.02					3.02
	rate for the cost reporting period. Also show date of	Program .03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to .04					3.04
		Provider .05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.10					3.10
		.50	04/05/2018	528,008			3.50
		.51					3.51
		Provider .52					3.52
		to .53					3.53
		Program .54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		-221,335		7,539	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99)			25,303,475		8,926,593	4
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)						
TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment	.01					5.01
	after desk review. Also show date of each payment.	.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program .03					5.03
		to .04					5.04
		Provider .05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
		.10					5.10
		.50					5.50
		.51					5.51
		Provider .52					5.52
		to .53					5.53
		Program .54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99					5.99
6	Determined net settlement amount (balance due)	.01		510,628			6.01
	based on the cost report (1)	.02				-125,180	6.02
7	Total Medicare program liability (see instructions)			25,814,103		8,801,413	7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)		8

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

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED**COMPONENT CCN: 14-5743****WORKSHEET E-1
PART I**

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				2,864,003			1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				2,864,003			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				2,864,003			7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E-3
PART VI****PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES**

	PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	Resource Utilization Group (RUGS) payment	3,103,108	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	3,103,108	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	Medical and other services. Do not use this line. (see instructions)		5
6	Deductibles		6
7	Coinsurance	180,656	7
8	Allowable bad debts (see instructions)		8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		9
10	Adjusted reimbursable bad debts (see instructions)		10
11	Utilization review		11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)	2,922,452	12
13	Inpatient primary payer payments		13
14	Other adjustments (specify) (see instructions)		14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		14.50
15	Subtotal (see instructions)	2,922,452	15
15.01	Sequestration adjustment (see instructions)	58,449	15.01
15.02	Demonstration payment adjustment amount after sequestration		15.02
16	Interim payments	2,864,003	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16 and 17)		18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-0049****WORKSHEET E-3
PART VII**

Check ☐ Title V
 Applicable ☒ Title XIX
 Boxes:

☒ Hospital
☐ SUB (Other)
☐ SNF

☐ NF
☐ ICF/IID

☐ PPS
☐ TEFRA
☒ Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	3,244,536		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	3,244,536		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	3,244,536		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	3,244,536		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	3,244,536		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS**WORKSHEET E-4**

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

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			57.10	1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			-2.99	4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			1.39	4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4.01 and 4.02 plus applicable subscripts)			55.50	5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			58.29	6
7	Enter the lesser of line 5 or line 6			55.50	7
		Primary Care 1	Other 2	Total 3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	58.04	0.25	58.29	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	55.26	0.24	55.50	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
10.01	Unweighted dental and podiatric resident FTE count for the current year				10.01
11	Total weighted FTE count	55.26	0.24		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	54.12	1.38		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	52.62	2.88		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	54.00	1.50		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
15.01	Unweighted adjustment for residents in initial years of new programs				15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01
17	Adjusted rolling average FTE count	54.00	1.50		17
18	Per resident amount	145,909.18	138,233.04		18
19	Approved amount for resident costs	7,879,096	207,350	8,086,446	19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)			2.79	21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)			8,086,446	25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	7,640	4,125		26
27	Total inpatient days (see instructions)	25,844	25,844		27
28	Ratio of inpatient days to total inpatient days	0.295620	0.159612		28
29	Program direct GME amount	2,390,515	1,290,694		29
30	Reduction for direct GME payments for Medicare Advantage		182,375		30
31	Net Program direct GME amount			3,498,834	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			1,885,161	33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	Part A Reasonable Cost				
37	Reasonable cost (see instructions)			24,110,449	37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)			14,261	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			24,096,188	41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)			8,749,157	42
43	Primary payer payments (see instructions)			7,928	43
44	Total Part B reasonable cost (line 42 minus line 43)			8,741,229	44
45	Total reasonable cost (sum of lines 41 and 44)			32,837,417	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.733803	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.266197	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			3,498,834	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			2,567,455	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			931,379	50

