

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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 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.		Date: 12/02/2019 Time: 11:04
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 05/01/2018 and ending 01/27/2019, 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 BAILEY
Chief Financial Officer or Administrator of Provider(s)

VP OF OPERATIONS REIMBURSEMENT
Title

12/02/2019 11:04
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII		HIT	TITLE XIX	
	TITLE V	PART A	PART B			
	1	2	3	4	5	
1	HOSPITAL	695,518	177,870			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	-1				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	695,517	177,870			200

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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

Hospital and Hospital Health Care Complex Address:

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

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 OLTC									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 / 2018	To: 01 / 27 / 2019		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.	1,298	1,453	10		5,815	215	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
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 OPSS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)			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	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

		1	2	3	
56	Teaching Hospitals 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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
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	2	
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
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.	1	2	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. 15-1, 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:	3,270,851			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 §1903(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
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)				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 / 2018	03 / 31 / 2018		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	02/25/2019	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		Y	
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

		Y/N	
Bed Complement		N	
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	11/13/2019	Y	11/13/2019	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	41
42	Employer: TENET EMPLOYMENT INC.			42
43	Phone number: 606.451.1228	E-mail Address: BETH1.SLOAN@TENETHEALTH.COM		43

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

		Inpatient Days / Outpatient Visits / Trips								
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	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	31,008			4,456	1,548	15,475	1
2	HMO and other (see instructions)						2,759	5,815		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	31,008			4,456	1,548	15,475	7
8	Intensive Care Unit	31	21	5,712			959	220	2,787	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						993	2,841	13
14	Total (see instructions)		135	36,720			5,415	2,761	21,103	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	10,608			3,911		7,641	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							65	1,163	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							215	331	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)					1,157	414	5,027	1
2	HMO and other (see instructions)					588	1,658		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)	57.52	827.86			1,157	414	5,027	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		32.70						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)	57.52	860.56						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	45,294,979		45,294,979	1,338,790.00	33.83	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		190,210		190,210	1,919.00	99.12	4.01
5	Physician-Part B							5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21	3,691,175	-190,210	3,500,965	110,606.00	31.65	7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44	1,575,389		1,575,389	50,872.00	30.97	9
10	Excluded area salaries (see instructions)		460,300	36,113	496,413	10,937.00	45.39	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		1,069,365		1,069,365	12,628.00	84.68	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries		3,262,432		3,262,432	91,468.00	35.67	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)		8,039,694		8,039,694			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		98,209		98,209			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		37,631		37,631			22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)		730,252		730,252			25
25.50	Home office wage-related		869,371		869,371			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		99,268	46,285	145,553	6,212.00	23.43	26
27	Administrative & General		4,531,197	-659,805	3,871,392	100,247.00	38.62	27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		1,243,645		1,243,645	48,714.00	25.53	30
31	Laundry & Linen Service							31
32	Housekeeping		1,065,471		1,065,471	67,490.00	15.79	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		915,268		915,268	52,995.00	17.27	34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		769,382		769,382	14,620.00	52.63	38
39	Central Services and Supply		200,432		200,432	10,063.00	19.92	39
40	Pharmacy		1,099,141	10,916	1,110,057	25,493.00	43.54	40
41	Medical Records & Medical Records Library		286,194	566,491	852,685	34,145.00	24.97	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		41,413,594	190,210	41,603,804	1,226,265.00	33.93	1
2	Excluded area salaries (see instructions)		2,035,689	36,113	2,071,802	61,809.00	33.52	2
3	Subtotal salaries (line 1 minus line 2)		39,377,905	154,097	39,532,002	1,164,456.00	33.95	3
4	Subtotal other wages & related costs (see instructions)		4,331,797		4,331,797	104,096.00	41.61	4
5	Subtotal wage-related costs (see instructions)		8,909,065		8,909,065		22.54%	5
6	Total (sum of lines 3 through 5)		52,618,767	154,097	52,772,864	1,268,552.00	41.60	6
7	Total overhead cost (see instructions)		10,209,998	-36,113	10,173,885	359,979.00	28.26	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	573,023	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)	3,254,618	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)	-74,048	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	957,793	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	3,134,281	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	133,956	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	2,216	22
23	Tuition Reimbursement	57,855	23
24	Total Wage Related cost (Sum of lines 1-23)	8,039,694	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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HOSPITAL CONTRACT LABOR AND BENEFIT COST**WORKSHEET S-3****Part V - Contract Labor and Benefit Cost****PART V****Hospital and Hospital-Based Component Identification:**

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	1,069,365	8,039,694	1
2	Hospital	1,069,365	8,039,694	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	14		14	3
4	RUL	110		110	4
5	RVX				5
6	RVL	1		1	6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML	14		14	10
11	RLX				11
12	RUC	175		175	12
13	RUB	256		256	13
14	RUA	2,588		2,588	14
15	RVC	72		72	15
16	RVB	70		70	16
17	RVA	416		416	17
18	RHC				18
19	RHB				19
20	RHA				20
21	RMC	1		1	21
22	RMB				22
23	RMA	48		48	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1	12		12	42
43	LB2				43
44	LB1	11		11	44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1	18		18	52
53	CA2				53
54	CA1	36		36	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
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

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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	
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1	35		35	76
77	PA2				77
78	PA1	34		34	78
199	AAA				199
200	TOTAL	3,911		3,911	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)	3,874,672			207

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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)	0.133199	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	18,575,025	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	8,740,282	5
6	Medicaid charges	238,044,630	6
7	Medicaid cost (line 1 times line 6)	31,707,307	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.	4,392,000	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)	4,392,000	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)	24,079,676	227,954	24,307,630	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,207,389	227,954	3,435,343	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)	3,207,389	227,954	3,435,343	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)	7,104,261	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	718,923	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,106,036	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	5,998,225	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,186,071	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	4,621,414	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,013,414	31

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				3,427,108	3,427,108	928,322	4,355,430	1
1.01	00101	CAP REL COSTS-BLDG & FIXT RIVER FOR						760,580	760,580	1.01
2	00200	Cap Rel Costs-Mvble Equip				2,070,328	2,070,328	893,812	2,964,140	2
4	00400	Employee Benefits Department	99,268	9,057,787	9,157,055	33,187	9,190,242	-1,043,719	8,146,523	4
5	00500	Administrative & General	4,531,197	14,298,415	18,829,612	-5,525,521	13,304,091	2,214,918	15,519,009	5
7	00700	Operation of Plant	1,243,645	4,271,263	5,514,908	-723,516	4,791,392	-18,520	4,772,872	7
7.01	00701	OPERATION OF PLANT-RIVER FOREST				723,834	723,834		723,834	7.01
8	00800	Laundry & Linen Service		575,922	575,922	12,539	588,461		588,461	8
9	00900	Housekeeping	1,065,471	948,855	2,014,326	-157,178	1,857,148	-77,026	1,780,122	9
9.01	00901	HOUSEKEEPING-RIVER FOREST				142,447	142,447		142,447	9.01
10	01000	Dietary	915,268	428,207	1,343,475	-12,304	1,331,171	-228,697	1,102,474	10
11	01100	Cafeteria								11
13	01300	Nursing Administration	769,382	34,140	803,522		803,522		803,522	13
14	01400	Central Services & Supply	200,432	393,684	594,116	-60,042	534,074	-1,084	532,990	14
15	01500	Pharmacy	1,099,141	3,368,596	4,467,737	-2,169,410	2,298,327	11,936	2,310,263	15
16	01600	Medical Records & Library	286,194	292,360	578,554	567,492	1,146,046	-12,804	1,133,242	16
21	02100	I&R Services-Salary & Fringes Apprvd	3,691,175		3,691,175	-190,210	3,500,965		3,500,965	21
22	02200	I&R Services-Other Prgm Costs Apprvd		1,236,862	1,236,862	190,210	1,427,072	-26,450	1,400,622	22
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	7,502,775	1,972,969	9,475,744	-165,682	9,310,062	-1,096,642	8,213,420	30
31	03100	Intensive Care Unit	1,731,802	815,687	2,547,489	-113,791	2,433,698	-75,349	2,358,349	31
43	04300	Nursery	673,614	55,974	729,588	-12,808	716,780		716,780	43
44	04400	Skilled Nursing Facility	1,575,389	220,194	1,795,583	-47,363	1,748,220	-24,872	1,723,348	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	2,635,661	4,027,419	6,663,080	-2,644,973	4,018,107	-11,475	4,006,632	50
51	05100	Recovery Room	464,944	58,807	523,751	-34,701	489,050		489,050	51
52	05200	Delivery Room & Labor Room	1,520,105	355,583	1,875,688	-139,854	1,735,834		1,735,834	52
53	05300	Anesthesiology	79,356	869,619	948,975	-28,956	920,019	-775,512	144,507	53
54	05400	Radiology-Diagnostic	2,047,477	916,475	2,963,952	-255,651	2,708,301	-53,112	2,655,189	54
55.01	03340	GASTRO INTESTINAL SERVICES	557,222	403,526	960,748	-213,586	747,162	-309	746,853	55.01
55.02	03630	ULTRA SOUND	597,813	37,647	635,460	-977	634,483		634,483	55.02
56	05600	Radioisotope	184,490	233,152	417,642	-151,227	266,415	-13,105	253,310	56
57	05700	CT Scan	528,767	235,880	764,647	-41,897	722,750	-2,491	720,259	57
58	05800	MRI	205,611	185,089	390,700	-15,611	375,089	-541	374,548	58
59	05900	Cardiac Catheterization	484,987	1,430,874	1,915,861	-901,904	1,013,957	-964	1,012,993	59
60	06000	Laboratory	1,426,460	1,677,388	3,103,848	-9,196	3,094,652		3,094,652	60
63	06300	Blood Storing, Processing & Trans.		432,538	432,538	-7,120	425,418		425,418	63
65	06500	Respiratory Therapy	760,872	183,030	943,902	-102,240	841,662	-5,189	836,473	65
66	06600	Physical Therapy	1,532,093	138,899	1,670,992	-9,127	1,661,865	-864	1,661,001	66
67	06700	Occupational Therapy	161,299	45,309	206,608		206,608		206,608	67
68	06800	Speech Pathology	130,719	2,171	132,890	-748	132,142		132,142	68
69	06900	Electrocardiology	433,889	137,344	571,233	-3,057	568,176	-82,849	485,327	69
71	07100	Medical Supplies Charged to Patients				1,762,129	1,762,129		1,762,129	71
72	07200	Impl. Dev. Charged to Patients				2,415,550	2,415,550		2,415,550	72
73	07300	Drugs Charged to Patients				4,894,786	4,894,786		4,894,786	73
74	07400	Renal Dialysis	51,687	610,074	661,761	-6,461	655,300		655,300	74
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	1,382,647	644,637	2,027,284	-164,629	1,862,655	-241,666	1,620,989	90
90.01	04950	DIABETOLOGY	38,782	478	39,260		39,260		39,260	90.01
90.02	04951	CANCER CENTER	422,065	3,818,852	4,240,917	-2,051,276	2,189,641	-3,723	2,185,918	90.02
90.03	09001	WOUND CARE	43,843	619,814	663,657	-16,251	647,406	-13,306	634,100	90.03
91	09100	Emergency	3,759,137	3,164,359	6,923,496	-170,867	6,752,629	-2,010,403	4,742,226	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	44,834,679	58,199,879	103,034,558	91,476	103,126,034	-1,011,104	102,114,930	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen		211	211		211		211	190
192	19200	Physicians' Private Offices								192
194	07950	MARKETING	98,261	422,237	520,498		520,498		520,498	194
194.01	07951	HOSPITALIST								194.01
194.02	07952	RETAIL PHARMACY	212,733	282,108	494,841	-132,973	361,868		361,868	194.02
194.03	07953	COMMUNITY RELATIONS	66,197	31,281	97,478		97,478		97,478	194.03
194.04	07954	PHYSICIAN CLINICS	83,109	1,207	84,316	-119	84,197		84,197	194.04
194.05	07955	GUEST MEALS								194.05
194.06	07956	CATERING MEALS								194.06
194.07	07957	RESEARCH,RIVER FOREST NONREIMB				41,616	41,616		41,616	194.07
200		TOTAL (sum of lines 118-199)	45,294,979	58,936,923	104,231,902		104,231,902	-1,011,104	103,220,798	200

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5
1	DEPRECIATION EXPENSE	A	Cap Rel Costs-Bldg & Fixt	1		3,080,670
2	DEPRECIATION EXPENSE	A	Cap Rel Costs-Mvble Equip	2		1,428,952
500	Total reclassifications					4,509,622
	Code Letter - A					
1	RENTS	B	Cap Rel Costs-Bldg & Fixt	1		250,459
2	RENTS	B	Cap Rel Costs-Mvble Equip	2		629,444
3	RENTS	B	Operation of Plant	7		327
4	RENTS	B				
5	RENTS	B				
6	RENTS	B				
7	RENTS	B				
8	RENTS	B				
9	RENTS	B				
10	RENTS	B				
11	RENTS	B				
500	Total reclassifications					880,230
	Code Letter - B					
1	INTEREST EXPENSE	C	Cap Rel Costs-Mvble Equip	2		11,932
500	Total reclassifications					11,932
	Code Letter - C					
1	PROPERTY TAX	D	Cap Rel Costs-Bldg & Fixt	1		76,044
500	Total reclassifications					76,044
	Code Letter - D					
1	INSURANCE	E	Cap Rel Costs-Bldg & Fixt	1		19,935
500	Total reclassifications					19,935
	Code Letter - E					
1	BILLABLE DRUGS	F	Drugs Charged to Patients	73		4,894,786
2	BILLABLE DRUGS	F	Central Services & Supply	14		10,539
3	BILLABLE DRUGS	F	Physical Therapy	66		1
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				
500	Total reclassifications					4,905,326
	Code Letter - F					
1	LINEN	G	Laundry & Linen Service	8		12,539
2	LINEN	G				
3	LINEN	G				
4	LINEN	G				
5	LINEN	G				
6	LINEN	G				
7	LINEN	G				
8	LINEN	G				
9	LINEN	G				
10	LINEN	G				
11	LINEN	G				
12	LINEN	G				

