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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

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. [X] ELECTRONICALLY FILED COST REPORT DATE: 01/28/2015 TIME: 11:44 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [F] MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.	
CONTRACTOR USE ONLY	5. [ ] COST REPORT STATUS 1 -AS SUBMITTED 2 -SETTLED WITHOUT AUDIT 3 -SETTLED WITH AUDIT 4 -REOPENED 5 -AMENDED 6. DATE RECEIVED: _____ 7. CONTRACTOR NO: _____ 8. [ ] INITIAL REPORT FOR THIS PROVIDER CCN 9. [ ] FINAL REPORT FOR THIS PROVIDER CCN	10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ___ 12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE 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 CENTRAL DUPAGE HOSPITAL (14-0242) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 07/01/2014 AND ENDING 08/31/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		127,975	-20,546			1
2	SUBPROVIDER - IPF		1				2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		127,976	-20,546			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 OMD 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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S PARTS I, II & III**

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.

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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: 0 NORTH 025 WINFIELD ROAD	P.O. Box: 11092012		1
2	City: WINFIELD	State: IL	ZIP Code: 60190	County: DUPAGE	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	CENTRAL DUPAGE HOSPITAL	14-0242	16974	1	07/01/1966	N	P	O	3
4	Subprovider - IPF	CENTRAL DUPAGE HOSPITAL PSYCH.	14-S242	16974	4	07/01/1985	N	P	O	4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based 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: 07 / 01 / 2014	To: 08 / 31 / 2014	20
21	Type of control (see instructions)	2		21

	Inpatient PPS Information	1	2	
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
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	1	N	23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	889	1,893			193	37	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.							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 in effect in the cost reporting period.			37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

		1	2	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		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?	N	Y	N	45
46	Is this facility eligible for additional paymetn exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	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	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.				

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	
	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.					
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived 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 Non-Provider Settings						
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N				63

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WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings-This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 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							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings-Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider 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							67
Inpatient Psychiatric Faciltiy PPS				1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.			Y			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.			N			71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						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
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

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WORKSHEET S-2
PART I

				V	XIX	
Title V and XIX Services				1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.			N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.			N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the appilcable column.				N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.					95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.					97
Rural Providers				1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	Column 1: 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. If yes, the GME elinination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.					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
Miscellaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If 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'		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.			2		118
			Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:					118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.			N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.			Y		121
Transplant Center Information						
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.			N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.					134

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WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	14H052	140

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

141	Name: CENTRAL DUPAGE HEALTH	Contractor's Name: NATIONAL GOVERNMENT SERVICES Contractor's Number: 00131		141
142	Street: 27 WEST 353 JEWELL ROAD	P.O. Box:		142
143	City: WINFIELD	State: IL	ZIP Code: 60190	143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	Y		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, section 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	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

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

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

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)	Y			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		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y			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 INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.		N		9
10	WAS AN INTERN-RESIDENT 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
BAD DEBTS				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
PS&R REPORT DATA		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	Y	12/19/2014	Y	12/19/2014
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	Y	12/19/2014	Y	12/19/2014
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

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 COSTS			
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 CAPITALIZED 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	WERE 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 REORT PREPARER INFORMATION				
41	FIRST NAME: JENNIFER	LAST NAME: STOGENTIN	TITLE: SYSTEM DIRECTOR OF FINANCE	41
42	EMPLOYER: CADENCE HEALTH			42
43	PHONE NUMBER: 630-933-6340	E-MAIL ADDRESS: JENNIFER.STOGENTIN@CADENCEHEALTH.ORG		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA 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	288	17,856			4,644	2,733	12,304	1
2	HMO AND OTHER (see instructions)						831	193		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)		288	17,856			4,644	2,733	12,304	7
8	INTENSIVE CARE UNIT	31	38	2,356			650	116	1,395	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	NEONATAL INTENSIVE CARE UNIT	35	23	1,426				352	1,013	12
13	NURSERY	43						196	1,211	13
14	TOTAL (see instructions)		349	21,638			5,294	3,397	15,923	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40	30	1,860			235	562	1,680	16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								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)		379							27
28	OBSERVATION BED DAYS								1,805	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)								400	32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	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)					1,114	1	3,694	1
2	HMO AND OTHER (see instructions)					195			2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	NEONATAL INTENSIVE CARE UNIT								12
13	NURSERY								13
14	TOTAL (see instructions)		2,838.88			1,114	1	3,694	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF		66.35			29	129	269	16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	TOTAL (sum of lines 14-26)		2,905.23						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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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	34,169,746	655,092	34,824,838	1,027,170.00	33.90	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B		1,146,226		1,146,226	9,623.00	119.11	5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)		478,295	16,274	494,569	15,843.00	31.22	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		518,429		518,429	8,064.00	64.29	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		26,313		26,313	141.00	186.62	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		10,834,753		10,834,753	157,166.00	68.94	14
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)		8,591,871		8,591,871			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		249,412		249,412			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							22.01
23	PHYSICIAN PART B		214,112		214,112			23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT							26
27	ADMINISTRATIVE & GENERAL		4,403,617	62,176	4,465,793	95,126.00	46.95	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		562,343		562,343	16,820.00	33.43	30
31	LAUNDRY & LINEN SERVICE		26,604		26,604	2,527.00	10.53	31
32	HOUSEKEEPING		623,427	22,727	646,154	43,919.00	14.71	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		344,518	-194,133	150,385	8,555.00	17.58	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA			229,620	229,620	17,096.00	13.43	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		591,505		591,505	12,039.00	49.13	38
39	CENTRAL SERVICES AND SUPPLY		384,817		384,817	21,743.00	17.70	39
40	PHARMACY		796,854		796,854	21,380.00	37.27	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		73,625		73,625	2,742.00	26.85	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)	33,023,520	655,092	33,678,612	1,017,547.00	33.10	1
2	EXCLUDED AREA SALARIES (see instructions)	478,295	16,274	494,569	15,843.00	31.22	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	32,545,225	638,818	33,184,043	1,001,704.00	33.13	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)	11,379,495		11,379,495	165,371.00	68.81	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)	8,591,871		8,591,871		25.89%	5

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

6	TOTAL (sum of lines 3 through 5)		52,516,591	638,818	53,155,409	1,167,075.00	45.55	6
7	TOTAL OVERHEAD COST (see instructions)		7,807,310	120,390	7,927,700	241,947.00	32.77	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	1,226,658	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)	3,291,216	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	196,247	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	224,821	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	224,395	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	870,616	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	2,226,632	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	20,693	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		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		22
23	TUITION REIMBURSEMENT	310,593	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	8,591,871	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4) **EXHIBIT 3**

	STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE			1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)			2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH			3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)			4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)			5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN			6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE			7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)			8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE			9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5			10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)			12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2			15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)			17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)			18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19

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HOSPITAL CONTRACT LABOR AND BENEFIT COST **WORKSHEET S-3 PART V**

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

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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)	0.206201	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	8,411,735	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	81,291,365	6
7	MEDICAID COST (line 1 times line 6)	16,762,361	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.	8,350,626	8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING 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)	8,350,626	19