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS**WORKSHEET E-4**

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

	COMPUTATION OF TOTAL DIRECT GME AMOUNT			
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)			2
3	Amount of reduction to Direct GME cap under §422 of MMA			3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4.01 and 4.02 plus applicable subscripts)			5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			6
7	Enter the lesser of line 5 or line 6			7
		Primary Care 1	Other 2	Total 3
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00 8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00 9
10	Weighted dental and podiatric resident FTE count for the current year		0.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year			10.01
11	Total weighted FTE count	0.00	0.00	11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00	12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00	13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00	14
15	Adjustment for residents in initial years of new programs	0.00	0.00	15
15.01	Unweighted adjustment for residents in initial years of new programs			15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00	16
16.01	Unweighted adjustment for residents displaced by program or hospital closure			16.01
17	Adjusted rolling average FTE count	0.00	0.00	17
18	Per resident amount	0.00	0.00	18
19	Approved amount for resident costs			19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)			20
21	Direct GME FTE unweighted resident count over cap (see instructions)			21
22	Allowable additional direct GME FTE resident count (see instructions)			22
23	Enter the locality adjustment national average per resident amount (see instructions)			23
24	Multiply line 22 times line 23			24
25	Total direct GME amount (sum of lines 19 and 24)			25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care	
26	Inpatient days (see instructions)	2,765	7,895	26
27	Total inpatient days (see instructions)	25,844	25,844	27
28	Ratio of inpatient days to total inpatient days	0.106988	0.305487	28
29	Program direct GME amount			29
30	Reduction for direct GME payments for Medicare Advantage			30
31	Net Program direct GME amount			31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			34
35	Medicare outpatient ESRD charges (see instructions)			35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME			
	Part A Reasonable Cost			
37	Reasonable cost (see instructions)			37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)			38
39	Cost of physicians' services in a teaching hospital (see instructions)			39
40	Primary payer payments (see instructions)			40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			41
	Part B Reasonable Cost			
42	Reasonable cost (see instructions)			42
43	Primary payer payments (see instructions)			43
44	Total Part B reasonable cost (line 42 minus line 43)			44
45	Total reasonable cost (sum of lines 41 and 44)			45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B			
48	Total program GME payment (line 31)			48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			50

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BALANCE SHEET**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets (Omit Cents)	1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	-665,476				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	27,547,222				4
5	Other receivables	528,517				5
6	Allowances for uncollectible notes and accounts receivable	-4,665,442				6
7	Inventory	2,955,363				7
8	Prepaid expenses	509,316				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	26,209,500				11
FIXED ASSETS						
12	Land	6,520,000				12
13	Land improvements	139,500				13
14	Accumulated depreciation					14
15	Buildings	47,531,417				15
16	Accumulated depreciation					16
17	Leasehold improvements	33,400				17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	16,293,836				23
24	Accumulated depreciation	-28,799,353				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable	97,009				29
30	Total fixed assets (sum of lines 12-29)	41,815,809				30
OTHER ASSETS						
31	Investments	1,556,585				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	300,000				34
35	Total other assets (sum of lines 31-34)	1,856,585				35
36	Total assets (sum of lines 11, 30 and 35)	69,881,894				36
	Liabilities and Fund Balances (Omit Cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	7,608,711				37
38	Salaries, wages and fees payable	7,697,268				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	123,261				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	601,386				44
45	Total current liabilities (sum of lines 37 thru 44)	16,030,626				45
LONG TERM LIABILITIES						
46	Mortgage payable	53,278,154				46
47	Notes payable	34,157				47
48	Unsecured loans					48
49	Other long term liabilities	5,193,921				49
50	Total long term liabilities (sum of lines 46 thru 49)	58,506,232				50
51	Total liabilities (sum of lines 45 and 50)	74,536,858				51
CAPITAL ACCOUNTS						
52	General fund balance	-4,654,964				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56