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RECLASSIFICATIONS
WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
13	LINEN	G					13
14	LINEN	G					14
15	LINEN	G					15
500	Total reclassifications					12,539	500
	Code Letter - G						
1	BILLABLE SUPPLIES	H	Medical Supplies Charged to P	71		1,762,129	1
2	BILLABLE SUPPLIES	H	Central Services & Supply	14		193,840	2
3	BILLABLE SUPPLIES	H					3
4	BILLABLE SUPPLIES	H					4
5	BILLABLE SUPPLIES	H					5
6	BILLABLE SUPPLIES	H					6
7	BILLABLE SUPPLIES	H					7
8	BILLABLE SUPPLIES	H					8
9	BILLABLE SUPPLIES	H					9
10	BILLABLE SUPPLIES	H					10
11	BILLABLE SUPPLIES	H					11
12	BILLABLE SUPPLIES	H					12
13	BILLABLE SUPPLIES	H					13
14	BILLABLE SUPPLIES	H					14
15	BILLABLE SUPPLIES	H					15
16	BILLABLE SUPPLIES	H					16
17	BILLABLE SUPPLIES	H					17
18	BILLABLE SUPPLIES	H					18
19	BILLABLE SUPPLIES	H					19
20	BILLABLE SUPPLIES	H					20
21	BILLABLE SUPPLIES	H					21
22	BILLABLE SUPPLIES	H					22
23	BILLABLE SUPPLIES	H					23
24	BILLABLE SUPPLIES	H					24
25	BILLABLE SUPPLIES	H					25
26	BILLABLE SUPPLIES	H					26
27	BILLABLE SUPPLIES	H					27
28	BILLABLE SUPPLIES	H					28
29	BILLABLE SUPPLIES	H					29
500	Total reclassifications					1,955,969	500
	Code Letter - H						
1	IMPLANTABLE DEVICES	I	Impl. Dev. Charged to Patient	72		2,415,550	1
2	IMPLANTABLE DEVICES	I					2
3	IMPLANTABLE DEVICES	I					3
4	IMPLANTABLE DEVICES	I					4
5	IMPLANTABLE DEVICES	I					5
6	IMPLANTABLE DEVICES	I					6
7	IMPLANTABLE DEVICES	I					7
8	IMPLANTABLE DEVICES	I					8
9	IMPLANTABLE DEVICES	I					9
10	IMPLANTABLE DEVICES	I					10
11	IMPLANTABLE DEVICES	I					11
500	Total reclassifications					2,415,550	500
	Code Letter - I						
1	CHICAGO MARKET (DEPT 5575)	J	Employee Benefits Department	4	46,285		1
2	CHICAGO MARKET (DEPT 5575)	J	Pharmacy	15	10,916	199	2
3	CHICAGO MARKET (DEPT 5575)	J	Medical Records & Library	16	566,491	1,001	3
4	CHICAGO MARKET (DEPT 5575)	J	RESEARCH,RIVER FOREST NONREIM	194.07	36,113	5,503	4
500	Total reclassifications				659,805	6,703	500
	Code Letter - J						
1	RIVER FOREST	K	OPERATION OF PLANT-RIVER FORE	7.01	115,559	608,275	1
2	RIVER FOREST	K	HOUSEKEEPING-RIVER FOREST	9.01		142,447	2
500	Total reclassifications				115,559	750,722	500
	Code Letter - K						
1	TEACHING PHYSICIAN	L	I&R Services-Other Prgm Costs	22	190,210		1
500	Total reclassifications				190,210		500
	Code Letter - L						
	GRAND TOTAL (Increases)				965,574	15,544,572	

(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		4,509,622	9		1
2	DEPRECIATION EXPENSE	A					9		2
500	Total reclassifications					4,509,622			500
	Code letter - A								
1	RENTS	B	Administrative & General	5		237,085	10		1
2	RENTS	B	Central Services & Supply	14		264,421	10		2
3	RENTS	B	Pharmacy	15		142,424			3
4	RENTS	B	Adults & Pediatrics	30		15,088			4
5	RENTS	B	Intensive Care Unit	31		20,818			5
6	RENTS	B	Skilled Nursing Facility	44		23,875			6
7	RENTS	B	Operating Room	50		70,478			7
8	RENTS	B	Radiology-Diagnostic	54		23,768			8
9	RENTS	B	Respiratory Therapy	65		61,356			9
10	RENTS	B	Clinic	90		20,209			10
11	RENTS	B	Emergency	91		708			11
500	Total reclassifications					880,230			500
	Code letter - B								
1	INTEREST EXPENSE	C	Administrative & General	5		11,932	11		1
500	Total reclassifications					11,932			500
	Code letter - C								
1	PROPERTY TAX	D	Administrative & General	5		76,044	13		1
500	Total reclassifications					76,044			500
	Code letter - D								
1	INSURANCE	E	Administrative & General	5		19,935	12		1
500	Total reclassifications					19,935			500
	Code letter - E								
1	BILLABLE DRUGS	F	Employee Benefits Department	4		13,098			1
2	BILLABLE DRUGS	F	Administrative & General	5		821			2
3	BILLABLE DRUGS	F	Operation of Plant	7		9			3
4	BILLABLE DRUGS	F	Dietary	10		11,038			4
5	BILLABLE DRUGS	F	Pharmacy	15		2,037,943			5
6	BILLABLE DRUGS	F	Adults & Pediatrics	30		59,470			6
7	BILLABLE DRUGS	F	Intensive Care Unit	31		33,668			7
8	BILLABLE DRUGS	F	Nursery	43		5,244			8
9	BILLABLE DRUGS	F	Skilled Nursing Facility	44		2,300			9
10	BILLABLE DRUGS	F	Operating Room	50		35,829			10
11	BILLABLE DRUGS	F	Recovery Room	51		5,310			11
12	BILLABLE DRUGS	F	Delivery Room & Labor Room	52		36,224			12
13	BILLABLE DRUGS	F	Anesthesiology	53		19,254			13
14	BILLABLE DRUGS	F	Radiology-Diagnostic	54		10,719			14
15	BILLABLE DRUGS	F	GASTRO INTESTINAL SERVICES	55.01		21,473			15
16	BILLABLE DRUGS	F	Radioisotope	56		148,230			16
17	BILLABLE DRUGS	F	CT Scan	57		29,017			17
18	BILLABLE DRUGS	F	MRI	58		15,241			18
19	BILLABLE DRUGS	F	Cardiac Catheterization	59		8,212			19
20	BILLABLE DRUGS	F	Laboratory	60		60			20
21	BILLABLE DRUGS	F	Blood Storing, Processing & T	63		6,867			21
22	BILLABLE DRUGS	F	Respiratory Therapy	65		838			22
23	BILLABLE DRUGS	F	Electrocardiology	69		293			23
24	BILLABLE DRUGS	F	Renal Dialysis	74		3,935			24
25	BILLABLE DRUGS	F	Clinic	90		125,226			25
26	BILLABLE DRUGS	F	CANCER CENTER	90.02		2,047,607			26
27	BILLABLE DRUGS	F	WOUND CARE	90.03		9,617			27
28	BILLABLE DRUGS	F	Emergency	91		84,691			28
29	BILLABLE DRUGS	F	RETAIL PHARMACY	194.02		132,973			29
30	BILLABLE DRUGS	F	PHYSICIAN CLINICS	194.04		119			30
500	Total reclassifications					4,905,326			500
	Code letter - F								
1	LINEN	G	Adults & Pediatrics	30		937			1
2	LINEN	G	Intensive Care Unit	31		1,106			2
3	LINEN	G	Nursery	43		223			3
4	LINEN	G	Skilled Nursing Facility	44		4			4
5	LINEN	G	Operating Room	50		185			5
6	LINEN	G	Delivery Room & Labor Room	52		68			6
7	LINEN	G	Radiology-Diagnostic	54		49			7
8	LINEN	G	GASTRO INTESTINAL SERVICES	55.01		532			8
9	LINEN	G	ULTRA SOUND	55.02		11			9
10	LINEN	G	Radioisotope	56		8			10
11	LINEN	G	MRI	58		181			11

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RECLASSIFICATIONS
WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
12	LINEN	G	Cardiac Catheterization	59		53		12
13	LINEN	G	Laboratory	60		5,565		13
14	LINEN	G	CANCER CENTER	90.02		30		14
15	LINEN	G	Emergency	91		3,587		15
500	Total reclassifications					12,539		500
	Code letter - G							
1	BILLABLE SUPPLIES	H	Administrative & General	5		3,574		1
2	BILLABLE SUPPLIES	H	Housekeeping	9		14,731		2
3	BILLABLE SUPPLIES	H	Dietary	10		1,266		3
4	BILLABLE SUPPLIES	H	Pharmacy	15		158		4
5	BILLABLE SUPPLIES	H	Adults & Pediatrics	30		90,049		5
6	BILLABLE SUPPLIES	H	Intensive Care Unit	31		57,505		6
7	BILLABLE SUPPLIES	H	Nursery	43		7,341		7
8	BILLABLE SUPPLIES	H	Skilled Nursing Facility	44		21,184		8
9	BILLABLE SUPPLIES	H	Operating Room	50		1,047,427		9
10	BILLABLE SUPPLIES	H	Recovery Room	51		29,391		10
11	BILLABLE SUPPLIES	H	Delivery Room & Labor Room	52		103,562		11
12	BILLABLE SUPPLIES	H	Anesthesiology	53		9,656		12
13	BILLABLE SUPPLIES	H	Radiology-Diagnostic	54		119,683		13
14	BILLABLE SUPPLIES	H	GASTRO INTESTINAL SERVICES	55.01		176,000		14
15	BILLABLE SUPPLIES	H	ULTRA SOUND	55.02		966		15
16	BILLABLE SUPPLIES	H	Radioisotope	56		2,989		16
17	BILLABLE SUPPLIES	H	CT Scan	57		11,553		17
18	BILLABLE SUPPLIES	H	MRI	58		189		18
19	BILLABLE SUPPLIES	H	Cardiac Catheterization	59		112,370		19
20	BILLABLE SUPPLIES	H	Laboratory	60		3,571		20
21	BILLABLE SUPPLIES	H	Blood Storing, Processing & T	63		253		21
22	BILLABLE SUPPLIES	H	Respiratory Therapy	65		40,046		22
23	BILLABLE SUPPLIES	H	Physical Therapy	66		9,128		23
24	BILLABLE SUPPLIES	H	Electrocardiology	69		2,764		24
25	BILLABLE SUPPLIES	H	Renal Dialysis	74		2,526		25
26	BILLABLE SUPPLIES	H	Clinic	90		476		26
27	BILLABLE SUPPLIES	H	CANCER CENTER	90.02		3,639		27
28	BILLABLE SUPPLIES	H	WOUND CARE	90.03		6,634		28
29	BILLABLE SUPPLIES	H	Emergency	91		77,338		29
500	Total reclassifications					1,955,969		500
	Code letter - H							
1	IMPLANTABLE DEVICES	I	Adults & Pediatrics	30		138		1
2	IMPLANTABLE DEVICES	I	Intensive Care Unit	31		694		2
3	IMPLANTABLE DEVICES	I	Operating Room	50		1,491,054		3
4	IMPLANTABLE DEVICES	I	Anesthesiology	53		46		4
5	IMPLANTABLE DEVICES	I	Radiology-Diagnostic	54		101,432		5
6	IMPLANTABLE DEVICES	I	GASTRO INTESTINAL SERVICES	55.01		15,581		6
7	IMPLANTABLE DEVICES	I	CT Scan	57		1,327		7
8	IMPLANTABLE DEVICES	I	Cardiac Catheterization	59		781,269		8
9	IMPLANTABLE DEVICES	I	Speech Pathology	68		748		9
10	IMPLANTABLE DEVICES	I	Clinic	90		18,718		10
11	IMPLANTABLE DEVICES	I	Emergency	91		4,543		11
500	Total reclassifications					2,415,550		500
	Code letter - I							
1	CHICAGO MARKET (DEPT 5575)	J	Administrative & General	5	659,805	6,703		1
2	CHICAGO MARKET (DEPT 5575)	J						2
3	CHICAGO MARKET (DEPT 5575)	J						3
4	CHICAGO MARKET (DEPT 5575)	J						4
500	Total reclassifications				659,805	6,703		500
	Code letter - J							
1	RIVER FOREST	K	Operation of Plant	7	115,559	608,275		1
2	RIVER FOREST	K	Housekeeping	9		142,447		2
500	Total reclassifications				115,559	750,722		500
	Code letter - K							
1	TEACHING PHYSICIAN	L	I&R Services-Salary & Fringes	21	190,210			1
500	Total reclassifications				190,210			500
	Code letter - L							
	GRAND TOTAL (Decreases)				965,574	15,544,572		

(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**

		Acquisitions							
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		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	157,985,781					157,985,781		3
4	Building Improvements								4
5	Fixed Equipment	20,640,059					20,640,059		5
6	Movable Equipment	106,342,663	1,180,511		1,180,511		107,523,174		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	289,259,244	1,180,511		1,180,511		290,439,755		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	289,259,244	1,180,511		1,180,511		290,439,755		10

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

		SUMMARY OF CAPITAL							
	Description	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

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	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	0.555775					1
1.01	CAP REL COSTS-BLDG & FI				0.000000					1.01
2	Cap Rel Costs-Mvble Equip	128,163,233		128,163,233	0.444225					2
3	Total (sum of lines 1-2)	288,509,403		288,509,403	1.000000					3

		SUMMARY OF CAPITAL							
	Description	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	4,155,679	250,459		19,935	-70,643		4,355,430	1
1.01	CAP REL COSTS-BLDG & FIXT RIVER FOR	28,095				732,485		760,580	1.01
2	Cap Rel Costs-Mvble Equip	2,322,764	629,444	11,932				2,964,140	2
3	Total (sum of lines 1-2)	6,506,538	879,903	11,932	19,935	661,842		8,080,150	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	-4,437,139				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-22,261				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-226,654	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	-12,804	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	-286,087	Cap Rel Costs-Bldg & Fixt	1	9	26
27	Depreciation--movable equipment	A	905,515	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	-13,748	Administrative & General	5		33
33.01	PBX SALARY	A	-24,390	Administrative & General	5		33.01
33.02	PBX BENEFITS	A	-45,525	Employee Benefits Department	4		33.02
33.03	TELEPHONE DEPRECIATION	A	-6,931	Cap Rel Costs-Mvble Equip	2	9	33.03
33.04	TELEVISION DEPRECIATION	A	-4,772	Cap Rel Costs-Mvble Equip	2	9	33.04
33.05	TELEVISION CABLE & SATELITE	A	-17,882	Operation of Plant	7		33.05
33.06	TELEVISION CABLE & SATELITE	A	-1,084	Central Services & Supply	14		33.06
33.07	TELEVISION CABLE & SATELITE	A	-34	Skilled Nursing Facility	44		33.07
33.08	TELEVISION CABLE & SATELITE	A	-4,307	Operating Room	50		33.08
33.09	TELEVISION CABLE & SATELITE	A	-309	GASTRO INTESTINAL SERVICES	55.01		33.09
33.10	TELEVISION CABLE & SATELITE	A	-291	Electrocardiology	69		33.10
33.11	TELEVISION CABLE & SATELITE	A	-1,395	CANCER CENTER	90.02		33.11
33.12	TELEVISION CABLE & SATELITE	A	-421	Emergency	91		33.12
33.13	OTHER OPERATING REVENUE	B	-15,387	Administrative & General	5		33.13
33.14	WSPH RECEIVABLE	B	-437,847	Administrative & General	5		33.14
33.15	MEDICAL STAFF APPLICATION FEES	B	39,485	Administrative & General	5		33.15
33.16	WELLNESS PROGRAMS	B	-249,677	Administrative & General	5		33.16
33.17	RESIDENCY PROGRAM REVENUES	B	-1,811,291	Administrative & General	5		33.17
33.18	ID BADGES	B	-638	Operation of Plant	7		33.18
33.19	RESIDENT STIPENDS	B	-25,939	I&R Services-Other Prgm Costs Apprvd	22		33.19
33.20	MATERNAL CHILD CARE CLASSES	B	-671	Adults & Pediatrics	30		33.20
33.21	OTHER OPERATING REVENUE	B	-4,135	Radiology-Diagnostic	54		33.21
33.22	INTEREST PAYMENTS	B	-517	Clinic	90		33.22
33.23	OTHER EXPENSE	A	-116	Administrative & General	5		33.23
33.24	OTHER EXPENSE	A	-9	Adults & Pediatrics	30		33.24
33.25	OTHER EXPENSE	A	-2	Operating Room	50		33.25
33.26	OTHER EXPENSE	A	-609	Radiology-Diagnostic	54		33.26
33.27	OTHER EXPENSE	A	-209	Clinic	90		33.27
33.28	OTHER EXPENSE	A	-446	Emergency	91		33.28
33.29	PURCHASED SVCS	A	-38,298	Administrative & General	5		33.29
33.30	PURCHASED SVCS	A	-77,026	Housekeeping	9		33.30
33.31	PURCHASED SVCS	A	-2,043	Dietary	10		33.31
33.32	PURCHASED SVCS	A	-383	Radiology-Diagnostic	54		33.32