		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	9,360,192	21,960,380	31,320,572	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	1,930,081	4,528,252	6,458,333	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	29,784	2,471,458	2,501,242	22
23	COST OF CHARITY CARE (line 21 minus line 22)	1,900,297	2,056,794	3,957,091	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, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	12,323,214	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)		27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	12,323,214	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	2,541,059	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	6,498,150	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	14,848,776	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		4,489,282	4,489,282	183,494	4,672,776	6,063,805	10,736,581	1
2	00200	CAP REL COSTS-MVBLE EQUIP		3,702,012	3,702,012	154,794	3,856,806		3,856,806	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT		-118,750	-118,750		-118,750		-118,750	4
5.10	00541	NON PATIENT TELEPHONES		13,361	13,361		13,361	-67,057	-53,696	5.10
5.30	00561	PURCHASING AND STORES						416,168	416,168	5.30
5.40	00571	ADMITTING	479,000	207,710	686,710	59,449	746,159		746,159	5.40
5.50	00581	ACCOUNTS RECEIVABLE AND CASHIERS								5.50
5.60	00590	ADMINISTRATION & GENERAL	3,924,617	24,475,493	28,400,110	-240,616	28,159,494	1,568,551	29,728,045	5.60
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	562,343	3,255,779	3,818,122		3,818,122	-284,666	3,533,456	7
8	00800	LAUNDRY & LINEN SERVICE	26,604	-13,056	13,548	-2,727	10,821		10,821	8
9	00900	HOUSEKEEPING	623,427	295,263	918,690		918,690	-19,739	898,951	9
10	01000	DIETARY	344,518	701,552	1,046,070	-697,202	348,868	-17,947	330,921	10
11	01100	CAFETERIA				697,202	697,202	-543,272	153,930	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	591,505	300,073	891,578		891,578	-327,684	563,894	13
14	01400	CENTRAL SERVICES & SUPPLY	384,817	244,233	629,050	-59,496	569,554		569,554	14
15	01500	PHARMACY	796,854	7,025,995	7,822,849	-6,852,337	970,512		970,512	15
16	01600	MEDICAL RECORDS & LIBRARY	73,625	20,273	93,898		93,898	644,898	738,796	16
17	01700	SOCIAL SERVICE								17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	6,244,616	5,332,464	11,577,080	-773,199	10,803,881	-669,406	10,134,475	30
31	03100	INTENSIVE CARE UNIT	1,700,432	706,020	2,406,452	-137,252	2,269,200	-43,269	2,225,931	31
35	02060	NEONATAL INTENSIVE CARE UNIT	607,971	330,985	938,956	27,632	966,588		966,588	35
40	04000	SUBPROVIDER - IPF	470,781	207,245	678,026	16,017	694,043	-69,266	624,777	40
43	04300	NURSERY				386,787	386,787		386,787	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	2,017,129	8,481,638	10,498,767	-5,179,165	5,319,602	-40,299	5,279,303	50
51	05100	RECOVERY ROOM	546,525	217,385	763,910	-11,636	752,274		752,274	51
52	05200	DELIVERY ROOM & LABOR ROOM	1,079,582	571,888	1,651,470	-29,402	1,622,068	-118,744	1,503,324	52
53	05300	ANESTHESIOLOGY	44,830	319,898	364,728	-141,834	222,894	-21,000	201,894	53
54	05400	RADIOLOGY-DIAGNOSTIC	902,018	390,484	1,292,502	-30,511	1,261,991	-29,727	1,232,264	54
55	05500	RADIOLOGY-THERAPEUTIC	779,980	445,532	1,225,512	-39,362	1,186,150	185,345	1,371,495	55
56	05600	RADIOISOTOPE	79,886	131,095	210,981	-226	210,755		210,755	56
57	05700	CT SCAN	206,670	162,211	368,881	-41,827	327,054	-21,000	306,054	57
58	05800	MRI	239,577	140,739	380,316	-8,773	371,543		371,543	58
60	06000	LABORATORY	3,677,224	4,706,884	8,384,108	-18,826	8,365,282	-286,214	8,079,068	60
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	93,262	466,869	560,131	-1,182	558,949		558,949	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	06400	INTRAVENOUS THERAPY	123,481	116,955	240,436		240,436		240,436	64
65	06500	RESPIRATORY THERAPY	451,262	184,489	635,751	-40,144	595,607		595,607	65
66	06600	PHYSICAL THERAPY	745,184	328,399	1,073,583	-3,507	1,070,076		1,070,076	66
67	06700	OCCUPATIONAL THERAPY	113,355	33,218	146,573	-1,802	144,771		144,771	67
68	06800	SPEECH PATHOLOGY	143,074	40,356	183,430	-318	183,112		183,112	68
69	06900	ELECTROCARDIOLOGY	1,592,201	3,556,157	5,148,358	-1,698,828	3,449,530	-1,041,534	2,407,996	69
70	07000	ELECTROENCEPHALOGRAPHY	211,873	101,598	313,471	-6,830	306,641	-13,264	293,377	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				3,027,921	3,027,921		3,027,921	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				4,510,469	4,510,469		4,510,469	72
73	07300	DRUGS CHARGED TO PATIENTS				6,809,047	6,809,047		6,809,047	73
74	07400	RENAL DIALYSIS				114,074	114,074		114,074	74
75.01	07501	CARDIAC REHAB	73,717	43,033	116,750		116,750		116,750	75.01
75.02	07502	SLEEP LAB								75.02
75.03	07503	INPATIENT DIALYSIS								75.03
75.04	07504	PAIN MANAGEMENT	41,202	34,732	75,934	-12,470	63,464		63,464	75.04

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	CLINIC	2,638,571	1,228,761	3,867,332	-34,188	3,833,144	-1,643,237	2,189,907	90
90.01	09001	PATIENT TREATMENT CENTER	235,649	119,438	355,087	-8,906	346,181	-75,219	270,962	90.01
90.02	09002	REHAB SERVICES-BLOOMINGDALE								90.02
90.03	09003	CANTERA								90.03
90.04	09004	MENTAL HEALTH O/P	135,118	50,434	185,552	165,217	350,769	-4,495	346,274	90.04
90.05	09005	WOMEN'S CLINIC								90.05
90.06	09006	WOUND CARE	36,504	24,055	60,559	-12,117	48,442		48,442	90.06
91	09100	EMERGENCY	1,123,248	694,450	1,817,698	-67,420	1,750,278	-189,254	1,561,024	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	34,162,232	73,766,632	107,928,864		107,928,864	3,352,474	111,281,338	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	355	31,451	31,806		31,806		31,806	190
190.01	19001	KOFEE KORNER								190.01
191	19100	RESEARCH								191
192.01	19201	WSKF								192.01
193.01	19301	DEVELOPMENT								193.01
193.02	19302	MARKETING								193.02
193.04	19303	PHYSICIAN ANSWERING SERVICE								193.04
193.05	19304	CAR SEAT SAFETY PROGRAM								193.05
193.07	19305	JOINT VENTURE								193.07
193.08	19306	PARKINSONS CENTER	7,159	1,957	9,116		9,116		9,116	193.08
200		TOTAL (sum of lines 118-199)	34,169,746	73,800,040	107,969,786		107,969,786	3,352,474	111,322,260	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	CHARGEABLE MEDICAL SUPPLIES	B	MEDICAL SUPPLIES CHARGED TO P	71		3,027,921	1
2			IMPL. DEV. CHARGED TO PATIENT	72		4,510,469	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
500	TOTAL RECLASSIFICATIONS					7,538,390	500
	CODE LETTER - B						
1	CAFETERIA	C	CAFETERIA	11	229,620	467,582	1
500	TOTAL RECLASSIFICATIONS				229,620	467,582	500
	CODE LETTER - C						
1	DRUGS	D	DRUGS CHARGED TO PATIENTS	73		6,809,047	1
500	TOTAL RECLASSIFICATIONS					6,809,047	500
	CODE LETTER - D						
1	INSURANCE	E	CAP REL COSTS-BLDG & FIXT	1		183,494	1
500	TOTAL RECLASSIFICATIONS					183,494	500
	CODE LETTER - E						
1	RENTAL	F	CAP REL COSTS-MVBLE EQUIP	2		154,794	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500	TOTAL RECLASSIFICATIONS					154,794	500
	CODE LETTER - F						
1	BHS CHEMICAL DEPENDENCY	H	MENTAL HEALTH O/P	90.04	114,522	55,606	1
500	TOTAL RECLASSIFICATIONS				114,522	55,606	500
	CODE LETTER - H						
1	NURSERY	I	NURSERY	43	261,725	125,062	1
500	TOTAL RECLASSIFICATIONS				261,725	125,062	500
	CODE LETTER - I						
1	RENAL DIALYSIS	J	RENAL DIALYSIS	74		114,074	1
2							2
3							3
500	TOTAL RECLASSIFICATIONS					114,074	500
	CODE LETTER - J						

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TEMPORARY PERSONNEL	K	ADMITTING	5.40	59,449		1
2			ADMINISTRATION & GENERAL	5.60	2,727		2
3			HOUSEKEEPING	9	22,727		3
4			DIETARY	10	35,487		4
5			ADULTS & PEDIATRICS	30	58,304		5
6			INTENSIVE CARE UNIT	31	2,677		6
7			NEONATAL INTENSIVE CARE UNIT	35	76,993		7
8			SUBPROVIDER - IPF	40	16,274		8
9			OPERATING ROOM	50	204,663		9
10			RECOVERY ROOM	51	19,994		10
11			DELIVERY ROOM & LABOR ROOM	52	58,943		11
12			RADIOLOGY-THERAPEUTIC	55	22,268		12
13			ELECTROCARDIOLOGY	69	74,586		13
500	TOTAL RECLASSIFICATIONS				655,092		500
	CODE LETTER - K						
	GRAND TOTAL (INCREASES)				1,260,959	15,448,049	