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BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets					
	(Omit Cents)	1	2	3	4	
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	-4,654,964				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	69,881,894				60

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STATEMENT OF CHANGES IN FUND BALANCES**WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		1,077,287		1
2	Net income (loss) (from Worksheet G-3, line 29)		1,434,678		2
3	Total (sum of line 1 and line 2)		2,511,965		3
4	Additions (credit adjustments) (specify)				4
5	ROUNDING	6			5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)		6		10
11	Subtotal (line 3 plus line 10)		2,511,971		11
12	Deductions (debit adjustments) (specify)				12
13	CHANGE IN RETAINED EARNINGS	7,166,935			13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)		7,166,935		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		-4,654,964		19

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

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	105,756,752		105,756,752	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	5,369,944		5,369,944	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	111,126,696		111,126,696	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	18,971,706		18,971,706	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	18,971,706		18,971,706	16
17	Total inpatient routine care services (sum of lines 10 and 16)	130,098,402		130,098,402	17
18	Ancillary services	279,128,245	343,731,498	622,859,743	18
19	Outpatient services	20,328,085	101,333,442	121,661,527	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	429,554,732	445,064,940	874,619,672	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		134,173,697	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		134,173,697	43

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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/25/2018 Run Time: 10:50 Version: 2018.04 (09/20/2018)
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STATEMENT OF REVENUES AND EXPENSES**WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	874,619,672	1
2	Less contractual allowances and discounts on patients' accounts	744,969,262	2
3	Net patient revenues (line 1 minus line 2)	129,650,410	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	134,173,697	4
5	Net income from service to patients (line 3 minus line 4)	-4,523,287	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	327,592	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	1,055,864	22
23	Governmental appropriations		23
24	Other (OTHER OPERATING REVENUE)	3,988,694	24
24.0	Other (RETAIL PHARMACY REVENUE)		24.0
1		585,815	1
25	Total other income (sum of lines 6-24)	5,957,965	25
26	Total (line 5 plus line 25)	1,434,678	26
29	Net income (or loss) for the period (line 26 minus line 28)	1,434,678	29

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CALCULATION OF CAPITAL PAYMENT**COMPONENT CCN: 14-0049****WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	1,215,611	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	13,002	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	70.81	3
4	Number of interns & residents (see instructions)	55.47	4
5	Indirect medical education percentage (see instructions)	24.74	5
6	Indirect medical education adjustment (see instructions)	300,742	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.1159	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.4072	8
9	Sum of lines 7 and 8	0.5231	9
10	Allowable disproportionate share percentage (see instructions)	0.1117	10
11	Disproportionate share adjustment (see instructions)	135,784	11
12	Total prospective capital payments (see instructions)	1,665,139	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS 0	SUBTOTAL (cols.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-BLDG & FIXT RIVER FOR							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
7.01	OPERATION OF PLANT-RIVER FOREST							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
9.01	HOUSEKEEPING-RIVER FOREST							9.01
10	Dietary							10
11	Cafeteria							11
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
43	Nursery							43
44	Skilled Nursing Facility							44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
55.01	GASTRO INTESTINAL SERVICES							55.01
55.02	ULTRA SOUND							55.02
56	Radioisotope							56
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
63	Blood Storing, Processing & Trans.							63
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	DIABETOLOGY							90.01
90.02	CANCER CENTER							90.02
90.03	WOUND CARE							90.03
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	MARKETING							194
194.0 1	HOSPITALIST							194.0 1
194.0 2	RETAIL PHARMACY							194.0 2
194.0 3	COMMUNITY RELATIONS							194.0 3

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
194.0 4	PHYSICIAN CLINICS							194.0 4
194.0 5	GUEST MEALS							194.0 5
194.0 6	CATERING MEALS							194.0 6
194.0 7	RESEARCH,RIVER FOREST NONREIMB							194.0 7
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202