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ADJUSTMENTS TO EXPENSES**WORKSHEET A-8**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE#		
		1	2	3	4	5	
33.33	PURCHASED SVCS	A	-541	MRI	58		33.33
33.34	PURCHASED SVCS	A	-864	Physical Therapy	66		33.34
33.35	TRAVEL	A	-87	Administrative & General	5		33.35
33.36	ALCOHOL	A	-511	I&R Services-Other Prgm Costs Apprvd	22		33.36
33.37	MEALS	A	-2,876	Administrative & General	5		33.37
33.38	PROPERTY TAXES	A	-146,687	Cap Rel Costs-Bldg & Fixt	1	13	33.38
33.39	DONATIONS/CONTRIBUTIONS	A	-1,527	Administrative & General	5		33.39
33.40	DUES & SUBSCRIPTION	A	-1,092	Administrative & General	5		33.40
33.41	DUES & SUBSCRIPTION	A	-964	Cardiac Catheterization	59		33.41
33.42	DUES & SUBSCRIPTION	A	-2,955	Clinic	90		33.42
33.43	DUES & SUBSCRIPTION	A	-207	CANCER CENTER	90.02		33.43
33.44	LOBBYING	A	-26,600	Administrative & General	5		33.44
33.45	PATIENT TRANSPORTATION	A	-598	Clinic	90		33.45
33.46	PENALTIES	A	-5,875	Administrative & General	5		33.46
33.47	PENALTIES	A	-2,411	Pharmacy	15		33.47
33.48	PENALTIES	A	-2,121	CANCER CENTER	90.02		33.48
33.49	NON-PATIENT BAD DEBT EXPENSE	A	-7,746	Administrative & General	5		33.49
33.50	RIVER FOREST PROPERTY TAXES	A	732,485	CAP REL COSTS-BLDG & FIXT RIVER FOR	1.01	13	33.50
33.51	RIVER FOREST DEPRECIATION EXP	A	28,095	CAP REL COSTS-BLDG & FIXT RIVER FOR	1.01	9	33.51
33.52	TENET H.O. WORKERS COMPENSATION	A	-551,251	Employee Benefits Department	4		33.52
33.53	PERIOD 13 ADJUSTMENT	A	-433,161	Employee Benefits Department	4		33.53
33.54	PERIOD 13 ADJUSTMENT	A	6,326,871	Administrative & General	5		33.54
33.55	CHIEF STRATEGY OFFICER	A	-70,422	Administrative & General	5		33.55
33.56	CHIEF STRATEGY OFFICER	A	-13,782	Employee Benefits Department	4		33.56
34							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)		-1,011,104				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 subscripits 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	855,189		855,189	9	1
2	1	Cap Rel Costs-Bldg & Fixt	HOME OFFICE POOLED CAPITAL	505,907		505,907	9	2
3	5	Administrative & General	HOME OFFICE SHARED SERVICES	1,676,158		1,676,158		3
4	5	Administrative & General	PERIOD 13 ADJ - IC OVERHEAD ALLOC		3,059,515	-3,059,515		4
4.01	1	Cap Rel Costs-Bldg & Fixt	REGIONAL ALLOCATION	230,243	230,243		10	4.01
4.02	2	Cap Rel Costs-Mvble Equip	REGIONAL ALLOCATION	6,972	6,972		10	4.02
4.03	4	Employee Benefits Department	REGIONAL ALLOCATION	46,285	46,285			4.03
4.04	5	Administrative & General	REGIONAL ALLOCATION	4,422,795	4,422,795			4.04
4.05	15	Pharmacy	REGIONAL ALLOCATION	11,115	11,115			4.05
4.06	16	Medical Records & Library	REGIONAL ALLOCATION	570,499	570,499			4.06
4.08	194.07	RESEARCH,RIVER FOREST NONREIMB	REGIONAL ALLOCATION	41,615	41,615			4.08
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			8,366,778	8,389,039	-22,261		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							7
8							8
9							9
10							10

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	5	Administrative & Gen ADMINISTRATIVE	61,102	61,102						1
2	15	Pharmacy PHARMACY	-14,347	-14,347						2
3	30	Adults & Pediatrics ADULTS & PEDIAT	1,095,962	1,095,962						3
4	31	Intensive Care Unit INTENSIVE CARE	75,349	75,349						4
5	44	Skilled Nursing Faci SKILLED NURSING	24,838	24,838						5
6	50	Operating Room OPERATING ROOM	7,166	7,166						6
7	53	Anesthesiology ANESTHESIOLOGY	775,512	775,512						7
8	54	Radiology-Diagnostic RADIOLOGY - DIA	47,985	47,985						8
9	56	Radioisotope RADIOISOTOPE	13,105	13,105						9
10	57	CT Scan CT SCAN	2,491	2,491						10
11	65	Respiratory Therapy RESPIRATORY THE	5,189	5,189						11
12	69	Electrocardiology ELECTRO CARDIOL	82,558	82,558						12
13	90	Clinic CLINIC	237,387	237,387						13
14	90.03	WOUND CARE WOUND CARE	13,306	13,306						14
15	91	Emergency EMERGENCY	2,009,536	2,009,536						15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	4,437,139	4,437,139						200

KPMG LLP Compu-Max 2552-10

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5	Administrative & Gen ADMINISTRATIVE							61,102	1
2	15	Pharmacy PHARMACY							-14,347	2
3	30	Adults & Pediatrics ADULTS & PEDIAT							1,095,962	3
4	31	Intensive Care Unit INTENSIVE CARE							75,349	4
5	44	Skilled Nursing Faci SKILLED NURSING							24,838	5
6	50	Operating Room OPERATING ROOM							7,166	6
7	53	Anesthesiology ANESTHESIOLOGY							775,512	7
8	54	Radiology-Diagnostic RADIOLOGY - DIA							47,985	8
9	56	Radioisotope RADIOISOTOPE							13,105	9
10	57	CT Scan CT SCAN							2,491	10
11	65	Respiratory Therapy RESPIRATORY THE							5,189	11
12	69	Electrocardiology ELECTRO CARDIOL							82,558	12
13	90	Clinic CLINIC							237,387	13
14	90.03	WOUND CARE WOUND CARE							13,306	14
15	91	Emergency EMERGENCY							2,009,536	15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							4,437,139	200

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES		CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	
		0	1	1.01	2	4	4A	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	4,355,430	4,355,430					1
1.01	CAP REL COSTS-BLDG & FIXT RIVER FOR	760,580		760,580				1.01
2	Cap Rel Costs-Mvble Equip	2,964,140			2,964,140			2
4	Employee Benefits Department	8,146,523				8,146,523		4
5	Administrative & General	15,519,009	282,597		183,370	698,535	16,683,511	5
7	Operation of Plant	4,772,872	1,127,376		731,523	203,546	6,835,317	7
7.01	OPERATION OF PLANT-RIVER FOREST	723,834		209,067	138,005	20,851	1,091,757	7.01
8	Laundry & Linen Service	588,461	14,599		9,473		612,533	8
9	Housekeeping	1,780,122	32,319		20,971	192,248	2,025,660	9
9.01	HOUSEKEEPING-RIVER FOREST	142,447					142,447	9.01
10	Dietary	1,102,474	146,175		94,849	165,146	1,508,644	10
11	Cafeteria							11
13	Nursing Administration	803,522	12,626		8,193	138,823	963,164	13
14	Central Services & Supply	532,990	52,914		34,334	36,165	656,403	14
15	Pharmacy	2,310,263	31,642		20,532	200,293	2,562,730	15
16	Medical Records & Library	1,133,242	6,193		4,018	153,854	1,297,307	16
21	I&R Services-Salary & Fringes Apprvd	3,500,965				631,697	4,132,662	21
22	I&R Services-Other Prgm Costs Apprvd	1,400,622	69,777		45,276	34,321	1,549,996	22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,213,420	551,831		358,069	1,353,751	10,477,071	30
31	Intensive Care Unit	2,358,349	135,076		87,647	312,478	2,893,550	31
43	Nursery	716,780	7,016		4,553	121,544	849,893	43
44	Skilled Nursing Facility	1,723,348	138,798		90,063	284,255	2,236,464	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,006,632	244,231		158,475	475,565	4,884,903	50
51	Recovery Room	489,050				83,892	572,942	51
52	Delivery Room & Labor Room	1,735,834	150,918		97,927	274,280	2,258,959	52
53	Anesthesiology	144,507	6,098		3,957	14,319	168,881	53
54	Radiology-Diagnostic	2,655,189	176,084	50,564	147,633	369,437	3,398,907	54
55.01	GASTRO INTESTINAL SERVICES	746,853	167,369		108,602	100,542	1,123,366	55.01
55.02	ULTRA SOUND	634,483				107,866	742,349	55.02
56	Radioisotope	253,310	24,686		16,018	33,288	327,302	56
57	CT Scan	720,259		36,879	24,344	95,408	876,890	57
58	MRI	374,548				37,099	411,647	58
59	Cardiac Catheterization	1,012,993	26,298		17,064	87,509	1,143,864	59
60	Laboratory	3,094,652	126,010		81,764	257,383	3,559,809	60
63	Blood Storing, Processing & Trans.	425,418	5,807		3,768		434,993	63
65	Respiratory Therapy	836,473	29,943		19,430	137,288	1,023,134	65
66	Physical Therapy	1,661,001	21,100	59,847	53,196	276,443	2,071,587	66
67	Occupational Therapy	206,608				29,104	235,712	67
68	Speech Pathology	132,142	12,832		8,326	23,586	176,886	68
69	Electrocardiology	485,327	24,214	41,306	42,978	78,289	672,114	69
71	Medical Supplies Charged to Patients	1,762,129					1,762,129	71
72	Impl. Dev. Charged to Patients	2,415,550					2,415,550	72
73	Drugs Charged to Patients	4,894,786					4,894,786	73
74	Renal Dialysis	655,300	4,589		2,978	9,326	672,193	74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,620,989	53,643		34,807	249,478	1,958,917	90
90.01	DIABETOLOGY	39,260				6,998	46,258	90.01
90.02	CANCER CENTER	2,185,918		108,033	71,312	76,155	2,441,418	90.02
90.03	WOUND CARE	634,100				7,911	642,011	90.03
91	Emergency	4,742,226	324,223		210,380	678,280	5,955,109	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	102,114,930	4,006,984	505,696	2,933,835	8,056,953	101,391,725	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	211	18,896		12,261		31,368	190
192	Physicians' Private Offices		301,742				301,742	192
194	MARKETING	520,498				17,730	538,228	194
194.01	HOSPITALIST							194.01
194.02	RETAIL PHARMACY	361,868		2,150		38,384	402,402	194.02
194.03	COMMUNITY RELATIONS	97,478				11,944	109,422	194.03
194.04	PHYSICIAN CLINICS	84,197	27,808		18,044	14,996	145,045	194.04
194.05	GUEST MEALS							194.05
194.06	CATERING MEALS							194.06
194.07	RESEARCH,RIVER FOREST NONREIMB	41,616		252,734		6,516	300,866	194.07
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	103,220,798	4,355,430	760,580	2,964,140	8,146,523	103,220,798	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	16,683,511						5
7	Operation of Plant	1,317,781	8,153,098					7
7.01	OPERATION OF PLANT-RIVER FOREST	210,480		1,302,237				7.01
8	Laundry & Linen Service	118,090	40,409		771,032			8
9	Housekeeping	390,527	89,461			2,505,648		9
9.01	HOUSEKEEPING-RIVER FOREST	27,462					169,909	9.01
10	Dietary	290,851	404,616			126,361		10
11	Cafeteria							11
13	Nursing Administration	185,688	34,949			10,914		13
14	Central Services & Supply	126,548	146,466			45,741		14
15	Pharmacy	494,069	87,585		626	27,353		15
16	Medical Records & Library	250,108	17,142			5,353		16
21	I&R Services-Salary & Fringes Apprvd	796,736						21
22	I&R Services-Other Prgm Costs Apprvd	298,824	193,143			60,319		22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,019,862	1,527,485		344,360	477,032		30
31	Intensive Care Unit	557,848	373,893		73,646	116,767		31
43	Nursery	163,851	19,421			6,065		43
44	Skilled Nursing Facility	431,168	384,198		88,736	119,985		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	941,760	676,038		82,566	211,126		50
51	Recovery Room	110,457						51
52	Delivery Room & Labor Room	435,505	417,745		3,726	130,462		52
53	Anesthesiology	32,559	16,881			5,272		53
54	Radiology-Diagnostic	655,275	487,405	119,391	42,440	152,216	15,578	54
55.01	GASTRO INTESTINAL SERVICES	216,574	463,283		12,488	144,683		55.01
55.02	ULTRA SOUND	143,117						55.02
56	Radioisotope	63,101	68,330			21,339		56
57	CT Scan	169,056		87,080			11,362	57
58	MRI	79,361						58
59	Cardiac Catheterization	220,526	72,794		1,421	22,733		59
60	Laboratory	686,296	348,798			108,929		60
63	Blood Storing, Processing & Trans.	83,862	16,074			5,020		63
65	Respiratory Therapy	197,250	82,884		1,308	25,885		65
66	Physical Therapy	399,381	58,406	141,311	3,981	18,240	18,437	66
67	Occupational Therapy	45,443						67
68	Speech Pathology	34,102	35,518			11,092		68
69	Electrocardiology	129,577	67,024	97,532	617	20,932	12,725	69
71	Medical Supplies Charged to Patients	339,721						71
72	Impl. Dev. Charged to Patients	465,694						72
73	Drugs Charged to Patients	943,666						73
74	Renal Dialysis	129,592	12,702		1,295	3,967		74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	377,660	148,484		3,362	46,372		90
90.01	DIABETOLOGY	8,918						90.01
90.02	CANCER CENTER	470,681		255,088			33,283	90.02
90.03	WOUND CARE	123,773						90.03
91	Emergency	1,148,085	897,458		110,460	280,275		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	16,330,885	7,188,592	700,402	771,032	2,204,433	91,385	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	6,047	52,304			16,335		190
192	Physicians' Private Offices	58,173	835,230			260,842		192
194	MARKETING	103,765						194
194.01	HOSPITALIST							194.01
194.02	RETAIL PHARMACY	77,579		5,077			662	194.02
194.03	COMMUNITY RELATIONS	21,095						194.03
194.04	PHYSICIAN CLINICS	27,963	76,972			24,038		194.04
194.05	GUEST MEALS							194.05
194.06	CATERING MEALS							194.06
194.07	RESEARCH,RIVER FOREST NONREIMB	58,004		596,758			77,862	194.07
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	16,683,511	8,153,098	1,302,237	771,032	2,505,648	169,909	202

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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	2,330,472						10
11	Cafeteria	1,161,065	1,161,065					11
13	Nursing Administration		23,475	1,218,190				13
14	Central Services & Supply		6,115		981,273			14
15	Pharmacy		33,869			3,206,232		15
16	Medical Records & Library		26,016				1,595,926	16
21	I&R Services-Salary & Fringes Apprvd		106,818					21
22	I&R Services-Other Prgm Costs Apprvd		5,803					22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	542,644	228,927	450,364			167,436	30
31	Intensive Care Unit	95,693	52,839	91,456			37,881	31
43	Nursery		20,553	29,054			26,455	43
44	Skilled Nursing Facility	262,320	48,067	104,177			8,985	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		80,417	148,047			142,960	50
51	Recovery Room		14,186	18,766			26,087	51
52	Delivery Room & Labor Room		46,380	78,282			32,574	52
53	Anesthesiology		2,421	6,465			19,389	53
54	Radiology-Diagnostic		62,471				81,212	54
55.01	GASTRO INTESTINAL SERVICES		17,001	31,465			52,938	55.01
55.02	ULTRA SOUND		18,240				31,619	55.02
56	Radioisotope		5,629				10,082	56
57	CT Scan		16,133				105,209	57
58	MRI		6,273				25,851	58
59	Cardiac Catheterization		14,797	17,703			43,911	59
60	Laboratory		43,523				162,257	60
63	Blood Storing, Processing & Trans.						10,019	63
65	Respiratory Therapy		23,215				38,353	65
66	Physical Therapy		46,746				40,731	66
67	Occupational Therapy		4,921				7,816	67
68	Speech Pathology		3,988				2,434	68
69	Electrocardiology		13,238	28,725			37,312	69
71	Medical Supplies Charged to Patients				412,135		53,989	71
72	Impl. Dev. Charged to Patients				569,138		41,680	72
73	Drugs Charged to Patients					3,206,232	171,020	73
74	Renal Dialysis		1,577				3,440	74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		42,186				11,836	90
90.01	DIABETOLOGY		1,183				109	90.01
90.02	CANCER CENTER		12,878				4,139	90.02
90.03	WOUND CARE		1,338				8,242	90.03
91	Emergency		114,695	213,686			189,960	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,061,722	1,145,918	1,218,190	981,273	3,206,232	1,595,926	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	268,750						192
194	MARKETING		2,998					194
194.01	HOSPITALIST							194.01
194.02	RETAIL PHARMACY		6,491					194.02
194.03	COMMUNITY RELATIONS		2,020					194.03
194.04	PHYSICIAN CLINICS		2,536					194.04
194.05	GUEST MEALS							194.05
194.06	CATERING MEALS							194.06
194.07	RESEARCH,RIVER FOREST NONREIMB		1,102					194.07
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,330,472	1,161,065	1,218,190	981,273	3,206,232	1,595,926	202