(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	CHARGEABLE MEDICAL SUPPLIES	B	CENTRAL SERVICES & SUPPLY	14		1,192		1
2			PHARMACY	15		43,290		2
3			ADULTS & PEDIATRICS	30		97,861		3
4			INTENSIVE CARE UNIT	31		71,471		4
5			NEONATAL INTENSIVE CARE UNIT	35		49,303		5
6			SUBPROVIDER - IPF	40		257		6
7								7
8			OPERATING ROOM	50		5,076,897		8
9			RECOVERY ROOM	51		11,636		9
10			DELIVERY ROOM & LABOR ROOM	52		20,764		10
11			ANESTHESIOLOGY	53		141,834		11
12			RADIOLOGY-DIAGNOSTIC	54		30,511		12
13			RADIOLOGY-THERAPEUTIC	55		39,362		13
14			RADIOISOTOPE	56		226		14
15			CT SCAN	57		41,827		15
16			MRI	58		8,773		16
17			LABORATORY	60		18,826		17
18			WHOLE BLOOD & PACKED RED BLOO	62		1,182		18
19			RESPIRATORY THERAPY	65		37,386		19
20			PHYSICAL THERAPY	66		3,507		20
21			OCCUPATIONAL THERAPY	67		1,802		21
22			SPEECH PATHOLOGY	68		318		22
23			ELECTROCARDIOLOGY	69		1,695,828		23
24			ELECTROENCEPHALOGRAPHY	70		6,632		24
25			PAIN MANAGEMENT	75.04		12,470		25
26			CLINIC	90		34,188		26
27			PATIENT TREATMENT CENTER	90.01		6,599		27
28			MENTAL HEALTH O/P	90.04		4,911		28
29			WOUND CARE	90.06		12,117		29
30			EMERGENCY	91		67,420		30
500	TOTAL RECLASSIFICATIONS					7,538,390		500
	CODE LETTER - B							
1	CAFETERIA	C	DIETARY	10	229,620	467,582		1
500	TOTAL RECLASSIFICATIONS				229,620	467,582		500
	CODE LETTER - C							
1	DRUGS	D	PHARMACY	15		6,809,047		1
500	TOTAL RECLASSIFICATIONS					6,809,047		500
	CODE LETTER - D							
1	INSURANCE	E	ADMINISTRATION & GENERAL	5.60		183,494	9	1
500	TOTAL RECLASSIFICATIONS					183,494		500
	CODE LETTER - E							
1	RENTAL	F	ADMINISTRATION & GENERAL	5.60		400	9	1
2			ADULTS & PEDIATRICS	30		31,235		2
3			INTENSIVE CARE UNIT	31		6,239		3
4			NEONATAL INTENSIVE CARE UNIT	35		58		4
5			OPERATING ROOM	50		102,268		5
6			DELIVERY ROOM & LABOR ROOM	52		8,638		6
7			RESPIRATORY THERAPY	65		2,758		7
8			ELECTROCARDIOLOGY	69		3,000		8
9			ELECTROENCEPHALOGRAPHY	70		198		9
500	TOTAL RECLASSIFICATIONS					154,794		500
	CODE LETTER - F							
1	BHS CHEMICAL DEPENDENCY	H	ADULTS & PEDIATRICS	30	114,522	55,606		1
500	TOTAL RECLASSIFICATIONS				114,522	55,606		500
	CODE LETTER - H							
1	NURSERY	I	ADULTS & PEDIATRICS	30	261,725	125,062		1
500	TOTAL RECLASSIFICATIONS				261,725	125,062		500
	CODE LETTER - I							
1	RENAL DIALYSIS	J	ADULTS & PEDIATRICS	30		68,499		1
2			INTENSIVE CARE UNIT	31		43,268		2
3			PATIENT TREATMENT CENTER	90.01		2,307		3
500	TOTAL RECLASSIFICATIONS					114,074		500
	CODE LETTER - J							

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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	TEMPORARY PERSONNEL	K	ADMINISTRATION & GENERAL	5.60		59,449		1
2			LAUNDRY & LINEN SERVICE	8		2,727		2
3			HOUSEKEEPING	9		22,727		3
4			DIETARY	10		35,487		4
5			CENTRAL SERVICES & SUPPLY	14		58,304		5
6			INTENSIVE CARE UNIT	31		2,677		6
7			ADULTS & PEDIATRICS	30		76,993		7
8			INTENSIVE CARE UNIT	31		16,274		8
9			OPERATING ROOM	50		204,663		9
10			RECOVERY ROOM	51		19,994		10
11			DELIVERY ROOM & LABOR ROOM	52		58,943		11
12			RADIOLOGY-THERAPEUTIC	55		22,268		12
13			ELECTROCARDIOLOGY	69		74,586		13
500	TOTAL RECLASSIFICATIONS					655,092		500
	CODE LETTER - K							
	GRAND TOTAL (DECREASES)				605,867	16,103,141		

(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 RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	4,917,000					4,917,000		1
2	LAND IMPROVEMENTS	24,908,000				460,000	24,448,000		2
3	BUILDINGS AND FIXTURES	486,450,000	2,071,000		2,071,000		488,521,000		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	111,531,000				1,046,000	110,485,000		5
6	MOVABLE EQUIPMENT	210,205,000					210,205,000		6
7	HIT DESIGNATED ASSETS	13,011,000					13,011,000		7
8	SUBTOTAL (sum of lines 1-7)	851,022,000	2,071,000		2,071,000	1,506,000	851,587,000		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	851,022,000	2,071,000		2,071,000	1,506,000	851,587,000		10

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

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	4,489,282						4,489,282	1
2	CAP REL COSTS-MVBLE EQUIP	3,702,012						3,702,012	2
3	TOTAL (sum of lines 1-2)	8,191,294						8,191,294	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	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	621,657,283		621,657,283	0.680269					1
2	CAP REL COSTS-MVBLE EQU	292,182,850		292,182,850	0.319731					2
3	TOTAL (sum of lines 1-2)	913,840,133		913,840,133	1.000000					3

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	8,357,522			2,379,059			10,736,581	1
2	CAP REL COSTS-MVBLE EQUIP	3,856,806						3,856,806	2
3	TOTAL (sum of lines 1-2)	12,214,328			2,379,059			14,593,387	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)	A	-67,057	NON PATIENT TELEPHONES	5.10		7
8	TELEVISION AND RADIO SERVICE (chapter 21)	A	-1	OPERATION OF PLANT	7		8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-3,102,679				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)	B	-305	RADIOLOGY-DIAGNOSTIC	54		11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	9,025,528				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-541,223	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-23,657	DELIVERY ROOM & LABOR ROOM	52		16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS						18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES	B	-2,049	CAFETERIA	11		20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33							33
34							34
35							35
36							36
36.01	OTHER INCOME	B	-10,312	ADMINISTRATION & GENERAL	5.60		36.01
36.02	OTHER INCOME	B	-19,739	HOUSEKEEPING	9		36.02
36.03	OTHER INCOME	B	-17,947	DIETARY	10		36.03
36.08	OTHER INCOME	B	-40	ELECTROCARDIOLOGY	69		36.08
36.09	OTHER INCOME	B	-1,000	ELECTROCARDIOLOGY	69		36.09
36.10	OTHER INCOME	B	-3,085	ELECTROCARDIOLOGY	69		36.10
36.11	OTHER INCOME	B	-35,354	PATIENT TREATMENT CENTER	90.01		36.11
36.12	OTHER INCOME	B	-12,702	CLINIC	90		36.12
36.13	OTHER INCOME	B	-1,330	CLINIC	90		36.13
37							37
38	TUITION INCOME	B	-245,034	NURSING ADMINISTRATION	13		38
38.01	TUITION INCOME	B	-4,912	EMERGENCY	91		38.01
39	RENTAL INCOME	B	-264,588	CLINIC	90		39
39.01	RENTAL INCOME	B	-4,559	SUBPROVIDER - IPF	40		39.01
39.02	RENTAL INCOME	B	-14,034	OPERATION OF PLANT	7		39.02
39.03	INTERCOMPANY RENTAL INCOME	B	-41,316	CLINIC	90		39.03
39.04	INTERCOMPANY RENTAL INCOME	B	-235,852	OPERATION OF PLANT	7		39.04
39.05	OTHER INCOME	B	-27,619	OPERATION OF PLANT	7		39.05
40	OTHER SERVICE REVENUE	B	-12,384	PATIENT TREATMENT CENTER	90.01		40
40.03	OTHER SERVICE REVENUE	B	-90	MENTAL HEALTH O/P	90.04		40.03
40.05	OTHER SERVICE REVENUE	B	-1,030	CLINIC	90		40.05

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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	
40.07	OTHER SERVICE REVENUE	B	-128,804	EMERGENCY	91		40.07
40.09	OTHER INCOME	B	-64	LABORATORY	60		40.09
41	INSTYMED REV	B	-385,248	CLINIC	90		41
41.01	WORK ORDER REV	B	-7,160	OPERATION OF PLANT	7		41.01
41.02	RECOVERY LIVING REV	B	-20,307	SUBPROVIDER - IPF	40		41.02
41.04	OTHER INCOME	B	-5,259	ADULTS & PEDIATRICS	30		41.04
42							42
42.07	REAL ESTATE TAXES	A	-1,094	ADMINISTRATION & GENERAL	5.60		42.07
43							43
44							44
45							45
46	NON PHYSICIAN PART B	A	-82,650	NURSING ADMINISTRATION	13		46
46.01	NON PHYSICIAN PART B	A	-77,907	ADULTS & PEDIATRICS	30		46.01
46.04	NON PHYSICIAN PART B	A	-44,129	ELECTROCARDIOLOGY	69		46.04
46.05	NON PHYSICIAN PART B	A	-205,360	CLINIC	90		46.05
46.06	NON PHYSICIAN PART B	A	-25,174	PATIENT TREATMENT CENTER	90.01		46.06
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		3,352,474				50

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

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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUST-MENTS (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 COST	3,684,746		3,684,746	9	1
2	1	CAP REL COSTS-BLDG & FIXT	HOME OFFICE COST-INTEREST	2,379,059		2,379,059	12	2
3	5.30	PURCHASING AND STORES	HOME OFFICE COST	416,168		416,168		3
3.01	5.60	ADMINISTRATION & GENERAL	HOME OFFICE COST	20,962,938	19,254,018	1,708,920		3.01
3.02	16	MEDICAL RECORDS & LIBRARY	HOME OFFICE COST	644,898		644,898		3.02
3.03	55	RADIOLOGY-THERAPEUTIC	HOME OFFICE COST	191,737		191,737		3.03
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			28,279,546	19,254,018	9,025,528		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	CADENCE HEALTH	100.00				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	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN / PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	5.60	ADMINISTRATION & GEN AGGREGATE	128,963	128,963						1
2										2
3	30	ADULTS & PEDIATRICS AGGREGATE	486,734	486,536	198	140,600	2	135	7	3
4	30	ADULTS & PEDIATRICS SALARIED	99,641	99,641						4
5	31	INTENSIVE CARE UNIT AGGREGATE	43,269	43,269						5
6										6
7										7
8	40	SUBPROVIDER - IPF AGGREGATE	44,400	44,400						8
9	50	OPERATING ROOM AGGREGATE	43,599	37,659	5,940	208,000	33	3,300	165	9
10										10
11	52	DELIVERY ROOM & LABO AGGREGATE	95,087	95,087						11
12	53	ANESTHESIOLOGY AGGREGATE	21,000	21,000						12
13	54	RADIOLOGY-DIAGNOSTIC AGGREGATE	29,422	29,422						13
14	55	RADIOLOGY-THERAPEUTI AGGREGATE	11,375		11,375	225,300	46	4,983	249	14
15										15
16	57	CT SCAN AGGREGATE	21,000	21,000						16
17										17
18	60	LABORATORY AGGREGATE	286,150	286,150						18
19	70	ELECTROENCEPHALOGRAP SALARIED	12,264	12,264						19
20	69	ELECTROCARDIOLOGY SLALRIED	303,182	303,182						20
21	69	ELECTROCARDIOLOGY AGGREGATE	690,098	690,098						21
22	70	ELECTROENCEPHALOGRAP AGGREGATE	3,000		3,000	208,000	20	2,000	100	22
23	90	CLINIC SALARIED	731,139	731,139						23
24	90	CLINIC AGGREGATE	524	524						24
25	90.01	PATIENT TREATMENT CE AGGREGATE	2,307	2,307						25
26	90.04	MENTAL HEALTH O/P AGGREGATE	4,405	4,405						26
27	91	EMERGENCY AGGREGATE	58,946	53,146	5,800	177,200	40	3,408	170	27
200		TOTAL	3,116,505	3,090,192	26,313		141	13,826	691	200

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATIO N	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRAC T-ICE INSURANC E	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW - ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1	5.60	ADMINISTRATION & GEN AGGREGATE							128,963	1
2										2
3	30	ADULTS & PEDIATRICS AGGREGATE					135	63	486,599	3
4	30	ADULTS & PEDIATRICS SALARIED							99,641	4
5	31	INTENSIVE CARE UNIT AGGREGATE							43,269	5
6										6
7										7
8	40	SUBPROVIDER - IPF AGGREGATE							44,400	8
9	50	OPERATING ROOM AGGREGATE					3,300	2,640	40,299	9
10										10
11	52	DELIVERY ROOM & LABO AGGREGATE							95,087	11
12	53	ANESTHESIOLOGY AGGREGATE							21,000	12
13	54	RADIOLOGY-DIAGNOSTIC AGGREGATE							29,422	13
14	55	RADIOLOGY-THERAPEUTI AGGREGATE					4,983	6,392	6,392	14
15										15
16	57	CT SCAN AGGREGATE							21,000	16
17										17
18	60	LABORATORY AGGREGATE							286,150	18
19	70	ELECTROENCEPHALOGRAP SALARIED							12,264	19
20	69	ELECTROCARDIOLOGY SLALRIED							303,182	20
21	69	ELECTROCARDIOLOGY AGGREGATE							690,098	21
22	70	ELECTROENCEPHALOGRAP AGGREGATE					2,000	1,000	1,000	22
23	90	CLINIC SALARIED							731,139	23
24	90	CLINIC AGGREGATE							524	24
25	90.01	PATIENT TREATMENT CE AGGREGATE							2,307	25
26	90.04	MENTAL HEALTH O/P AGGREGATE							4,405	26
27	91	EMERGENCY AGGREGATE					3,408	2,392	55,538	27
200		TOTAL					13,826	12,487	3,102,679	200

KPMG LLP

COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NON PATIENT TELEPHONES	PURCHASING AND STORES	
		0	1	2	4	5.10	5.30	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	10,736,581	10,736,581					1
2	CAP REL COSTS-MVBLE EQUIP	3,856,806		3,856,806				2
4	EMPLOYEE BENEFITS DEPARTMENT	-118,750			-118,750			4
5.10	NON PATIENT TELEPHONES	-53,696				-53,696		5.10
5.30	PURCHASING AND STORES	416,168					416,168	5.30
5.40	ADMITTING	746,159	211	76			222	5.40
5.50	ACCOUNTS RECEIVABLE AND CASHIERS							5.50
5.60	ADMINISTRATION & GENERAL	29,728,045	157,557	56,598				5.60
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	3,533,456	6,550,946	2,353,237			2,741	7
8	LAUNDRY & LINEN SERVICE	10,821	31,493	11,313			103	8
9	HOUSEKEEPING	898,951	90,096	32,364			2,802	9
10	DIETARY	330,921	116,129	41,716			307	10
11	CAFETERIA	153,930	81,237	29,182				11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	563,894	59,402	21,339			1,135	13
14	CENTRAL SERVICES & SUPPLY	569,554	65,464	23,516			3,594	14
15	PHARMACY	970,512	32,268	11,591			1,870	15
16	MEDICAL RECORDS & LIBRARY	738,796						16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	10,134,475	954,009	342,700			8,990	30
31	INTENSIVE CARE UNIT	2,225,931	174,277	62,604			3,176	31
35	NEONATAL INTENSIVE CARE UNIT	966,588	44,244	15,894			1,072	35
40	SUBPROVIDER - IPF	624,777	133,310	47,888			104	40
43	NURSERY	386,787	84,488	30,350				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	5,279,303	501,726	180,230			69,205	50
51	RECOVERY ROOM	752,274	76,538	27,494			948	51
52	DELIVERY ROOM & LABOR ROOM	1,503,324	156,194	56,108			2,152	52
53	ANESTHESIOLOGY	201,894					4,325	53
54	RADIOLOGY-DIAGNOSTIC	1,232,264	223,873	80,420			899	54
55	RADIOLOGY-THERAPEUTIC	1,371,495	164,470	59,081			1,683	55
56	RADIOISOTOPE	210,755	21,008	7,547			3,224	56
57	CT SCAN	306,054	25,451	9,142			1,180	57
58	MRI	371,543	26,622	9,563			728	58
60	LABORATORY	8,079,068	198,991	71,482			61,018	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	558,949	8,046	2,890			553	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	240,436	3,975	1,428				64
65	RESPIRATORY THERAPY	595,607	21,226	7,625			681	65
66	PHYSICAL THERAPY	1,070,076	46,203	16,597			128	66
67	OCCUPATIONAL THERAPY	144,771	2,023	727			13	67
68	SPEECH PATHOLOGY	183,112	2,938	1,055			10	68
69	ELECTROCARDIOLOGY	2,407,996	151,290	54,347			10,384	69
70	ELECTROENCEPHALOGRAPHY	293,377	29,855	10,724			162	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,027,921					90,530	71
72	IMPL. DEV. CHARGED TO PATIENTS	4,510,469					134,906	72
73	DRUGS CHARGED TO PATIENTS	6,809,047						73
74	RENAL DIALYSIS	114,074	8,309	2,985				74
75.01	CARDIAC REHAB	116,750					60	75.01
75.02	SLEEP LAB							75.02
75.03	INPATIENT DIALYSIS							75.03
75.04	PAIN MANAGEMENT	63,464	20,400	7,328			251	75.04
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	2,189,907	123,785	44,466			1,782	90
90.01	PATIENT TREATMENT CENTER	270,962	41,306	14,838			421	90.01
90.02	REHAB SERVICES-BLOOMINGDALE							90.02
90.03	CANTERA							90.03
90.04	MENTAL HEALTH O/P	346,274	34,796	12,500			59	90.04