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

	COST CENTER DESCRIPTIONS	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		21	22	24	25	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	5,036,216						21
22	I&R Services-Other Prgm Costs Apprvd		2,108,085					22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,036,216	2,108,085	23,379,482	-7,144,301	16,235,181		30
31	Intensive Care Unit			4,293,573		4,293,573		31
43	Nursery			1,115,292		1,115,292		43
44	Skilled Nursing Facility			3,684,100		3,684,100		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			7,167,817		7,167,817		50
51	Recovery Room			742,438		742,438		51
52	Delivery Room & Labor Room			3,403,633		3,403,633		52
53	Anesthesiology			251,868		251,868		53
54	Radiology-Diagnostic			5,014,895		5,014,895		54
55.01	GASTRO INTESTINAL SERVICES			2,061,798		2,061,798		55.01
55.02	ULTRA SOUND			935,325		935,325		55.02
56	Radioisotope			495,783		495,783		56
57	CT Scan			1,265,730		1,265,730		57
58	MRI			523,132		523,132		58
59	Cardiac Catheterization			1,537,749		1,537,749		59
60	Laboratory			4,909,612		4,909,612		60
63	Blood Storing, Processing & Trans.			549,968		549,968		63
65	Respiratory Therapy			1,392,029		1,392,029		65
66	Physical Therapy			2,798,820		2,798,820		66
67	Occupational Therapy			293,892		293,892		67
68	Speech Pathology			264,020		264,020		68
69	Electrocardiology			1,079,796		1,079,796		69
71	Medical Supplies Charged to Patients			2,567,974		2,567,974		71
72	Impl. Dev. Charged to Patients			3,492,062		3,492,062		72
73	Drugs Charged to Patients			9,215,704		9,215,704		73
74	Renal Dialysis			824,766		824,766		74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			2,588,817		2,588,817		90
90.01	DIABETOLOGY			56,468		56,468		90.01
90.02	CANCER CENTER			3,217,487		3,217,487		90.02
90.03	WOUND CARE			775,364		775,364		90.03
91	Emergency			8,909,728		8,909,728		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,036,216	2,108,085	98,809,122	-7,144,301	91,664,821		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			106,054		106,054		190
192	Physicians' Private Offices			1,724,737		1,724,737		192
194	MARKETING			644,991		644,991		194
194.01	HOSPITALIST							194.01
194.02	RETAIL PHARMACY			492,211		492,211		194.02
194.03	COMMUNITY RELATIONS			132,537		132,537		194.03
194.04	PHYSICIAN CLINICS			276,554		276,554		194.04
194.05	GUEST MEALS							194.05
194.06	CATERING MEALS							194.06
194.07	RESEARCH,RIVER FOREST NONREIMB			1,034,592		1,034,592		194.07
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,036,216	2,108,085	103,220,798	-7,144,301	96,076,497		202

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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		282,597		183,370	465,967	465,967	5
7	Operation of Plant		1,127,376		731,523	1,858,899	36,808	7
7.01	OPERATION OF PLANT-RIVER FOREST			209,067	138,005	347,072	5,879	7.01
8	Laundry & Linen Service		14,599		9,473	24,072	3,298	8
9	Housekeeping		32,319		20,971	53,290	10,908	9
9.01	HOUSEKEEPING-RIVER FOREST						767	9.01
10	Dietary		146,175		94,849	241,024	8,124	10
11	Cafeteria							11
13	Nursing Administration		12,626		8,193	20,819	5,187	13
14	Central Services & Supply		52,914		34,334	87,248	3,535	14
15	Pharmacy		31,642		20,532	52,174	13,800	15
16	Medical Records & Library		6,193		4,018	10,211	6,986	16
21	I&R Services-Salary & Fringes Apprvd						22,254	21
22	I&R Services-Other Prgm Costs Apprvd		69,777		45,276	115,053	8,347	22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		551,831		358,069	909,900	56,385	30
31	Intensive Care Unit		135,076		87,647	222,723	15,582	31
43	Nursery		7,016		4,553	11,569	4,577	43
44	Skilled Nursing Facility		138,798		90,063	228,861	12,043	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		244,231		158,475	402,706	26,305	50
51	Recovery Room						3,085	51
52	Delivery Room & Labor Room		150,918		97,927	248,845	12,164	52
53	Anesthesiology		6,098		3,957	10,055	909	53
54	Radiology-Diagnostic		176,084	50,564	147,633	374,281	18,303	54
55.01	GASTRO INTESTINAL SERVICES		167,369		108,602	275,971	6,049	55.01
55.02	ULTRA SOUND						3,998	55.02
56	Radioisotope		24,686		16,018	40,704	1,763	56
57	CT Scan			36,879	24,344	61,223	4,722	57
58	MRI						2,217	58
59	Cardiac Catheterization		26,298		17,064	43,362	6,160	59
60	Laboratory		126,010		81,764	207,774	19,170	60
63	Blood Storing, Processing & Trans.		5,807		3,768	9,575	2,342	63
65	Respiratory Therapy		29,943		19,430	49,373	5,510	65
66	Physical Therapy		21,100	59,847	53,196	134,143	11,155	66
67	Occupational Therapy						1,269	67
68	Speech Pathology		12,832		8,326	21,158	953	68
69	Electrocardiology		24,214	41,306	42,978	108,498	3,619	69
71	Medical Supplies Charged to Patients						9,489	71
72	Impl. Dev. Charged to Patients						13,008	72
73	Drugs Charged to Patients						26,358	73
74	Renal Dialysis		4,589		2,978	7,567	3,620	74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		53,643		34,807	88,450	10,549	90
90.01	DIABETOLOGY						249	90.01
90.02	CANCER CENTER			108,033	71,312	179,345	13,147	90.02
90.03	WOUND CARE						3,457	90.03
91	Emergency		324,223		210,380	534,603	32,068	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		4,006,984	505,696	2,933,835	7,446,515	456,118	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		18,896		12,261	31,157	169	190
192	Physicians' Private Offices		301,742			301,742	1,625	192
194	MARKETING						2,898	194
194.01	HOSPITALIST							194.01
194.02	RETAIL PHARMACY			2,150		2,150	2,167	194.02
194.03	COMMUNITY RELATIONS						589	194.03
194.04	PHYSICIAN CLINICS		27,808		18,044	45,852	781	194.04
194.05	GUEST MEALS							194.05
194.06	CATERING MEALS							194.06
194.07	RESEARCH,RIVER FOREST NONREIMB			252,734		252,734	1,620	194.07
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		4,355,430	760,580	2,964,140	8,080,150	465,967	202

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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	1,895,707						7
7.01	OPERATION OF PLANT-RIVER FOREST		352,951					7.01
8	Laundry & Linen Service	9,396		36,766				8
9	Housekeeping	20,801			84,999			9
9.01	HOUSEKEEPING-RIVER FOREST					767		9.01
10	Dietary	94,079			4,287		347,514	10
11	Cafeteria						173,135	11
13	Nursing Administration	8,126			370			13
14	Central Services & Supply	34,055			1,552			14
15	Pharmacy	20,365		30	928			15
16	Medical Records & Library	3,986			182			16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	44,908			2,046			22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	355,161		16,421	16,181		80,918	30
31	Intensive Care Unit	86,935		3,512	3,961		14,270	31
43	Nursery	4,516			206			43
44	Skilled Nursing Facility	89,331		4,231	4,070		39,116	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	157,188		3,937	7,162			50
51	Recovery Room							51
52	Delivery Room & Labor Room	97,132		178	4,426			52
53	Anesthesiology	3,925			179			53
54	Radiology-Diagnostic	113,328	32,359	2,024	5,164	70		54
55.01	GASTRO INTESTINAL SERVICES	107,720		595	4,908			55.01
55.02	ULTRA SOUND							55.02
56	Radioisotope	15,888			724			56
57	CT Scan		23,602			51		57
58	MRI							58
59	Cardiac Catheterization	16,926		68	771			59
60	Laboratory	81,100			3,695			60
63	Blood Storing, Processing & Trans.	3,737			170			63
65	Respiratory Therapy	19,272		62	878			65
66	Physical Therapy	13,580	38,300	190	619	83		66
67	Occupational Therapy							67
68	Speech Pathology	8,259			376			68
69	Electrocardiology	15,584	26,434	29	710	57		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	2,953		62	135			74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	34,525		160	1,573			90
90.01	DIABETOLOGY							90.01
90.02	CANCER CENTER		69,138			150		90.02
90.03	WOUND CARE							90.03
91	Emergency	208,671		5,267	9,508			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,671,447	189,833	36,766	74,781	411	307,439	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	12,161			554			190
192	Physicians' Private Offices	194,202			8,849		40,075	192
194	MARKETING							194
194.01	HOSPITALIST							194.01
194.02	RETAIL PHARMACY		1,376			3		194.02
194.03	COMMUNITY RELATIONS							194.03
194.04	PHYSICIAN CLINICS	17,897			815			194.04
194.05	GUEST MEALS							194.05
194.06	CATERING MEALS							194.06
194.07	RESEARCH,RIVER FOREST NONREIMB		161,742			353		194.07
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,895,707	352,951	36,766	84,999	767	347,514	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	173,135						11
13	Nursing Administration	3,501	38,003					13
14	Central Services & Supply	912		127,302				14
15	Pharmacy	5,051			92,348			15
16	Medical Records & Library	3,880				25,245		16
21	I&R Services-Salary & Fringes Apprvd	15,929					38,183	21
22	I&R Services-Other Prgm Costs Apprvd	865						22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	34,132	14,051			2,671		30
31	Intensive Care Unit	7,880	2,853			604		31
43	Nursery	3,065	906			422		43
44	Skilled Nursing Facility	7,168	3,250			143		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	11,992	4,618			2,281		50
51	Recovery Room	2,115	585			416		51
52	Delivery Room & Labor Room	6,916	2,442			520		52
53	Anesthesiology	361	202			309		53
54	Radiology-Diagnostic	9,316				1,296		54
55.01	GASTRO INTESTINAL SERVICES	2,535	982			845		55.01
55.02	ULTRA SOUND	2,720				504		55.02
56	Radioisotope	839				161		56
57	CT Scan	2,406				1,679		57
58	MRI	936				412		58
59	Cardiac Catheterization	2,207	552			701		59
60	Laboratory	6,490				2,589		60
63	Blood Storing, Processing & Trans.					160		63
65	Respiratory Therapy	3,462				612		65
66	Physical Therapy	6,971				650		66
67	Occupational Therapy	734				125		67
68	Speech Pathology	595				39		68
69	Electrocardiology	1,974	896			595		69
71	Medical Supplies Charged to Patients			53,467		861		71
72	Impl. Dev. Charged to Patients			73,835		665		72
73	Drugs Charged to Patients				92,348	2,729		73
74	Renal Dialysis	235				55		74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	6,291				189		90
90.01	DIABETOLOGY	176				2		90.01
90.02	CANCER CENTER	1,920				66		90.02
90.03	WOUND CARE	199				132		90.03
91	Emergency	17,104	6,666			2,812		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	170,877	38,003	127,302	92,348	25,245		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	MARKETING	447						194
194.01	HOSPITALIST							194.01
194.02	RETAIL PHARMACY	968						194.02
194.03	COMMUNITY RELATIONS	301						194.03
194.04	PHYSICIAN CLINICS	378						194.04
194.05	GUEST MEALS							194.05
194.06	CATERING MEALS							194.06
194.07	RESEARCH,RIVER FOREST NONREIMB	164						194.07
200	Cross Foot Adjustments						38,183	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	173,135	38,003	127,302	92,348	25,245	38,183	202

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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			
	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	171,219						22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,485,820		1,485,820			30
31	Intensive Care Unit		358,320		358,320			31
43	Nursery		25,261		25,261			43
44	Skilled Nursing Facility		388,213		388,213			44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		616,189		616,189			50
51	Recovery Room		6,201		6,201			51
52	Delivery Room & Labor Room		372,623		372,623			52
53	Anesthesiology		15,940		15,940			53
54	Radiology-Diagnostic		556,141		556,141			54
55.01	GASTRO INTESTINAL SERVICES		399,605		399,605			55.01
55.02	ULTRA SOUND		7,222		7,222			55.02
56	Radioisotope		60,079		60,079			56
57	CT Scan		93,683		93,683			57
58	MRI		3,565		3,565			58
59	Cardiac Catheterization		70,747		70,747			59
60	Laboratory		320,818		320,818			60
63	Blood Storing, Processing & Trans.		15,984		15,984			63
65	Respiratory Therapy		79,169		79,169			65
66	Physical Therapy		205,691		205,691			66
67	Occupational Therapy		2,128		2,128			67
68	Speech Pathology		31,380		31,380			68
69	Electrocardiology		158,396		158,396			69
71	Medical Supplies Charged to Patients		63,817		63,817			71
72	Impl. Dev. Charged to Patients		87,508		87,508			72
73	Drugs Charged to Patients		121,435		121,435			73
74	Renal Dialysis		14,627		14,627			74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		141,737		141,737			90
90.01	DIABETOLOGY		427		427			90.01
90.02	CANCER CENTER		263,766		263,766			90.02
90.03	WOUND CARE		3,788		3,788			90.03
91	Emergency		816,699		816,699			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		6,786,979		6,786,979			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		44,041		44,041			190
192	Physicians' Private Offices		546,493		546,493			192
194	MARKETING		3,345		3,345			194
194.01	HOSPITALIST							194.01
194.02	RETAIL PHARMACY		6,664		6,664			194.02
194.03	COMMUNITY RELATIONS		890		890			194.03
194.04	PHYSICIAN CLINICS		65,723		65,723			194.04
194.05	GUEST MEALS							194.05
194.06	CATERING MEALS							194.06
194.07	RESEARCH,RIVER FOREST NONREIMB		416,613		416,613			194.07
200	Cross Foot Adjustments	171,219	209,402		209,402			200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	171,219	8,080,150		8,080,150			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 DEPARTMENT 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				45,149,426			4
5	Administrative & General	32,947		32,947	3,871,392	-16,683,511	86,537,287	5
7	Operation of Plant	131,437		131,437	1,128,086		6,835,317	7
7.01	OPERATION OF PLANT-RIVER FOREST		24,796	24,796	115,559		1,091,757	7.01
8	Laundry & Linen Service	1,702		1,702			612,533	8
9	Housekeeping	3,768		3,768	1,065,471		2,025,660	9
9.01	HOUSEKEEPING-RIVER FOREST						142,447	9.01
10	Dietary	17,042		17,042	915,268		1,508,644	10
11	Cafeteria							11
13	Nursing Administration	1,472		1,472	769,382		963,164	13
14	Central Services & Supply	6,169		6,169	200,432		656,403	14
15	Pharmacy	3,689		3,689	1,110,057		2,562,730	15
16	Medical Records & Library	722		722	852,685		1,297,307	16
21	I&R Services-Salary & Fringes Apprvd				3,500,965		4,132,662	21
22	I&R Services-Other Prgm Costs Apprvd	8,135		8,135	190,210		1,549,996	22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	64,336		64,336	7,502,775		10,477,071	30
31	Intensive Care Unit	15,748		15,748	1,731,802		2,893,550	31
43	Nursery	818		818	673,614		849,893	43
44	Skilled Nursing Facility	16,182		16,182	1,575,389		2,236,464	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	28,474		28,474	2,635,661		4,884,903	50
51	Recovery Room				464,944		572,942	51
52	Delivery Room & Labor Room	17,595		17,595	1,520,105		2,258,959	52
53	Anesthesiology	711		711	79,356		168,881	53
54	Radiology-Diagnostic	20,529	5,997	26,526	2,047,477		3,398,907	54
55.01	GASTRO INTESTINAL SERVICES	19,513		19,513	557,222		1,123,366	55.01
55.02	ULTRA SOUND				597,813		742,349	55.02
56	Radioisotope	2,878		2,878	184,490		327,302	56
57	CT Scan		4,374	4,374	528,767		876,890	57
58	MRI				205,611		411,647	58
59	Cardiac Catheterization	3,066		3,066	484,987		1,143,864	59
60	Laboratory	14,691		14,691	1,426,460		3,559,809	60
63	Blood Storing, Processing & Trans.	677		677			434,993	63
65	Respiratory Therapy	3,491		3,491	760,872		1,023,134	65
66	Physical Therapy	2,460	7,098	9,558	1,532,093		2,071,587	66
67	Occupational Therapy				161,299		235,712	67
68	Speech Pathology	1,496		1,496	130,719		176,886	68
69	Electrocardiology	2,823	4,899	7,722	433,889		672,114	69
71	Medical Supplies Charged to Patients						1,762,129	71
72	Impl. Dev. Charged to Patients						2,415,550	72
73	Drugs Charged to Patients						4,894,786	73
74	Renal Dialysis	535		535	51,687		672,193	74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	6,254		6,254	1,382,647		1,958,917	90
90.01	DIABETOLOGY				38,782		46,258	90.01
90.02	CANCER CENTER		12,813	12,813	422,065		2,441,418	90.02
90.03	WOUND CARE				43,843		642,011	90.03
91	Emergency	37,800		37,800	3,759,137		5,955,109	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	44,653,013	-16,683,511	84,708,214	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	2,203		2,203			31,368	190
192	Physicians' Private Offices	35,179					301,742	192
194	MARKETING				98,261		538,228	194
194.01	HOSPITALIST							194.01
194.02	RETAIL PHARMACY		255		212,733		402,402	194.02
194.03	COMMUNITY RELATIONS				66,197		109,422	194.03
194.04	PHYSICIAN CLINICS	3,242		3,242	83,109		145,045	194.04
194.05	GUEST MEALS							194.05
194.06	CATERING MEALS							194.06
194.07	RESEARCH,RIVER FOREST NONREIMB		29,975		36,113		300,866	194.07
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	4,355,430	760,580	2,964,140	8,146,523		16,683,511	202
203	Unit Cost Multiplier (Wkst. B, Part I)	8.577328	8.431496	5.565603	0.180435		0.192790	203
204	Cost to be allocated (Per Wkst. B, Part II)						465,967	204
205	Unit Cost Multiplier (Wkst. B, Part II)						0.005385	205

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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 DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
		1	1.01	2	4	5A	5	
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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		801,352				8
9	Housekeeping	3,768			337,930			9
9.01	HOUSEKEEPING-RIVER FOREST					65,411		9.01
10	Dietary	17,042			17,042		286,325	10
11	Cafeteria						142,650	11
13	Nursing Administration	1,472			1,472			13
14	Central Services & Supply	6,169			6,169			14
15	Pharmacy	3,689		651	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		357,901	64,336		66,670	30
31	Intensive Care Unit	15,748		76,542	15,748		11,757	31
43	Nursery	818			818			43
44	Skilled Nursing Facility	16,182		92,225	16,182		32,229	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	28,474		85,813	28,474			50
51	Recovery Room							51
52	Delivery Room & Labor Room	17,595		3,873	17,595			52
53	Anesthesiology	711			711			53
54	Radiology-Diagnostic	20,529	5,997	44,109	20,529	5,997		54
55.01	GASTRO INTESTINAL SERVICES	19,513		12,979	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		1,477	3,066			59
60	Laboratory	14,691			14,691			60
63	Blood Storing, Processing & Trans.	677			677			63
65	Respiratory Therapy	3,491		1,359	3,491			65
66	Physical Therapy	2,460	7,098	4,138	2,460	7,098		66
67	Occupational Therapy							67
68	Speech Pathology	1,496			1,496			68
69	Electrocardiology	2,823	4,899	641	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		1,346	535			74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	6,254		3,494	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		114,804	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	801,352	297,306	35,181	253,306	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	2,203			2,203			190
192	Physicians' Private Offices	35,179			35,179		33,019	192
194	MARKETING							194
194.01	HOSPITALIST							194.01
194.02	RETAIL PHARMACY		255			255		194.02
194.03	COMMUNITY RELATIONS							194.03
194.04	PHYSICIAN CLINICS	3,242			3,242			194.04
194.05	GUEST MEALS							194.05
194.06	CATERING MEALS							194.06
194.07	RESEARCH,RIVER FOREST NONREIMB		29,975			29,975		194.07
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	8,153,098	1,302,237	771,032	2,505,648	169,909	2,330,472	202
203	Unit Cost Multiplier (Wkst. B, Part I)	23.742277	19.908532	0.962164	7.414695	2.597560	8.139254	203
204	Cost to be allocated (Per Wkst. B, Part II)	1,895,707	352,951	36,766	84,999	767	347,514	204
205	Unit Cost Multiplier (Wkst. B, Part II)	5.520405	5.395897	0.045880	0.251528	0.011726	1.213705	205

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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	
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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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	38,053,650						11
13	Nursing Administration		594,871					13
14	Central Services & Supply	200,432		100				14
15	Pharmacy	1,110,057			100			15
16	Medical Records & Library	852,685				688,179,440		16
21	I&R Services-Salary & Fringes Apprvd	3,500,965					5,752	21
22	I&R Services-Other Prgm Costs Apprvd	190,210						22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	7,502,775	219,923			72,202,024	5,752	30
31	Intensive Care Unit	1,731,802	44,660			16,334,990		31
43	Nursery	673,614	14,188			11,407,723		43
44	Skilled Nursing Facility	1,575,389	50,872			3,874,672		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,635,661	72,295			61,647,454		50
51	Recovery Room	464,944	9,164			11,249,168		51
52	Delivery Room & Labor Room	1,520,105	38,227			14,046,580		52
53	Anesthesiology	79,356	3,157			8,360,909		53
54	Radiology-Diagnostic	2,047,477				35,020,173		54
55.01	GASTRO INTESTINAL SERVICES	557,222	15,365			22,828,075		55.01
55.02	ULTRA SOUND	597,813				13,634,756		55.02
56	Radioisotope	184,490				4,347,508		56
57	CT Scan	528,767				45,368,166		57
58	MRI	205,611				11,147,352		58
59	Cardiac Catheterization	484,987	8,645			18,935,178		59
60	Laboratory	1,426,460				69,968,589		60
63	Blood Storing, Processing & Trans.					4,320,255		63
65	Respiratory Therapy	760,872				16,538,487		65
66	Physical Therapy	1,532,093				17,564,057		66
67	Occupational Therapy	161,299				3,370,310		67
68	Speech Pathology	130,719				1,049,433		68
69	Electrocardiology	433,889	14,027			16,089,829		69
71	Medical Supplies Charged to Patients			42		23,281,067		71
72	Impl. Dev. Charged to Patients			58		17,973,277		72
73	Drugs Charged to Patients				100	73,747,381		73
74	Renal Dialysis	51,687				1,483,581		74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,382,647				5,103,926		90
90.01	DIABETOLOGY	38,782				46,792		90.01
90.02	CANCER CENTER	422,065				1,784,649		90.02
90.03	WOUND CARE	43,843				3,554,130		90.03
91	Emergency	3,759,137	104,348			81,898,949		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	37,557,237	594,871	100	100	688,179,440	5,752	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	MARKETING	98,261						194
194.01	HOSPITALIST							194.01
194.02	RETAIL PHARMACY	212,733						194.02
194.03	COMMUNITY RELATIONS	66,197						194.03
194.04	PHYSICIAN CLINICS	83,109						194.04
194.05	GUEST MEALS							194.05
194.06	CATERING MEALS							194.06
194.07	RESEARCH,RIVER FOREST NONREIMB	36,113						194.07
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,161,065	1,218,190	981,273	3,206,232	1,595,926	5,036,216	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.030511	2.047822	9,812.730000	32,062.320000	0.002319	875.559110	203
204	Cost to be allocated (Per Wkst. B, Part II)	173,135	38,003	127,302	92,348	25,245	38,183	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.004550	0.063884	1,273.020000	923.480000	0.000037	6.638213	205

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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	
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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	5,752						22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,752						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)	5,752						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	MARKETING							194
194.01	HOSPITALIST							194.01
194.02	RETAIL PHARMACY							194.02
194.03	COMMUNITY RELATIONS							194.03
194.04	PHYSICIAN CLINICS							194.04
194.05	GUEST MEALS							194.05
194.06	CATERING MEALS							194.06
194.07	RESEARCH,RIVER FOREST NONREIMB							194.07
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,108,085						202
203	Unit Cost Multiplier (Wkst. B, Part I)	366.496001						203

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	I&R PROGRAM COSTS ASSIGNED TIME						
		22						
204	Cost to be allocated (Per Wkst. B, Part II)	171,219						204
205	Unit Cost Multiplier (Wkst. B, Part II)	29.766864						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

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	16,235,181		16,235,181		16,235,181	30
31	Intensive Care Unit	4,293,573		4,293,573		4,293,573	31
43	Nursery	1,115,292		1,115,292		1,115,292	43
44	Skilled Nursing Facility	3,684,100		3,684,100		3,684,100	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	7,167,817		7,167,817		7,167,817	50
51	Recovery Room	742,438		742,438		742,438	51
52	Delivery Room & Labor Room	3,403,633		3,403,633		3,403,633	52
53	Anesthesiology	251,868		251,868		251,868	53
54	Radiology-Diagnostic	5,014,895		5,014,895		5,014,895	54
55.01	GASTRO INTESTINAL SERVICES	2,061,798		2,061,798		2,061,798	55.01
55.02	ULTRA SOUND	935,325		935,325		935,325	55.02
56	Radioisotope	495,783		495,783		495,783	56
57	CT Scan	1,265,730		1,265,730		1,265,730	57
58	MRI	523,132		523,132		523,132	58
59	Cardiac Catheterization	1,537,749		1,537,749		1,537,749	59
60	Laboratory	4,909,612		4,909,612		4,909,612	60
63	Blood Storing, Processing & Trans.	549,968		549,968		549,968	63
65	Respiratory Therapy	1,392,029		1,392,029		1,392,029	65
66	Physical Therapy	2,798,820		2,798,820		2,798,820	66
67	Occupational Therapy	293,892		293,892		293,892	67
68	Speech Pathology	264,020		264,020		264,020	68
69	Electrocardiology	1,079,796		1,079,796		1,079,796	69
71	Medical Supplies Charged to Patients	2,567,974		2,567,974		2,567,974	71
72	Impl. Dev. Charged to Patients	3,492,062		3,492,062		3,492,062	72
73	Drugs Charged to Patients	9,215,704		9,215,704		9,215,704	73
74	Renal Dialysis	824,766		824,766		824,766	74
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	2,588,817		2,588,817		2,588,817	90
90.01	DIABETOLOGY	56,468		56,468		56,468	90.01
90.02	CANCER CENTER	3,217,487		3,217,487		3,217,487	90.02
90.03	WOUND CARE	775,364		775,364		775,364	90.03
91	Emergency	8,909,728		8,909,728		8,909,728	91
92	Observation Beds (Non-Distinct Part)	1,134,844		1,134,844		1,134,844	92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	92,799,665		92,799,665		92,799,665	200
201	Less Observation Beds	1,134,844		1,134,844		1,134,844	201
202	Total (line 200 minus line 201)	91,664,821		91,664,821		91,664,821	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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	67,965,273		67,965,273				30
31	Intensive Care Unit	16,334,990		16,334,990				31
43	Nursery	11,407,723		11,407,723				43
44	Skilled Nursing Facility	3,874,672		3,874,672				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	27,492,864	34,154,590	61,647,454	0.116271	0.116271	0.116271	50
51	Recovery Room	4,970,237	6,278,931	11,249,168	0.065999	0.065999	0.065999	51
52	Delivery Room & Labor Room	13,859,551	187,029	14,046,580	0.242310	0.242310	0.242310	52
53	Anesthesiology	3,019,789	5,341,120	8,360,909	0.030124	0.030124	0.030124	53
54	Radiology-Diagnostic	5,419,656	29,600,517	35,020,173	0.143200	0.143200	0.143200	54
55.01	GASTRO INTESTINAL SERVICES	3,750,975	19,077,100	22,828,075	0.090319	0.090319	0.090319	55.01
55.02	ULTRA SOUND	2,358,699	11,276,057	13,634,756	0.068599	0.068599	0.068599	55.02
56	Radioisotope	1,850,783	2,496,725	4,347,508	0.114038	0.114038	0.114038	56
57	CT Scan	13,901,531	31,466,635	45,368,166	0.027899	0.027899	0.027899	57
58	MRI	2,098,759	9,048,593	11,147,352	0.046929	0.046929	0.046929	58
59	Cardiac Catheterization	10,420,108	8,515,070	18,935,178	0.081211	0.081211	0.081211	59
60	Laboratory	41,752,064	28,216,525	69,968,589	0.070169	0.070169	0.070169	60
63	Blood Storing, Processing & Trans.	3,584,219	736,036	4,320,255	0.127300	0.127300	0.127300	63
65	Respiratory Therapy	14,440,791	2,097,696	16,538,487	0.084169	0.084169	0.084169	65
66	Physical Therapy	11,523,287	6,040,770	17,564,057	0.159349	0.159349	0.159349	66
67	Occupational Therapy	3,200,302	170,008	3,370,310	0.087200	0.087200	0.087200	67
68	Speech Pathology	1,015,851	33,582	1,049,433	0.251583	0.251583	0.251583	68
69	Electrocardiology	8,161,911	7,927,918	16,089,829	0.067110	0.067110	0.067110	69
71	Medical Supplies Charged to Patients	10,708,882	12,572,185	23,281,067	0.110303	0.110303	0.110303	71
72	Impl. Dev. Charged to Patients	10,077,214	7,896,063	17,973,277	0.194292	0.194292	0.194292	72
73	Drugs Charged to Patients	28,692,305	45,055,076	73,747,381	0.124963	0.124963	0.124963	73
74	Renal Dialysis	1,429,621	53,960	1,483,581	0.555929	0.555929	0.555929	74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	110,378	4,993,548	5,103,926	0.507221	0.507221	0.507221	90
90.01	DIABETOLOGY		46,792	46,792	1.206787	1.206787	1.206787	90.01
90.02	CANCER CENTER	312	1,784,337	1,784,649	1.802868	1.802868	1.802868	90.02
90.03	WOUND CARE	4,020	3,550,110	3,554,130	0.218159	0.218159	0.218159	90.03
91	Emergency	14,755,279	67,143,670	81,898,949	0.108789	0.108789	0.108789	91
92	Observation Beds (Non-Distinct Part)	736,966	3,499,785	4,236,751	0.267857	0.267857	0.267857	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	338,919,012	349,260,428	688,179,440				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	338,919,012	349,260,428	688,179,440				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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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 (from Wkst. B, Part I, col. 26)	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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	67,965,273		67,965,273				30
31	Intensive Care Unit	16,334,990		16,334,990				31
43	Nursery	11,407,723		11,407,723				43
44	Skilled Nursing Facility	3,874,672		3,874,672				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	27,492,864	34,154,590	61,647,454				50
51	Recovery Room	4,970,237	6,278,931	11,249,168				51
52	Delivery Room & Labor Room	13,859,551	187,029	14,046,580				52
53	Anesthesiology	3,019,789	5,341,120	8,360,909				53
54	Radiology-Diagnostic	5,419,656	29,600,517	35,020,173				54
55.01	GASTRO INTESTINAL SERVICES	3,750,975	19,077,100	22,828,075				55.01
55.02	ULTRA SOUND	2,358,699	11,276,057	13,634,756				55.02
56	Radioisotope	1,850,783	2,496,725	4,347,508				56
57	CT Scan	13,901,531	31,466,635	45,368,166				57
58	MRI	2,098,759	9,048,593	11,147,352				58
59	Cardiac Catheterization	10,420,108	8,515,070	18,935,178				59
60	Laboratory	41,752,064	28,216,525	69,968,589				60
63	Blood Storing, Processing & Trans.	3,584,219	736,036	4,320,255				63
65	Respiratory Therapy	14,440,791	2,097,696	16,538,487				65
66	Physical Therapy	11,523,287	6,040,770	17,564,057				66
67	Occupational Therapy	3,200,302	170,008	3,370,310				67
68	Speech Pathology	1,015,851	33,582	1,049,433				68
69	Electrocardiology	8,161,911	7,927,918	16,089,829				69
71	Medical Supplies Charged to Patients	10,708,882	12,572,185	23,281,067				71
72	Impl. Dev. Charged to Patients	10,077,214	7,896,063	17,973,277				72
73	Drugs Charged to Patients	28,692,305	45,055,076	73,747,381				73
74	Renal Dialysis	1,429,621	53,960	1,483,581				74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	110,378	4,993,548	5,103,926				90
90.01	DIABETOLOGY		46,792	46,792				90.01
90.02	CANCER CENTER	312	1,784,337	1,784,649				90.02
90.03	WOUND CARE	4,020	3,550,110	3,554,130				90.03
91	Emergency	14,755,279	67,143,670	81,898,949				91
92	Observation Beds (Non-Distinct Part)	736,966	3,499,785	4,236,751				92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	338,919,012	349,260,428	688,179,440				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	338,919,012	349,260,428	688,179,440				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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	16,235,181		16,235,181		16,235,181	30
31	Intensive Care Unit	4,293,573		4,293,573		4,293,573	31
43	Nursery	1,115,292		1,115,292		1,115,292	43
44	Skilled Nursing Facility	3,684,100		3,684,100		3,684,100	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	7,167,817		7,167,817		7,167,817	50
51	Recovery Room	742,438		742,438		742,438	51
52	Delivery Room & Labor Room	3,403,633		3,403,633		3,403,633	52
53	Anesthesiology	251,868		251,868		251,868	53
54	Radiology-Diagnostic	5,014,895		5,014,895		5,014,895	54
55.01	GASTRO INTESTINAL SERVICES	2,061,798		2,061,798		2,061,798	55.01
55.02	ULTRA SOUND	935,325		935,325		935,325	55.02
56	Radioisotope	495,783		495,783		495,783	56
57	CT Scan	1,265,730		1,265,730		1,265,730	57
58	MRI	523,132		523,132		523,132	58
59	Cardiac Catheterization	1,537,749		1,537,749		1,537,749	59
60	Laboratory	4,909,612		4,909,612		4,909,612	60
63	Blood Storing, Processing & Trans.	549,968		549,968		549,968	63
65	Respiratory Therapy	1,392,029		1,392,029		1,392,029	65
66	Physical Therapy	2,798,820		2,798,820		2,798,820	66
67	Occupational Therapy	293,892		293,892		293,892	67
68	Speech Pathology	264,020		264,020		264,020	68
69	Electrocardiology	1,079,796		1,079,796		1,079,796	69
71	Medical Supplies Charged to Patients	2,567,974		2,567,974		2,567,974	71
72	Impl. Dev. Charged to Patients	3,492,062		3,492,062		3,492,062	72
73	Drugs Charged to Patients	9,215,704		9,215,704		9,215,704	73
74	Renal Dialysis	824,766		824,766		824,766	74
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	2,588,817		2,588,817		2,588,817	90
90.01	DIABETOLOGY	56,468		56,468		56,468	90.01
90.02	CANCER CENTER	3,217,487		3,217,487		3,217,487	90.02
90.03	WOUND CARE	775,364		775,364		775,364	90.03
91	Emergency	8,909,728		8,909,728		8,909,728	91
92	Observation Beds (Non-Distinct Part)	1,134,844		1,134,844		1,134,844	92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	92,799,665		92,799,665		92,799,665	200
201	Less Observation Beds	1,134,844		1,134,844		1,134,844	201
202	Total (line 200 minus line 201)	91,664,821		91,664,821		91,664,821	202