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NON PATIENT TELEPHONES	PURCHASING AND STORES	
		0	1	2	4	5.10	5.30	
90.05	WOMEN'S CLINIC							90.05
90.06	WOUND CARE	48,442	9,787	3,516			59	90.06
91	EMERGENCY	1,561,024	262,638	94,345			4,691	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	111,281,338	10,736,581	3,856,806			416,168	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,806						190
190.01	KOFEE KORNER							190.01
191	RESEARCH							191
192.01	WSKF							192.01
193.01	DEVELOPMENT							193.01
193.02	MARKETING							193.02
193.04	PHYSICIAN ANSWERING SERVICE							193.04
193.05	CAR SEAT SAFETY PROGRAM							193.05
193.07	JOINT VENTURE							193.07
193.08	PARKINSONS CENTER	9,116						193.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER				-118,750	-53,696		201
202	TOTAL (sum of lines 118-201)	111,322,260	10,736,581	3,856,806	-118,750	-53,696	416,168	202

KPMG LLP

COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ADMITTING	SUBTOTAL (cols.0-4)	ADMIN AND GENERAL	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	
		5.40	4A	5.60	7	8	9	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT TELEPHONES							5.10
5.30	PURCHASING AND STORES							5.30
5.40	ADMITTING	746,668						5.40
5.50	ACCOUNTS RECEIVABLE AND CASHIERS							5.50
5.60	ADMINISTRATION & GENERAL		29,942,200	29,942,200				5.60
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		12,440,380	4,567,541	17,007,921			7
8	LAUNDRY & LINEN SERVICE		53,730	19,727	132,983	206,440		8
9	HOUSEKEEPING		1,024,213	376,042	380,434		1,780,689	9
10	DIETARY		489,073	179,564	490,362		52,938	10
11	CAFETERIA		264,349	97,056	343,026		37,032	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		645,770	237,096	250,830		27,079	13
14	CENTRAL SERVICES & SUPPLY		662,128	243,102	276,427	1,869	29,842	14
15	PHARMACY		1,016,241	373,115	136,254		14,709	15
16	MEDICAL RECORDS & LIBRARY		738,796	271,250				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	108,025	11,548,199	4,239,944	4,028,362	85,722	434,886	30
31	INTENSIVE CARE UNIT	23,675	2,489,663	914,085	735,894	5,246	79,445	31
35	NEONATAL INTENSIVE CARE UNIT	14,268	1,042,066	382,597	186,825	1,049	20,169	35
40	SUBPROVIDER - IPF	10,797	816,876	299,918	562,908	2,098	60,770	40
43	NURSERY	5,630	507,255	186,240	356,757		38,514	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	71,013	6,101,477	2,240,169	2,118,567	37,979	228,713	50
51	RECOVERY ROOM	9,229	866,483	318,131	323,187	3,777	34,890	51
52	DELIVERY ROOM & LABOR ROOM	16,441	1,734,219	636,722	659,537	14,375	71,201	52
53	ANESTHESIOLOGY	9,149	215,368	79,073				53
54	RADIOLOGY-DIAGNOSTIC	17,427	1,554,883	570,878	945,315	14,268	102,053	54
55	RADIOLOGY-THERAPEUTIC	1,300	1,598,029	586,720	694,485	210	74,974	55
56	RADIOISOTOPE	2,876	245,410	90,103	88,709		9,577	56
57	CT SCAN	23,330	365,157	134,068	107,468	2,098	11,602	57
58	MRI	8,919	417,375	153,240	112,414		12,136	58
60	LABORATORY	48,834	8,459,393	3,105,883	840,253	210	90,711	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,025	573,463	210,548	33,976		3,668	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	8,770	254,609	93,480	16,785		1,812	64
65	RESPIRATORY THERAPY	20,963	646,102	237,218	89,628		9,676	65
66	PHYSICAL THERAPY	3,410	1,136,414	417,237	195,096	1,235	21,062	66
67	OCCUPATIONAL THERAPY	1,914	149,448	54,870	8,541		922	67
68	SPEECH PATHOLOGY	1,754	188,869	69,344	12,406		1,339	68
69	ELECTROCARDIOLOGY	20,853	2,644,870	971,069	638,833	6,714	68,966	69
70	ELECTROENCEPHALOGRAPHY	3,537	337,655	123,971	126,064	2,938	13,609	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	100,610	3,219,061	1,181,885				71
72	IMPL. DEV. CHARGED TO PATIENTS	76,135	4,721,510	1,733,512				72
73	DRUGS CHARGED TO PATIENTS	102,467	6,911,514	2,537,576				73
74	RENAL DIALYSIS	2,421	127,789	46,918	35,084		3,788	74
75.01	CARDIAC REHAB	133	116,943	42,936				75.01
75.02	SLEEP LAB							75.02
75.03	INPATIENT DIALYSIS							75.03
75.04	PAIN MANAGEMENT	1,020	92,463	33,948	86,142	1,469	9,300	75.04
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	55	2,359,995	866,477	522,689	1,263	56,428	90
90.01	PATIENT TREATMENT CENTER	4,112	331,639	121,762	174,419	1,469	18,830	90.01
90.02	REHAB SERVICES-BLOOMINGDALE							90.02
90.03	CANTERA							90.03
90.04	MENTAL HEALTH O/P	1,566	395,195	145,097	146,930		15,862	90.04
90.05	WOMEN'S CLINIC							90.05

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	ADMITTING	SUBTOTAL (cols.0-4)	ADMIN AND GENERAL	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	
		5.40	4A	5.60	7	8	9	
90.06	WOUND CARE	11	61,815	22,696	41,327		4,462	90.06
91	EMERGENCY	22,999	1,945,697	714,367	1,109,004	22,451	119,724	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	746,668	111,453,784	29,927,175	17,007,921	206,440	1,780,689	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		31,806	11,678				190
190.01	KOFEE KORNER							190.01
191	RESEARCH							191
192.01	WSKF							192.01
193.01	DEVELOPMENT							193.01
193.02	MARKETING							193.02
193.04	PHYSICIAN ANSWERING SERVICE							193.04
193.05	CAR SEAT SAFETY PROGRAM							193.05
193.07	JOINT VENTURE							193.07
193.08	PARKINSONS CENTER		9,116	3,347				193.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER		-172,446					201
202	TOTAL (sum of lines 118-201)	746,668	111,322,260	29,942,200	17,007,921	206,440	1,780,689	202