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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	67,965,273		67,965,273				30
31	Intensive Care Unit	16,334,990		16,334,990				31
43	Nursery	11,407,723		11,407,723				43
44	Skilled Nursing Facility	3,874,672		3,874,672				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	27,492,864	34,154,590	61,647,454	0.116271	0.116271	0.116271	50
51	Recovery Room	4,970,237	6,278,931	11,249,168	0.065999	0.065999	0.065999	51
52	Delivery Room & Labor Room	13,859,551	187,029	14,046,580	0.242310	0.242310	0.242310	52
53	Anesthesiology	3,019,789	5,341,120	8,360,909	0.030124	0.030124	0.030124	53
54	Radiology-Diagnostic	5,419,656	29,600,517	35,020,173	0.143200	0.143200	0.143200	54
55.01	GASTRO INTESTINAL SERVICES	3,750,975	19,077,100	22,828,075	0.090319	0.090319	0.090319	55.01
55.02	ULTRA SOUND	2,358,699	11,276,057	13,634,756	0.068599	0.068599	0.068599	55.02
56	Radioisotope	1,850,783	2,496,725	4,347,508	0.114038	0.114038	0.114038	56
57	CT Scan	13,901,531	31,466,635	45,368,166	0.027899	0.027899	0.027899	57
58	MRI	2,098,759	9,048,593	11,147,352	0.046929	0.046929	0.046929	58
59	Cardiac Catheterization	10,420,108	8,515,070	18,935,178	0.081211	0.081211	0.081211	59
60	Laboratory	41,752,064	28,216,525	69,968,589	0.070169	0.070169	0.070169	60
63	Blood Storing, Processing & Trans.	3,584,219	736,036	4,320,255	0.127300	0.127300	0.127300	63
65	Respiratory Therapy	14,440,791	2,097,696	16,538,487	0.084169	0.084169	0.084169	65
66	Physical Therapy	11,523,287	6,040,770	17,564,057	0.159349	0.159349	0.159349	66
67	Occupational Therapy	3,200,302	170,008	3,370,310	0.087200	0.087200	0.087200	67
68	Speech Pathology	1,015,851	33,582	1,049,433	0.251583	0.251583	0.251583	68
69	Electrocardiology	8,161,911	7,927,918	16,089,829	0.067110	0.067110	0.067110	69
71	Medical Supplies Charged to Patients	10,708,882	12,572,185	23,281,067	0.110303	0.110303	0.110303	71
72	Impl. Dev. Charged to Patients	10,077,214	7,896,063	17,973,277	0.194292	0.194292	0.194292	72
73	Drugs Charged to Patients	28,692,305	45,055,076	73,747,381	0.124963	0.124963	0.124963	73
74	Renal Dialysis	1,429,621	53,960	1,483,581	0.555929	0.555929	0.555929	74
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	110,378	4,993,548	5,103,926	0.507221	0.507221	0.507221	90
90.01	DIABETOLOGY		46,792	46,792	1.206787	1.206787	1.206787	90.01
90.02	CANCER CENTER	312	1,784,337	1,784,649	1.802868	1.802868	1.802868	90.02
90.03	WOUND CARE	4,020	3,550,110	3,554,130	0.218159	0.218159	0.218159	90.03
91	Emergency	14,755,279	67,143,670	81,898,949	0.108789	0.108789	0.108789	91
92	Observation Beds (Non-Distinct Part)	736,966	3,499,785	4,236,751	0.267857	0.267857	0.267857	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	338,919,012	349,260,428	688,179,440				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	338,919,012	349,260,428	688,179,440				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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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	7,167,817	616,189	6,551,628		50
51	Recovery Room	742,438	6,201	736,237		51
52	Delivery Room & Labor Room	3,403,633	372,623	3,031,010		52
53	Anesthesiology	251,868	15,940	235,928		53
54	Radiology-Diagnostic	5,014,895	556,141	4,458,754		54
55.01	GASTRO INTESTINAL SERVICES	2,061,798	399,605	1,662,193		55.01
55.02	ULTRA SOUND	935,325	7,222	928,103		55.02
56	Radioisotope	495,783	60,079	435,704		56
57	CT Scan	1,265,730	93,683	1,172,047		57
58	MRI	523,132	3,565	519,567		58
59	Cardiac Catheterization	1,537,749	70,747	1,467,002		59
60	Laboratory	4,909,612	320,818	4,588,794		60
63	Blood Storing, Processing & Trans.	549,968	15,984	533,984		63
65	Respiratory Therapy	1,392,029	79,169	1,312,860		65
66	Physical Therapy	2,798,820	205,691	2,593,129		66
67	Occupational Therapy	293,892	2,128	291,764		67
68	Speech Pathology	264,020	31,380	232,640		68
69	Electrocardiology	1,079,796	158,396	921,400		69
71	Medical Supplies Charged to Patients	2,567,974	63,817	2,504,157		71
72	Impl. Dev. Charged to Patients	3,492,062	87,508	3,404,554		72
73	Drugs Charged to Patients	9,215,704	121,435	9,094,269		73
74	Renal Dialysis	824,766	14,627	810,139		74
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic	2,588,817	141,737	2,447,080		90
90.01	DIABETOLOGY	56,468	427	56,041		90.01
90.02	CANCER CENTER	3,217,487	263,766	2,953,721		90.02
90.03	WOUND CARE	775,364	3,788	771,576		90.03
91	Emergency	8,909,728	816,699	8,093,029		91
92	Observation Beds (Non-Distinct Part)	1,134,844	103,860	1,030,984		92
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal	67,471,519	4,633,225	62,838,294		200
201	Less Observation Beds	1,134,844	103,860	1,030,984		201
202	Total	66,336,675	4,529,365	61,807,310		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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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		7,167,817	61,647,454	0.116271	50
51	Recovery Room		742,438	11,249,168	0.065999	51
52	Delivery Room & Labor Room		3,403,633	14,046,580	0.242310	52
53	Anesthesiology		251,868	8,360,909	0.030124	53
54	Radiology-Diagnostic		5,014,895	35,020,173	0.143200	54
55.01	GASTRO INTESTINAL SERVICES		2,061,798	22,828,075	0.090319	55.01
55.02	ULTRA SOUND		935,325	13,634,756	0.068599	55.02
56	Radioisotope		495,783	4,347,508	0.114038	56
57	CT Scan		1,265,730	45,368,166	0.027899	57
58	MRI		523,132	11,147,352	0.046929	58
59	Cardiac Catheterization		1,537,749	18,935,178	0.081211	59
60	Laboratory		4,909,612	69,968,589	0.070169	60
63	Blood Storing, Processing & Trans.		549,968	4,320,255	0.127300	63
65	Respiratory Therapy		1,392,029	16,538,487	0.084169	65
66	Physical Therapy		2,798,820	17,564,057	0.159349	66
67	Occupational Therapy		293,892	3,370,310	0.087200	67
68	Speech Pathology		264,020	1,049,433	0.251583	68
69	Electrocardiology		1,079,796	16,089,829	0.067110	69
71	Medical Supplies Charged to Patients		2,567,974	23,281,067	0.110303	71
72	Impl. Dev. Charged to Patients		3,492,062	17,973,277	0.194292	72
73	Drugs Charged to Patients		9,215,704	73,747,381	0.124963	73
74	Renal Dialysis		824,766	1,483,581	0.555929	74
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic		2,588,817	5,103,926	0.507221	90
90.01	DIABETOLOGY		56,468	46,792	1.206787	90.01
90.02	CANCER CENTER		3,217,487	1,784,649	1.802868	90.02
90.03	WOUND CARE		775,364	3,554,130	0.218159	90.03
91	Emergency		8,909,728	81,898,949	0.108789	91
92	Observation Beds (Non-Distinct Part)		1,134,844	4,236,751	0.267857	92
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal		67,471,519	588,596,782		200
201	Less Observation Beds		1,134,844	4,236,751		201
202	Total		66,336,675	584,360,031		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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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)	1,485,820		1,485,820	16,638	89.30	4,456	397,921	30
31	Intensive Care Unit	358,320		358,320	2,787	128.57	959	123,299	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	25,261		25,261	2,841	8.89			43
44	Skilled Nursing Facility	388,213		388,213	7,641	50.81	3,911	198,718	44
45	Nursing Facility								45
200	Total (lines 30-199)	2,257,614		2,257,614	29,907		9,326	719,938	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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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 ☐ TEFRA
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	616,189	61,647,454	0.009995	9,538,764	95,340	50
51	Recovery Room	6,201	11,249,168	0.000551	1,376,637	759	51
52	Delivery Room & Labor Room	372,623	14,046,580	0.026528	46,110	1,223	52
53	Anesthesiology	15,940	8,360,909	0.001906	906,527	1,728	53
54	Radiology-Diagnostic	556,141	35,020,173	0.015881	1,484,823	23,580	54
55.01	GASTRO INTESTINAL SERVICES	399,605	22,828,075	0.017505	1,159,222	20,292	55.01
55.02	ULTRA SOUND	7,222	13,634,756	0.000530	254,564	135	55.02
56	Radioisotope	60,079	4,347,508	0.013819	511,797	7,073	56
57	CT Scan	93,683	45,368,166	0.002065	4,363,482	9,011	57
58	MRI	3,565	11,147,352	0.000320	601,862	193	58
59	Cardiac Catheterization	70,747	18,935,178	0.003736	3,103,268	11,594	59
60	Laboratory	320,818	69,968,589	0.004585	12,711,998	58,285	60
63	Blood Storing, Processing & Tra	15,984	4,320,255	0.003700	622,800	2,304	63
65	Respiratory Therapy	79,169	16,538,487	0.004787	3,987,739	19,089	65
66	Physical Therapy	205,691	17,564,057	0.011711	1,607,767	18,829	66
67	Occupational Therapy	2,128	3,370,310	0.000631	1,234,620	779	67
68	Speech Pathology	31,380	1,049,433	0.029902	288,829	8,637	68
69	Electrocardiology	158,396	16,089,829	0.009844	2,782,850	27,394	69
71	Medical Supplies Charged to Pat	63,817	23,281,067	0.002741	2,125,581	5,826	71
72	Impl. Dev. Charged to Patients	87,508	17,973,277	0.004869	4,885,306	23,787	72
73	Drugs Charged to Patients	121,435	73,747,381	0.001647	7,373,644	12,144	73
74	Renal Dialysis	14,627	1,483,581	0.009859	744,560	7,341	74
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	141,737	5,103,926	0.027770			90
90.01	DIABETOLOGY	427	46,792	0.009125			90.01
90.02	CANCER CENTER	263,766	1,784,649	0.147797			90.02
90.03	WOUND CARE	3,788	3,554,130	0.001066			90.03
91	Emergency	816,699	81,898,949	0.009972	4,119,998	41,085	91
92	Observation Beds (Non-Distinct	103,860	4,236,751	0.024514	217,987	5,344	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	4,633,225	588,596,782		66,050,735	401,772	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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	16,638		4,456		30
31	Intensive Care Unit	2,787		959		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	2,841				43
44	Skilled Nursing Facility	7,641		3,911		44
45	Nursing Facility					45
200	Total (lines 30-199)	29,907		9,326		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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0049

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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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 [XX] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
Applicable [XX] 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	61,647,454			9,538,764		9,139,245		50
51	Recovery Room	11,249,168			1,376,637		1,524,341		51
52	Delivery Room & Labor Room	14,046,580			46,110		954		52
53	Anesthesiology	8,360,909			906,527		908,413		53
54	Radiology-Diagnostic	35,020,173			1,484,823		1,687,596		54
55.01	GASTRO INTESTINAL SERVICES	22,828,075			1,159,222		3,169,198		55.01
55.02	ULTRA SOUND	13,634,756			254,564		640,124		55.02
56	Radioisotope	4,347,508			511,797		477,959		56
57	CT Scan	45,368,166			4,363,482		5,495,376		57
58	MRI	11,147,352			601,862		1,605,191		58
59	Cardiac Catheterization	18,935,178			3,103,268		2,115,096		59
60	Laboratory	69,968,589			12,711,998		3,823,481		60
63	Blood Storing, Processing & Tra	4,320,255			622,800		26,246		63
65	Respiratory Therapy	16,538,487			3,987,739		237,307		65
66	Physical Therapy	17,564,057			1,607,767		49,438		66
67	Occupational Therapy	3,370,310			1,234,620		40,262		67
68	Speech Pathology	1,049,433			288,829		3,055		68
69	Electrocardiology	16,089,829			2,782,850		1,962,421		69
71	Medical Supplies Charged to Pat	23,281,067			2,125,581		2,252,847		71
72	Impl. Dev. Charged to Patients	17,973,277			4,885,306		2,075,494		72
73	Drugs Charged to Patients	73,747,381			7,373,644		12,601,249		73
74	Renal Dialysis	1,483,581			744,560		26,295		74
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	5,103,926					221,882		90
90.01	DIABETOLOGY	46,792							90.01
90.02	CANCER CENTER	1,784,649							90.02
90.03	WOUND CARE	3,554,130					198,032		90.03
91	Emergency	81,898,949			4,119,998		6,255,064		91
92	Observation Beds (Non-Distinct	4,236,751			217,987		668,665		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	588,596,782			66,050,735		57,205,231		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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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 [XX] Hospital [] SUB (Other) [] Swing Bed SNF
Applicable [XX] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
Boxes: [] Title XIX - O/P [] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.116271	9,139,245			1,062,629			50
51	Recovery Room	0.065999	1,524,341			100,605			51
52	Delivery Room & Labor Room	0.242310	954			231			52
53	Anesthesiology	0.030124	908,413			27,365			53
54	Radiology-Diagnostic	0.143200	1,687,596			241,664			54
55.01	GASTRO INTESTINAL SERVICES	0.090319	3,169,198			286,239			55.01
55.02	ULTRA SOUND	0.068599	640,124			43,912			55.02
56	Radioisotope	0.114038	477,959			54,505			56
57	CT Scan	0.027899	5,495,376			153,315			57
58	MRI	0.046929	1,605,191			75,330			58
59	Cardiac Catheterization	0.081211	2,115,096			171,769			59
60	Laboratory	0.070169	3,823,481		120	268,290		8	60
63	Blood Storing, Processing & Tra	0.127300	26,246			3,341			63
65	Respiratory Therapy	0.084169	237,307			19,974			65
66	Physical Therapy	0.159349	49,438			7,878			66
67	Occupational Therapy	0.087200	40,262			3,511			67
68	Speech Pathology	0.251583	3,055			769			68
69	Electrocardiology	0.067110	1,962,421			131,698			69
71	Medical Supplies Charged to Pat	0.110303	2,252,847			248,496			71
72	Impl. Dev. Charged to Patients	0.194292	2,075,494			403,252			72
73	Drugs Charged to Patients	0.124963	12,601,249		27,444	1,574,690		3,429	73
74	Renal Dialysis	0.555929	26,295			14,618			74
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.507221	221,882			112,543			90
90.01	DIABETOLOGY	1.206787							90.01
90.02	CANCER CENTER	1.802868							90.02
90.03	WOUND CARE	0.218159	198,032			43,202			90.03
91	Emergency	0.108789	6,255,064			680,482			91
92	Observation Beds (Non-Distinct	0.267857	668,665			179,107			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		57,205,231		27,564	5,909,415		3,437	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		57,205,231		27,564	5,909,415		3,437	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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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

		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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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	61,647,454			5,439				50
51	Recovery Room	11,249,168							51
52	Delivery Room & Labor Room	14,046,580							52
53	Anesthesiology	8,360,909							53
54	Radiology-Diagnostic	35,020,173			61,508				54
55.01	GASTRO INTESTINAL SERVICES	22,828,075							55.01
55.02	ULTRA SOUND	13,634,756			5,359				55.02
56	Radioisotope	4,347,508							56
57	CT Scan	45,368,166			20,702				57
58	MRI	11,147,352							58
59	Cardiac Catheterization	18,935,178			42,585				59
60	Laboratory	69,968,589			1,484,952				60
63	Blood Storing, Processing & Tra	4,320,255			33,481				63
65	Respiratory Therapy	16,538,487			477,946				65
66	Physical Therapy	17,564,057			4,638,456				66
67	Occupational Therapy	3,370,310							67
68	Speech Pathology	1,049,433			230,266				68
69	Electrocardiology	16,089,829			41,232				69
71	Medical Supplies Charged to Pat	23,281,067			255,303				71
72	Impl. Dev. Charged to Patients	17,973,277							72
73	Drugs Charged to Patients	73,747,381			1,712,351				73
74	Renal Dialysis	1,483,581			1,384				74
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	5,103,926							90
90.01	DIABETOLOGY	46,792							90.01
90.02	CANCER CENTER	1,784,649							90.02
90.03	WOUND CARE	3,554,130							90.03
91	Emergency	81,898,949							91
92	Observation Beds (Non-Distinct	4,236,751							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	588,596,782			9,010,964				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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-5743

WORKSHEET D
PART V

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.116271							50
51	Recovery Room	0.065999							51
52	Delivery Room & Labor Room	0.242310							52
53	Anesthesiology	0.030124							53
54	Radiology-Diagnostic	0.143200							54
55.01	GASTRO INTESTINAL SERVICES	0.090319							55.01
55.02	ULTRA SOUND	0.068599							55.02
56	Radioisotope	0.114038							56
57	CT Scan	0.027899							57
58	MRI	0.046929							58
59	Cardiac Catheterization	0.081211							59
60	Laboratory	0.070169							60
63	Blood Storing, Processing & Tra	0.127300							63
65	Respiratory Therapy	0.084169							65
66	Physical Therapy	0.159349							66
67	Occupational Therapy	0.087200							67
68	Speech Pathology	0.251583							68
69	Electrocardiology	0.067110							69
71	Medical Supplies Charged to Pat	0.110303							71
72	Impl. Dev. Charged to Patients	0.194292							72
73	Drugs Charged to Patients	0.124963							73
74	Renal Dialysis	0.555929							74
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.507221							90
90.01	DIABETOLOGY	1.206787							90.01
90.02	CANCER CENTER	1.802868							90.02
90.03	WOUND CARE	0.218159							90.03
91	Emergency	0.108789							91
92	Observation Beds (Non-Distinct	0.267857							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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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)	1,485,820		1,485,820	16,638	89.30	1,548	138,236	30
31	Intensive Care Unit	358,320		358,320	2,787	128.57	220	28,285	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	25,261		25,261	2,841	8.89	993	8,828	43
44	Skilled Nursing Facility	388,213		388,213	7,641	50.81			44
45	Nursing Facility								45
200	Total (lines 30-199)	2,257,614		2,257,614	29,907		2,761	175,349	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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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	616,189	61,647,454	0.009995			50
51	Recovery Room	6,201	11,249,168	0.000551			51
52	Delivery Room & Labor Room	372,623	14,046,580	0.026528			52
53	Anesthesiology	15,940	8,360,909	0.001906			53
54	Radiology-Diagnostic	556,141	35,020,173	0.015881			54
55.01	GASTRO INTESTINAL SERVICES	399,605	22,828,075	0.017505			55.01
55.02	ULTRA SOUND	7,222	13,634,756	0.000530			55.02
56	Radioisotope	60,079	4,347,508	0.013819			56
57	CT Scan	93,683	45,368,166	0.002065			57
58	MRI	3,565	11,147,352	0.000320			58
59	Cardiac Catheterization	70,747	18,935,178	0.003736			59
60	Laboratory	320,818	69,968,589	0.004585			60
63	Blood Storing, Processing & Tra	15,984	4,320,255	0.003700			63
65	Respiratory Therapy	79,169	16,538,487	0.004787			65
66	Physical Therapy	205,691	17,564,057	0.011711			66
67	Occupational Therapy	2,128	3,370,310	0.000631			67
68	Speech Pathology	31,380	1,049,433	0.029902			68
69	Electrocardiology	158,396	16,089,829	0.009844			69
71	Medical Supplies Charged to Pat	63,817	23,281,067	0.002741			71
72	Impl. Dev. Charged to Patients	87,508	17,973,277	0.004869			72
73	Drugs Charged to Patients	121,435	73,747,381	0.001647			73
74	Renal Dialysis	14,627	1,483,581	0.009859			74
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	141,737	5,103,926	0.027770			90
90.01	DIABETOLOGY	427	46,792	0.009125			90.01
90.02	CANCER CENTER	263,766	1,784,649	0.147797			90.02
90.03	WOUND CARE	3,788	3,554,130	0.001066			90.03
91	Emergency	816,699	81,898,949	0.009972			91
92	Observation Beds (Non-Distinct	103,860	4,236,751	0.024514			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	4,633,225	588,596,782				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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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)	16,638		1,548		30
31	Intensive Care Unit	2,787		220		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	2,841		993		43
44	Skilled Nursing Facility	7,641				44
45	Nursing Facility					45
200	Total (lines 30-199)	29,907		2,761		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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0049

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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0049

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

		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	61,647,454							50
51	Recovery Room	11,249,168							51
52	Delivery Room & Labor Room	14,046,580							52
53	Anesthesiology	8,360,909							53
54	Radiology-Diagnostic	35,020,173							54
55.01	GASTRO INTESTINAL SERVICES	22,828,075							55.01
55.02	ULTRA SOUND	13,634,756							55.02
56	Radioisotope	4,347,508							56
57	CT Scan	45,368,166							57
58	MRI	11,147,352							58
59	Cardiac Catheterization	18,935,178							59
60	Laboratory	69,968,589							60
63	Blood Storing, Processing & Tra	4,320,255							63
65	Respiratory Therapy	16,538,487							65
66	Physical Therapy	17,564,057							66
67	Occupational Therapy	3,370,310							67
68	Speech Pathology	1,049,433							68
69	Electrocardiology	16,089,829							69
71	Medical Supplies Charged to Pat	23,281,067							71
72	Impl. Dev. Charged to Patients	17,973,277							72
73	Drugs Charged to Patients	73,747,381							73
74	Renal Dialysis	1,483,581							74
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	5,103,926							90
90.01	DIABETOLOGY	46,792							90.01
90.02	CANCER CENTER	1,784,649							90.02
90.03	WOUND CARE	3,554,130							90.03
91	Emergency	81,898,949							91
92	Observation Beds (Non-Distinct	4,236,751							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	588,596,782							200

(A) Worksheet A line numbers

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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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 [XX] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
 Boxes: [XX] Title XIX - O/P [] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.116271							50
51	Recovery Room	0.065999							51
52	Delivery Room & Labor Room	0.242310							52
53	Anesthesiology	0.030124							53
54	Radiology-Diagnostic	0.143200							54
55.01	GASTRO INTESTINAL SERVICES	0.090319							55.01
55.02	ULTRA SOUND	0.068599							55.02
56	Radioisotope	0.114038							56
57	CT Scan	0.027899							57
58	MRI	0.046929							58
59	Cardiac Catheterization	0.081211							59
60	Laboratory	0.070169							60
63	Blood Storing, Processing & Tra	0.127300							63
65	Respiratory Therapy	0.084169							65
66	Physical Therapy	0.159349							66
67	Occupational Therapy	0.087200							67
68	Speech Pathology	0.251583							68
69	Electrocardiology	0.067110							69
71	Medical Supplies Charged to Pat	0.110303							71
72	Impl. Dev. Charged to Patients	0.194292							72
73	Drugs Charged to Patients	0.124963							73
74	Renal Dialysis	0.555929							74
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.507221							90
90.01	DIABETOLOGY	1.206787							90.01
90.02	CANCER CENTER	1.802868							90.02
90.03	WOUND CARE	0.218159							90.03
91	Emergency	0.108789							91
92	Observation Beds (Non-Distinct	0.267857							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

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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)	16,638	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,638	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)	15,475	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,456	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)	16,235,181	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)	16,235,181	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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)	16,235,181	37

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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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)						975.79 38
39	Program general inpatient routine service cost (line 9 x line 38)						4,348,120 39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)						4,348,120 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	4,293,573	2,787	1,540.57	959	1,477,407	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)					6,989,353	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					12,814,880	49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					521,220	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					401,772	51
52	Total Program excludable cost (sum of lines 50 and 51)					922,992	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					11,891,888	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

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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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)					1,163	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					975.79	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,134,844	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	1,485,820	16,235,181	0.091519	1,134,844	103,860	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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	☐ Other
Boxes:	☐ Title XIX - I/P	☐ IRF	☐ NF		

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

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,641	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,641	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	7,641	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)	3,911	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)	3,684,100	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)	3,684,100	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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)	3,684,100	37

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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	☐ Other
Boxes:	☐ Title XIX - I/P	☐ IRF	☐ NF		

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

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	3,684,100	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	482.15	71
72	Program routine service cost (line 9 x line 71)	1,885,689	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)	1,885,689	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)	1,885,689	83
84	Program inpatient ancillary services (see instructions)	1,205,274	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	3,090,963	86

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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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)	16,638	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,638	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)	15,475	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,548	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)	2,841	15
16	Nursery days (title V or XIX only)	993	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)	16,235,181	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)	16,235,181	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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)	16,235,181	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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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)						975.79 38
39	Program general inpatient routine service cost (line 9 x line 38)						1,510,523 39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)						1,510,523 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)	1,115,292	2,841	392.57	993	389,822	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	4,293,573	2,787	1,540.57	220	338,925	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,239,270	49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					175,349	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)					175,349	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