KPMG LLP

COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	NURSING ADMINI-STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10	11	13	14	15	16	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT TELEPHONES							5.10
5.30	PURCHASING AND STORES							5.30
5.40	ADMITTING							5.40
5.50	ACCOUNTS RECEIVABLE AND CASHIERS							5.50
5.60	ADMINISTRATION & GENERAL							5.60
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY	1,211,937						10
11	CAFETERIA		741,463					11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		10,572	1,171,347				13
14	CENTRAL SERVICES & SUPPLY		19,093		1,232,461			14
15	PHARMACY		18,774	31,021		1,590,114		15
16	MEDICAL RECORDS & LIBRARY		2,408				1,012,454	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	969,620	152,982	252,776		507	74,551	30
31	INTENSIVE CARE UNIT	109,921	39,029	64,488		184	14,830	31
35	NEONATAL INTENSIVE CARE UNIT		14,280	23,595			8,938	35
40	SUBPROVIDER - IPF	132,396	13,698			1	6,764	40
43	NURSERY		5,942	9,819			3,527	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		54,004	496,422	105,459	479	90,233	50
51	RECOVERY ROOM		14,180	89,233			19,123	51
52	DELIVERY ROOM & LABOR ROOM		24,168	39,934		82	10,313	52
53	ANESTHESIOLOGY		1,944	3,212		22	11,663	53
54	RADIOLOGY-DIAGNOSTIC		24,264			868	37,863	54
55	RADIOLOGY-THERAPEUTIC		19,933			441	15,053	55
56	RADIOISOTOPE		1,750	2,892		55	7,370	56
57	CT SCAN		5,744			152	45,186	57
58	MRI		5,501			8,579	22,071	58
60	LABORATORY		144,248			1,061	183,145	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		2,777				5,802	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY					170	13,293	64
65	RESPIRATORY THERAPY		13,827	22,847		33	14,467	65
66	PHYSICAL THERAPY		21,509	35,541		113	9,513	66
67	OCCUPATIONAL THERAPY		1,122	1,854			2,423	67
68	SPEECH PATHOLOGY		3,021	4,991			2,129	68
69	ELECTROCARDIOLOGY		21,626	35,734	23,726	615	28,974	69
70	ELECTROENCEPHALOGRAPHY		5,803	9,589			6,772	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				443,044		96,146	71
72	IMPL. DEV. CHARGED TO PATIENTS				660,232		62,705	72
73	DRUGS CHARGED TO PATIENTS					1,560,143	145,620	73
74	RENAL DIALYSIS						1,517	74
75.01	CARDIAC REHAB		1,860				758	75.01
75.02	SLEEP LAB							75.02
75.03	INPATIENT DIALYSIS							75.03
75.04	PAIN MANAGEMENT		1,196				3,466	75.04
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		55,905			14,413	10,883	90
90.01	PATIENT TREATMENT CENTER		6,017			8	4,367	90.01
90.02	REHAB SERVICES-BLOOMINGDALE							90.02
90.03	CANTERA							90.03
90.04	MENTAL HEALTH O/P		4,120				4,132	90.04
90.05	WOMEN'S CLINIC							90.05

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	NURSING ADMINI-STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10	11	13	14	15	16	
90.06	WOUND CARE		1,264			30	395	90.06
91	EMERGENCY		28,686	47,399		2,158	48,462	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,211,937	741,247	1,171,347	1,232,461	1,590,114	1,012,454	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		29					190
190.01	KOFEE KORNER							190.01
191	RESEARCH							191
192.01	WSKF							192.01
193.01	DEVELOPMENT							193.01
193.02	MARKETING							193.02
193.04	PHYSICIAN ANSWERING SERVICE							193.04
193.05	CAR SEAT SAFETY PROGRAM							193.05
193.07	JOINT VENTURE							193.07
193.08	PARKINSONS CENTER		187					193.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,211,937	741,463	1,171,347	1,232,461	1,590,114	1,012,454	202

KPMG LLP

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT TELEPHONES							5.10
5.30	PURCHASING AND STORES							5.30
5.40	ADMITTING							5.40
5.50	ACCOUNTS RECEIVABLE AND CASHIERS							5.50
5.60	ADMINISTRATION & GENERAL							5.60
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	21,787,549		21,787,549				30
31	INTENSIVE CARE UNIT	4,452,785		4,452,785				31
35	NEONATAL INTENSIVE CARE UNIT	1,679,519		1,679,519				35
40	SUBPROVIDER - IPF	1,895,429		1,895,429				40
43	NURSERY	1,108,054		1,108,054				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	11,473,502		11,473,502				50
51	RECOVERY ROOM	1,669,004		1,669,004				51
52	DELIVERY ROOM & LABOR ROOM	3,190,551		3,190,551				52
53	ANESTHESIOLOGY	311,282		311,282				53
54	RADIOLOGY-DIAGNOSTIC	3,250,392		3,250,392				54
55	RADIOLOGY-THERAPEUTIC	2,989,845		2,989,845				55
56	RADIOISOTOPE	445,866		445,866				56
57	CT SCAN	671,475		671,475				57
58	MRI	731,316		731,316				58
60	LABORATORY	12,824,904		12,824,904				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	830,234		830,234				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	380,149		380,149				64
65	RESPIRATORY THERAPY	1,033,798		1,033,798				65
66	PHYSICAL THERAPY	1,837,720		1,837,720				66
67	OCCUPATIONAL THERAPY	219,180		219,180				67
68	SPEECH PATHOLOGY	282,099		282,099				68
69	ELECTROCARDIOLOGY	4,441,127		4,441,127				69
70	ELECTROENCEPHALOGRAPHY	626,401		626,401				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,940,136		4,940,136				71
72	IMPL. DEV. CHARGED TO PATIENTS	7,177,959		7,177,959				72
73	DRUGS CHARGED TO PATIENTS	11,154,853		11,154,853				73
74	RENAL DIALYSIS	215,096		215,096				74
75.01	CARDIAC REHAB	162,497		162,497				75.01
75.02	SLEEP LAB							75.02
75.03	INPATIENT DIALYSIS							75.03
75.04	PAIN MANAGEMENT	227,984		227,984				75.04
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	3,888,053		3,888,053				90
90.01	PATIENT TREATMENT CENTER	658,511		658,511				90.01
90.02	REHAB SERVICES-BLOOMINGDALE							90.02
90.03	CANTERA							90.03
90.04	MENTAL HEALTH O/P	711,336		711,336				90.04
90.05	WOMEN'S CLINIC							90.05

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
90.06	WOUND CARE	131,989		131,989				90.06
91	EMERGENCY	4,037,948		4,037,948				91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	111,438,543		111,438,543				118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43,513		43,513				190
190.01	KOFEE KORNER							190.01
191	RESEARCH							191
192.01	WSKF							192.01
193.01	DEVELOPMENT							193.01
193.02	MARKETING							193.02
193.04	PHYSICIAN ANSWERING SERVICE							193.04
193.05	CAR SEAT SAFETY PROGRAM							193.05
193.07	JOINT VENTURE							193.07
193.08	PARKINSONS CENTER	12,650		12,650				193.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER	-172,446		-172,446				201
202	TOTAL (sum of lines 118-201)	111,322,260		111,322,260				202

KPMG LLP

COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	SUBTOTAL	ADMITTING	ADMIN AND GENERAL	
		0	1	2	2A	5.40	5.60	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT TELEPHONES							5.10
5.30	PURCHASING AND STORES							5.30
5.40	ADMITTING		211	76	287	287		5.40
5.50	ACCOUNTS RECEIVABLE AND CASHIERS							5.50
5.60	ADMINISTRATION & GENERAL		157,557	56,598	214,155		214,155	5.60
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		6,550,946	2,353,237	8,904,183		32,667	7
8	LAUNDRY & LINEN SERVICE		31,493	11,313	42,806		141	8
9	HOUSEKEEPING		90,096	32,364	122,460		2,690	9
10	DIETARY		116,129	41,716	157,845		1,284	10
11	CAFETERIA		81,237	29,182	110,419		694	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		59,402	21,339	80,741		1,696	13
14	CENTRAL SERVICES & SUPPLY		65,464	23,516	88,980		1,739	14
15	PHARMACY		32,268	11,591	43,859		2,669	15
16	MEDICAL RECORDS & LIBRARY						1,940	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		954,009	342,700	1,296,709	73	30,326	30
31	INTENSIVE CARE UNIT		174,277	62,604	236,881	8	6,538	31
35	NEONATAL INTENSIVE CARE UNIT		44,244	15,894	60,138	5	2,736	35
40	SUBPROVIDER - IPF		133,310	47,888	181,198	4	2,145	40
43	NURSERY		84,488	30,350	114,838	2	1,332	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		501,726	180,230	681,956	24	16,022	50
51	RECOVERY ROOM		76,538	27,494	104,032	3	2,275	51
52	DELIVERY ROOM & LABOR ROOM		156,194	56,108	212,302	5	4,554	52
53	ANESTHESIOLOGY					3	566	53
54	RADIOLOGY-DIAGNOSTIC		223,873	80,420	304,293	6	4,083	54
55	RADIOLOGY-THERAPEUTIC		164,470	59,081	223,551		4,196	55
56	RADIOISOTOPE		21,008	7,547	28,555	1	644	56
57	CT SCAN		25,451	9,142	34,593	8	959	57
58	MRI		26,622	9,563	36,185	3	1,096	58
60	LABORATORY		198,991	71,482	270,473	16	22,214	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		8,046	2,890	10,936	1	1,506	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY		3,975	1,428	5,403	3	669	64
65	RESPIRATORY THERAPY		21,226	7,625	28,851	7	1,697	65
66	PHYSICAL THERAPY		46,203	16,597	62,800	1	2,984	66
67	OCCUPATIONAL THERAPY		2,023	727	2,750	1	392	67
68	SPEECH PATHOLOGY		2,938	1,055	3,993	1	496	68
69	ELECTROCARDIOLOGY		151,290	54,347	205,637	7	6,945	69
70	ELECTROENCEPHALOGRAPHY		29,855	10,724	40,579	1	887	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					34	8,453	71
72	IMPL. DEV. CHARGED TO PATIENTS					25	12,399	72
73	DRUGS CHARGED TO PATIENTS					34	18,150	73
74	RENAL DIALYSIS		8,309	2,985	11,294	1	336	74
75.01	CARDIAC REHAB						307	75.01
75.02	SLEEP LAB							75.02
75.03	INPATIENT DIALYSIS							75.03
75.04	PAIN MANAGEMENT		20,400	7,328	27,728		243	75.04
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		123,785	44,466	168,251		6,197	90
90.01	PATIENT TREATMENT CENTER		41,306	14,838	56,144	1	871	90.01
90.02	REHAB SERVICES-BLOOMINGDALE							90.02
90.03	CANTERA							90.03
90.04	MENTAL HEALTH O/P		34,796	12,500	47,296	1	1,038	90.04
90.05	WOMEN'S CLINIC							90.05

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	SUBTOTAL	ADMITTING	ADMIN AND GENERAL	
		0	1	2	2A	5.40	5.60	
90.06	WOUND CARE		9,787	3,516	13,303		162	90.06
91	EMERGENCY		262,638	94,345	356,983	8	5,109	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		10,736,581	3,856,806	14,593,387	287	214,047	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						84	190
190.01	KOFEE KORNER							190.01
191	RESEARCH							191
192.01	WSKF							192.01
193.01	DEVELOPMENT							193.01
193.02	MARKETING							193.02
193.04	PHYSICIAN ANSWERING SERVICE							193.04
193.05	CAR SEAT SAFETY PROGRAM							193.05
193.07	JOINT VENTURE							193.07
193.08	PARKINSONS CENTER						24	193.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		10,736,581	3,856,806	14,593,387	287	214,155	202

KPMG LLP

COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINI-STRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT TELEPHONES							5.10
5.30	PURCHASING AND STORES							5.30
5.40	ADMITTING							5.40
5.50	ACCOUNTS RECEIVABLE AND CASHIERS							5.50
5.60	ADMINISTRATION & GENERAL							5.60
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	8,936,850						7
8	LAUNDRY & LINEN SERVICE	69,876	112,823					8
9	HOUSEKEEPING	199,900		325,050				9
10	DIETARY	257,662		9,663	426,454			10
11	CAFETERIA	180,244		6,760		298,117		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	131,799		4,943		4,250	223,429	13
14	CENTRAL SERVICES & SUPPLY	145,249	1,022	5,447		7,677		14
15	PHARMACY	71,595		2,685		7,548	5,917	15
16	MEDICAL RECORDS & LIBRARY					968		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	2,116,711	46,846	79,387	341,188	61,510	48,216	30
31	INTENSIVE CARE UNIT	386,677	2,867	14,502	38,679	15,692	12,301	31
35	NEONATAL INTENSIVE CARE UNIT	98,168	573	3,682		5,741	4,501	35
40	SUBPROVIDER - IPF	295,781	1,147	11,093	46,587	5,507		40
43	NURSERY	187,459		7,030		2,389	1,873	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,113,206	20,756	41,750		21,713	94,689	50
51	RECOVERY ROOM	169,819	2,064	6,369		5,701	17,021	51
52	DELIVERY ROOM & LABOR ROOM	346,555	7,856	12,997		9,717	7,617	52
53	ANESTHESIOLOGY					782	613	53
54	RADIOLOGY-DIAGNOSTIC	496,718	7,798	18,629		9,756		54
55	RADIOLOGY-THERAPEUTIC	364,919	115	13,686		8,014		55
56	RADIOISOTOPE	46,613		1,748		704	552	56
57	CT SCAN	56,469	1,147	2,118		2,309		57
58	MRI	59,068		2,215		2,212		58
60	LABORATORY	441,513	115	16,559		57,997		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	17,853		670		1,117		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	8,820		331				64
65	RESPIRATORY THERAPY	47,095		1,766		5,559	4,358	65
66	PHYSICAL THERAPY	102,514	675	3,845		8,648	6,779	66
67	OCCUPATIONAL THERAPY	4,488		168		451	354	67
68	SPEECH PATHOLOGY	6,519		244		1,215	952	68
69	ELECTROCARDIOLOGY	335,676	3,670	12,589		8,695	6,816	69
70	ELECTROENCEPHALOGRAPHY	66,240	1,605	2,484		2,333	1,829	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS	18,435		691				74
75.01	CARDIAC REHAB					748		75.01
75.02	SLEEP LAB							75.02
75.03	INPATIENT DIALYSIS							75.03
75.04	PAIN MANAGEMENT	45,263	803	1,698		481		75.04
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	274,648	691	10,300		22,478		90
90.01	PATIENT TREATMENT CENTER	91,649	803	3,437		2,419		90.01
90.02	REHAB SERVICES-BLOOMINGDALE							90.02
90.03	CANTERA							90.03
90.04	MENTAL HEALTH O/P	77,205		2,895		1,657		90.04
90.05	WOMEN'S CLINIC							90.05

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINI-STRATION	
		7	8	9	10	11	13	
90.06	WOUND CARE	21,716		814		508		90.06
91	EMERGENCY	582,728	12,270	21,855		11,534	9,041	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	8,936,850	112,823	325,050	426,454	298,030	223,429	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					12		190
190.01	KOFEE KORNER							190.01
191	RESEARCH							191
192.01	WSKF							192.01
193.01	DEVELOPMENT							193.01
193.02	MARKETING							193.02
193.04	PHYSICIAN ANSWERING SERVICE							193.04
193.05	CAR SEAT SAFETY PROGRAM							193.05
193.07	JOINT VENTURE							193.07
193.08	PARKINSONS CENTER					75		193.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	8,936,850	112,823	325,050	426,454	298,117	223,429	202

KPMG LLP

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		14	15	16	24	25	26	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT TELEPHONES							5.10
5.30	PURCHASING AND STORES							5.30
5.40	ADMITTING							5.40
5.50	ACCOUNTS RECEIVABLE AND CASHIERS							5.50
5.60	ADMINISTRATION & GENERAL							5.60
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	250,114						14
15	PHARMACY		134,273					15
16	MEDICAL RECORDS & LIBRARY			2,908				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		43	199	4,021,208		4,021,208	30
31	INTENSIVE CARE UNIT		16	40	714,201		714,201	31
35	NEONATAL INTENSIVE CARE UNIT			24	175,568		175,568	35
40	SUBPROVIDER - IPF			18	543,480		543,480	40
43	NURSERY			9	314,932		314,932	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	21,402	40	241	2,011,799		2,011,799	50
51	RECOVERY ROOM			51	307,335		307,335	51
52	DELIVERY ROOM & LABOR ROOM		7	28	601,638		601,638	52
53	ANESTHESIOLOGY		2	31	1,997		1,997	53
54	RADIOLOGY-DIAGNOSTIC		73	101	841,457		841,457	54
55	RADIOLOGY-THERAPEUTIC		37	40	614,558		614,558	55
56	RADIOISOTOPE		5	20	78,842		78,842	56
57	CT SCAN		13	121	97,737		97,737	57
58	MRI		724	59	101,562		101,562	58
60	LABORATORY		90	695	809,672		809,672	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS			15	32,098		32,098	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY		14	35	15,275		15,275	64
65	RESPIRATORY THERAPY		3	39	89,375		89,375	65
66	PHYSICAL THERAPY		10	25	188,281		188,281	66
67	OCCUPATIONAL THERAPY			6	8,610		8,610	67
68	SPEECH PATHOLOGY			6	13,426		13,426	68
69	ELECTROCARDIOLOGY	4,815	52	77	584,979		584,979	69
70	ELECTROENCEPHALOGRAPHY			18	115,976		115,976	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	89,912		257	98,656		98,656	71
72	IMPL. DEV. CHARGED TO PATIENTS	133,985		167	146,576		146,576	72
73	DRUGS CHARGED TO PATIENTS		131,741	389	150,314		150,314	73
74	RENAL DIALYSIS			4	30,761		30,761	74
75.01	CARDIAC REHAB			2	1,057		1,057	75.01
75.02	SLEEP LAB							75.02
75.03	INPATIENT DIALYSIS							75.03
75.04	PAIN MANAGEMENT			9	76,225		76,225	75.04
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		1,217	29	483,811		483,811	90
90.01	PATIENT TREATMENT CENTER		1	12	155,337		155,337	90.01
90.02	REHAB SERVICES-BLOOMINGDALE							90.02
90.03	CANTERA							90.03
90.04	MENTAL HEALTH O/P			11	130,103		130,103	90.04
90.05	WOMEN'S CLINIC							90.05