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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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)					1,163	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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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 ☐ 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		21,108,438		30
31	Intensive Care Unit		5,565,077		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.116271	9,538,764	1,109,082	50
51	Recovery Room	0.065999	1,376,637	90,857	51
52	Delivery Room & Labor Room	0.242310	46,110	11,173	52
53	Anesthesiology	0.030124	906,527	27,308	53
54	Radiology-Diagnostic	0.143200	1,484,823	212,627	54
55.01	GASTRO INTESTINAL SERVICES	0.090319	1,159,222	104,700	55.01
55.02	ULTRA SOUND	0.068599	254,564	17,463	55.02
56	Radioisotope	0.114038	511,797	58,364	56
57	CT Scan	0.027899	4,363,482	121,737	57
58	MRI	0.046929	601,862	28,245	58
59	Cardiac Catheterization	0.081211	3,103,268	252,019	59
60	Laboratory	0.070169	12,711,998	891,988	60
63	Blood Storing, Processing & Trans.	0.127300	622,800	79,282	63
65	Respiratory Therapy	0.084169	3,987,739	335,644	65
66	Physical Therapy	0.159349	1,607,767	256,196	66
67	Occupational Therapy	0.087200	1,234,620	107,659	67
68	Speech Pathology	0.251583	288,829	72,664	68
69	Electrocardiology	0.067110	2,782,850	186,757	69
71	Medical Supplies Charged to Patients	0.110303	2,125,581	234,458	71
72	Impl. Dev. Charged to Patients	0.194292	4,885,306	949,176	72
73	Drugs Charged to Patients	0.124963	7,373,644	921,433	73
74	Renal Dialysis	0.555929	744,560	413,922	74
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.507221			90
90.01	DIABETOLOGY	1.206787			90.01
90.02	CANCER CENTER	1.802868			90.02
90.03	WOUND CARE	0.218159			90.03
91	Emergency	0.108789	4,119,998	448,210	91
92	Observation Beds (Non-Distinct Part)	0.267857	217,987	58,389	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		66,050,735	6,989,353	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		66,050,735		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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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	0.116271	5,439	632	50
51	Recovery Room	0.065999			51
52	Delivery Room & Labor Room	0.242310			52
53	Anesthesiology	0.030124			53
54	Radiology-Diagnostic	0.143200	61,508	8,808	54
55.01	GASTRO INTESTINAL SERVICES	0.090319			55.01
55.02	ULTRA SOUND	0.068599	5,359	368	55.02
56	Radioisotope	0.114038			56
57	CT Scan	0.027899	20,702	578	57
58	MRI	0.046929			58
59	Cardiac Catheterization	0.081211	42,585	3,458	59
60	Laboratory	0.070169	1,484,952	104,198	60
63	Blood Storing, Processing & Trans.	0.127300	33,481	4,262	63
65	Respiratory Therapy	0.084169	477,946	40,228	65
66	Physical Therapy	0.159349	4,638,456	739,133	66
67	Occupational Therapy	0.087200			67
68	Speech Pathology	0.251583	230,266	57,931	68
69	Electrocardiology	0.067110	41,232	2,767	69
71	Medical Supplies Charged to Patients	0.110303	255,303	28,161	71
72	Impl. Dev. Charged to Patients	0.194292			72
73	Drugs Charged to Patients	0.124963	1,712,351	213,981	73
74	Renal Dialysis	0.555929	1,384	769	74
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.507221			90
90.01	DIABETOLOGY	1.206787			90.01
90.02	CANCER CENTER	1.802868			90.02
90.03	WOUND CARE	0.218159			90.03
91	Emergency	0.108789			91
92	Observation Beds (Non-Distinct Part)	0.267857			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		9,010,964	1,205,274	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		9,010,964		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: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0049

WORKSHEET D-3

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ Swing Bed SNF
☐ Swing Bed NF
☐ ICF/IID

☐ PPS
☐ TEFRA
☒ 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	0.116271			50
51	Recovery Room	0.065999			51
52	Delivery Room & Labor Room	0.242310			52
53	Anesthesiology	0.030124			53
54	Radiology-Diagnostic	0.143200			54
55.01	GASTRO INTESTINAL SERVICES	0.090319			55.01
55.02	ULTRA SOUND	0.068599			55.02
56	Radioisotope	0.114038			56
57	CT Scan	0.027899			57
58	MRI	0.046929			58
59	Cardiac Catheterization	0.081211			59
60	Laboratory	0.070169			60
63	Blood Storing, Processing & Trans.	0.127300			63
65	Respiratory Therapy	0.084169			65
66	Physical Therapy	0.159349			66
67	Occupational Therapy	0.087200			67
68	Speech Pathology	0.251583			68
69	Electrocardiology	0.067110			69
71	Medical Supplies Charged to Patients	0.110303			71
72	Impl. Dev. Charged to Patients	0.194292			72
73	Drugs Charged to Patients	0.124963			73
74	Renal Dialysis	0.555929			74
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.507221			90
90.01	DIABETOLOGY	1.206787			90.01
90.02	CANCER CENTER	1.802868			90.02
90.03	WOUND CARE	0.218159			90.03
91	Emergency	0.108789			91
92	Observation Beds (Non-Distinct Part)	0.267857			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

KPMG LLP Compu-Max 2552-10

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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)	6,107,806			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,903,877			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)	173,291			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
2.03	Outlier payment for discharges occurring prior to October 1 (see instructions)				2.03
2.04	Outlier payment for discharges occurring on or after October 1 (see instructions)				2.04
3	Managed care simulated payments	5,289,993			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	130.72			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	57.52			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)	0.424342			19
20	Prior year resident to bed ratio (see instructions)	0.422854			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.422854			21
22	IME payment adjustment (see instructions)	2,282,392			22
22.01	IME payment adjustment - Managed Care (see instructions)	1,096,457			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)	2.05			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)	2,282,392			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	1,096,457			29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.1328			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.4101			31
32	Sum of lines 30 and 31	0.5429			32
33	Allowable disproportionate share percentage (see instructions)	0.3400			33
34	Disproportionate share adjustment (see instructions)	935,994			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		8,272,872,447	35
35.01	Factor 3 (see instructions)	0.000289184		0.000242136	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,956,820		2,003,159	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	820,256		653,084	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,473,340			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
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

KPMG LLP Compu-Max 2552-10

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

		1	1.01	1.02	
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)	15,876,700			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)	16,973,157			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,246,125			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)	2,374,858			52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				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)	20,594,140			59
60	Primary payer payments	15,854			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	20,578,286			61
62	Deductibles billed to program beneficiaries	1,056,236			62
63	Coinurance billed to program beneficiaries	52,763			63
64	Allowable bad debts (see instructions)	592,536			64
65	Adjusted reimbursable bad debts (see instructions)	385,148			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	328,541			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	19,854,435			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)	27,405			70.93
70.94	HRR adjustment amount (see instructions)	-63,885			70.94
71	Amount due provider (see instructions)	19,817,955			71
71.01	Sequestration adjustment (see instructions)	396,359			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	18,726,078			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	695,518			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	578,519			75
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96
HSP Bonus Payment Amount		Prior to 10/1	On or After 10/1		
100	HSP bonus amount (see instructions)				100
HVBP Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
HRR Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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)	3,437			1
2	Medical and other services reimbursed under OPPS (see instructions)	5,909,415			2
3	OPPS payments	6,649,766			3
4	Outlier payment (see instructions)	8,437			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)	3,437			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	27,564			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)	27,564			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)	27,564			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	24,127			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)	3,437			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)	6,658,203			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,257,218			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)	5,404,422			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	835,754			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	6,240,176			30
31	Primary payer payments	5,087			31
32	Subtotal (line 30 minus line 31)	6,235,089			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)	513,500			34
35	Adjusted reimbursable bad debts (see instructions)	333,775			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	359,200			36
37	Subtotal (see instructions)	6,568,864			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)	6,568,864			40
40.01	Sequestration adjustment (see instructions)	131,377			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	6,259,617			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	177,870			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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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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

WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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WORKSHEET E-1
PART I

			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			18,726,078		6,259,617	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero						2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)		.01				3.01
			.02				3.02
		Program	.03				3.03
		to	.04				3.04
		Provider	.05				3.05
			.06				3.06
			.07				3.07
			.08				3.08
			.09				3.09
			.10				3.10
			.50				3.50
			.51				3.51
		Provider	.52				3.52
		to	.53				3.53
		Program	.54				3.54
			.55				3.55
			.56				3.56
			.57				3.57
			.58				3.58
			.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			18,726,078		6,259,617	4
	TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)		.01				5.01
			.02				5.02
		Program	.03				5.03
		to	.04				5.04
		Provider	.05				5.05
			.06				5.06
			.07				5.07
			.08				5.08
			.09				5.09
			.10				5.10
			.50				5.50
			.51				5.51
		Provider	.52				5.52
		to	.53				5.53
		Program	.54				5.54
			.55				5.55
			.56				5.56
			.57				5.57
			.58				5.58
			.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)		.01	695,518		177,870	6.01
			.02				6.02
7	Total Medicare program liability (see instructions)			19,421,596		6,437,487	7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)		8

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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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			1,981,564		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)			1,981,564		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	-1		6.02
7	Total Medicare program liability (see instructions)			1,981,563		7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

(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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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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	2,102,640	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	2,102,640	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	80,637	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)	2,022,003	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)	2,022,003	15
15.01	Sequestration adjustment (see instructions)	40,440	15.01
15.02	Demonstration payment adjustment amount after sequestration		15.02
16	Interim payments	1,981,564	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)	-1	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0049

WORKSHEET E-3
PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	2,239,270		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	2,239,270		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	2,239,270		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 cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	2,239,270		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)	2,239,270		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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WEST SUBURBAN HOSP MED CTR Provider CCN: 14-0049	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 01/27/2019	Run Date: 12/02/2019 Run Time: 11:04 Version: 2018.12 (10/24/2019)
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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 plus 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)			42.86	6
7	Enter the lesser of line 5 or line 6			42.86	7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	42.86	0.00	42.86	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	42.86	0.00	42.86	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	42.86	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	55.26	0.24		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	54.12	1.38		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	50.75	0.54		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	50.75	0.54		17
18	Per resident amount	149,600.68	141,730.34		18
19	Approved amount for resident costs	7,592,235	76,534	7,668,769	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)			7,668,769	25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	5,415	2,759		26
27	Total inpatient days (see instructions)	18,593	18,593		27
28	Ratio of inpatient days to total inpatient days	0.291239	0.148389		28
29	Program direct GME amount	2,233,445	1,137,961		29
30	Reduction for direct GME payments for Medicare Advantage		160,794		30
31	Net Program direct GME amount			3,210,612	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)			1,483,581	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)			16,803,209	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)			15,854	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			16,787,355	41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)			5,912,852	42
43	Primary payer payments (see instructions)			5,087	43
44	Total Part B reasonable cost (line 42 minus line 43)			5,907,765	44
45	Total reasonable cost (sum of lines 41 and 44)			22,695,120	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.739690	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.260310	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			3,210,612	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			2,374,858	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			835,754	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 plus 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	Other	Total
		1	2	3
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00
10	Weighted dental and podiatric resident FTE count for the current year		0.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year			
11	Total weighted FTE count	0.00	0.00	
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00	
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00	
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00	
15	Adjustment for residents in initial years of new programs	0.00	0.00	
15.01	Unweighted adjustment for residents in initial years of new programs			
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure			
17	Adjusted rolling average FTE count	0.00	0.00	
18	Per resident amount	0.00	0.00	
19	Approved amount for resident costs			
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)			
21	Direct GME FTE unweighted resident count over cap (see instructions)			
22	Allowable additional direct GME FTE resident count (see instructions)			
23	Enter the locality adjustment national average per resident amount (see instructions)			
24	Multiply line 22 times line 23			
25	Total direct GME amount (sum of lines 19 and 24)			
COMPUTATION OF PROGRAM PATIENT LOAD				
		Inpatient Part A	Managed Care	
26	Inpatient days (see instructions)	1,983	5,815	
27	Total inpatient days (see instructions)	18,593	18,593	
28	Ratio of inpatient days to total inpatient days	0.106653	0.312752	
29	Program direct GME amount			
30	Reduction for direct GME payments for Medicare Advantage			
31	Net Program direct GME amount			
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)			
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			
35	Medicare outpatient ESRD charges (see instructions)			
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
Part A Reasonable Cost				
37	Reasonable cost (see instructions)			
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)			
39	Cost of physicians' services in a teaching hospital (see instructions)			
40	Primary payer payments (see instructions)			
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			
Part B Reasonable Cost				
42	Reasonable cost (see instructions)			
43	Primary payer payments (see instructions)			
44	Total Part B reasonable cost (line 42 minus line 43)			
45	Total reasonable cost (sum of lines 41 and 44)			
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			

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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)

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	-3,608,606				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	36,163,923				4
5	Other receivables	524,195				5
6	Allowances for uncollectible notes and accounts receivable	-5,513,604				6
7	Inventory	3,665,041				7
8	Prepaid expenses	638,234				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	31,869,183				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	17,505,970				23
24	Accumulated depreciation	-33,325,554				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable	282,678				29
30	Total fixed assets (sum of lines 12-29)	38,687,411				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	1,735,894				34
35	Total other assets (sum of lines 31-34)	1,735,894				35
36	Total assets (sum of lines 11, 30 and 35)	72,292,488				36
	Liabilities and Fund Balances					
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	7,609,924				37
38	Salaries, wages and fees payable	8,774,673				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	-24,083				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	607,166				44
45	Total current liabilities (sum of lines 37 thru 44)	16,967,680				45
	LONG TERM LIABILITIES					
46	Mortgage payable	73,173,325				46
47	Notes payable	-347,561				47
48	Unsecured loans					48
49	Other long term liabilities	5,515,792				49
50	Total long term liabilities (sum of lines 46 thru 49)	78,341,556				50
51	Total liabilities (sum of lines 45 and 50)	95,309,236				51
	CAPITAL ACCOUNTS					
52	General fund balance	-23,016,748				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	-23,016,748				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	72,292,488				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		-4,654,964		1
2	Net income (loss) (from Worksheet G-3, line 29)		-10,393,899		2
3	Total (sum of line 1 and line 2)		-15,048,863		3
4	Additions (credit adjustments) (specify)				4
5					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)		-15,048,863		11
12	Deductions (debit adjustments) (specify)				12
13	CHANGE IN RETAINED EARNINGS	7,908,839			13
14	ROUNDING	59,046			14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)		7,967,885		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		-23,016,748		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					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	ROUNDING				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	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	79,372,996		79,372,996	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	3,874,672		3,874,672	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	83,247,668		83,247,668	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	16,334,990		16,334,990	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)	16,334,990		16,334,990	16
17	Total inpatient routine care services (sum of lines 10 and 16)	99,582,658		99,582,658	17
18	Ancillary services	223,729,398	268,242,183	491,971,581	18
19	Outpatient services	15,606,954	81,018,243	96,625,197	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)	338,919,010	349,260,426	688,179,436	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		104,231,902	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)		104,231,902	43

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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)	688,179,436	1
2	Less contractual allowances and discounts on patients' accounts	598,343,270	2
3	Net patient revenues (line 1 minus line 2)	89,836,166	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	104,231,902	4
5	Net income from service to patients (line 3 minus line 4)	-14,395,736	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	-120,248	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	226,741	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	857,140	22
23	Governmental appropriations		23
24	Other (OTHER OPERATING REVENUE)	2,522,491	24
24.01	Other (RETAIL PHARMACY REVENUE)	515,713	24.01
25	Total other income (sum of lines 6-24)	4,001,837	25
26	Total (line 5 plus line 25)	-10,393,899	26
29	Net income (or loss) for the period (line 26 minus line 28)	-10,393,899	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	896,402	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	14,917	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)	68.36	3
4	Number of interns & residents (see instructions)	55.47	4
5	Indirect medical education percentage (see instructions)	25.73	5
6	Indirect medical education adjustment (see instructions)	230,644	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.1328	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.4101	8
9	Sum of lines 7 and 8	0.5429	9
10	Allowable disproportionate share percentage (see instructions)	0.1162	10
11	Disproportionate share adjustment (see instructions)	104,162	11
12	Total prospective capital payments (see instructions)	1,246,125	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	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	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
194.01	HOSPITALIST							194.01
194.02	RETAIL PHARMACY							194.02
194.03	COMMUNITY RELATIONS							194.03
194.04	PHYSICIAN CLINICS							194.04
194.05	GUEST MEALS							194.05
194.06	CATERING MEALS							194.06
194.07	RESEARCH,RIVER FOREST NONREIMB							194.07
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202