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		14	15	16	24	25	26	
90.06	WOUND CARE		3	1	36,507		36,507	90.06
91	EMERGENCY		182	129	999,839		999,839	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	250,114	134,273	2,908	14,593,192		14,593,192	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				96		96	190
190.01	KOFEE KORNER							190.01
191	RESEARCH							191
192.01	WSKF							192.01
193.01	DEVELOPMENT							193.01
193.02	MARKETING							193.02
193.04	PHYSICIAN ANSWERING SERVICE							193.04
193.05	CAR SEAT SAFETY PROGRAM							193.05
193.07	JOINT VENTURE							193.07
193.08	PARKINSONS CENTER				99		99	193.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	250,114	134,273	2,908	14,593,387		14,593,387	202

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

	COST CENTER DESCRIPTIONS	NEW CAP-REL COSTS BLDG&FIXT (SQUARE FEET)	NEW CAP-REL COSTS MOV EQUIP SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NON PATIENT TELEPHONES (NONPT PHONES)	PURCHASING AND STORES (SUPPLIES EXPENSE)	ADMITTING INPATIENT REVENUE	
		1	2	4	5.10	5.30	5.40	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,677,299						1
2	CAP REL COSTS-MVBLE EQUIP		1,677,299					2
4	EMPLOYEE BENEFITS DEPARTMENT			34,824,838				4
5.10	NON PATIENT TELEPHONES				4,049			5.10
5.30	PURCHASING AND STORES				23	13,914,038		5.30
5.40	ADMITTING	33	33	538,449	94	7,437	249,706,690	5.40
5.50	ACCOUNTS RECEIVABLE AND CASHIERS							5.50
5.60	ADMINISTRATION & GENERAL	24,614	24,614	3,927,344	188			5.60
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,023,407	1,023,407	562,343	126	91,632		7
8	LAUNDRY & LINEN SERVICE	4,920	4,920	26,604	3	3,460		8
9	HOUSEKEEPING	14,075	14,075	646,154	37	93,686		9
10	DIETARY	18,142	18,142	150,385	44	10,269		10
11	CAFETERIA	12,691	12,691	229,620	18			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	9,280	9,280	591,505	74	37,958		13
14	CENTRAL SERVICES & SUPPLY	10,227	10,227	384,817	93	120,154		14
15	PHARMACY	5,041	5,041	796,854	61	62,535		15
16	MEDICAL RECORDS & LIBRARY			73,625	52			16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	149,038	149,038	5,926,673	640	300,569	36,112,804	30
31	INTENSIVE CARE UNIT	27,226	27,226	1,703,109	121	106,176	7,917,980	31
35	NEONATAL INTENSIVE CARE UNIT	6,912	6,912	684,964	33	35,832	4,771,832	35
40	SUBPROVIDER - IPF	20,826	20,826	487,055	84	3,470	3,611,115	40
43	NURSERY	13,199	13,199	261,725	57		1,883,105	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	78,381	78,381	2,221,792	409	2,313,765	23,750,023	50
51	RECOVERY ROOM	11,957	11,957	566,519	11	31,689	3,086,514	51
52	DELIVERY ROOM & LABOR ROOM	24,401	24,401	1,138,525	174	71,944	5,498,597	52
53	ANESTHESIOLOGY			44,830	48	144,591	3,059,848	53
54	RADIOLOGY-DIAGNOSTIC	34,974	34,974	902,018	246	30,052	5,828,414	54
55	RADIOLOGY-THERAPEUTIC	25,694	25,694	802,248	219	56,268	434,935	55
56	RADIOISOTOPE	3,282	3,282	79,886	1	107,793	962,031	56
57	CT SCAN	3,976	3,976	206,670	4	39,445	7,802,758	57
58	MRI	4,159	4,159	239,577	7	24,323	2,983,107	58
60	LABORATORY	31,087	31,087	3,677,224	169	2,040,055	16,332,448	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,257	1,257	93,262	7	18,486	1,011,841	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	621	621	123,481			2,933,219	64
65	RESPIRATORY THERAPY	3,316	3,316	451,262	23	22,758	7,010,936	65
66	PHYSICAL THERAPY	7,218	7,218	745,184	76	4,278	1,140,560	66
67	OCCUPATIONAL THERAPY	316	316	113,355	5	418	640,225	67
68	SPEECH PATHOLOGY	459	459	143,074	3	342	586,741	68
69	ELECTROCARDIOLOGY	23,635	23,635	1,666,787	135	347,188	6,974,291	69
70	ELECTROENCEPHALOGRAPHY	4,664	4,664	211,873	17	5,422	1,183,049	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					3,026,731	33,648,719	71
72	IMPL. DEV. CHARGED TO PATIENTS					4,510,469	25,463,295	72
73	DRUGS CHARGED TO PATIENTS						34,269,929	73
74	RENAL DIALYSIS	1,298	1,298				809,700	74
75.01	CARDIAC REHAB			73,717		1,995	44,458	75.01
75.02	SLEEP LAB							75.02
75.03	INPATIENT DIALYSIS							75.03
75.04	PAIN MANAGEMENT	3,187	3,187	41,202	14	8,401	341,297	75.04
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	19,338	19,338	2,638,571	442	59,568	18,412	90
90.01	PATIENT TREATMENT CENTER	6,453	6,453	235,649	73	14,080	1,375,238	90.01
90.02	REHAB SERVICES-BLOOMINGDALE							90.02
90.03	CANTERA							90.03

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	NEW CAP-REL COSTS BLDG&FIXT (SQUARE FEET)	NEW CAP-REL COSTS MOV EQUIP SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NON PATIENT TELEPHONES (NONPT PHONES)	PURCHASING AND STORES (SUPPLIES EXPENSE)	ADMITTING INPATIENT REVENUE	
		1	2	4	5.10	5.30	5.40	
90.04	MENTAL HEALTH O/P	5,436	5,436	249,640		1,982	523,618	90.04
90.05	WOMEN'S CLINIC							90.05
90.06	WOUND CARE	1,529	1,529	36,504	10	1,983	3,605	90.06
91	EMERGENCY	41,030	41,030	1,123,248	201	156,834	7,692,046	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,677,299	1,677,299	34,817,324	4,042	13,914,038	249,706,690	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			355				190
190.01	KOFEE KORNER							190.01
191	RESEARCH				7			191
192.01	WSKF							192.01
193.01	DEVELOPMENT							193.01
193.02	MARKETING							193.02
193.04	PHYSICIAN ANSWERING SERVICE							193.04
193.05	CAR SEAT SAFETY PROGRAM							193.05
193.07	JOINT VENTURE							193.07
193.08	PARKINSONS CENTER			7,159				193.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	10,736,581	3,856,806			416,168	746,668	202
203	UNIT COST MULT-WS B PT I	6.401113	2.299415			0.029910	0.002990	203
204	COST TO BE ALLOC PER B PT II						287	204
205	UNIT COST MULT-WS B PT II						0.000001	205

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	RECON-CILIATION	ADMIN AND GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING SQUARE FEET	DIETARY (MEALS SERVED)	
		5A.60	5.60	7	8	9	10	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT TELEPHONES							5.10
5.30	PURCHASING AND STORES							5.30
5.40	ADMITTING							5.40
5.50	ACCOUNTS RECEIVABLE AND CASHIERS							5.50
5.60	ADMINISTRATION & GENERAL	-29,942,200	81,552,506					5.60
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		12,440,380	629,245				7
8	LAUNDRY & LINEN SERVICE		53,730	4,920	242,307			8
9	HOUSEKEEPING		1,024,213	14,075		610,250		9
10	DIETARY		489,073	18,142		18,142	41,522	10
11	CAFETERIA		264,349	12,691		12,691		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		645,770	9,280		9,280		13
14	CENTRAL SERVICES & SUPPLY		662,128	10,227	2,194	10,227		14
15	PHARMACY		1,016,241	5,041		5,041		15
16	MEDICAL RECORDS & LIBRARY		738,796					16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		11,548,199	149,038	100,615	149,038	33,220	30
31	INTENSIVE CARE UNIT		2,489,663	27,226	6,157	27,226	3,766	31
35	NEONATAL INTENSIVE CARE UNIT		1,042,066	6,912	1,231	6,912		35
40	SUBPROVIDER - IPF		816,876	20,826	2,463	20,826	4,536	40
43	NURSERY		507,255	13,199		13,199		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		6,101,477	78,381	44,577	78,381		50
51	RECOVERY ROOM		866,483	11,957	4,433	11,957		51
52	DELIVERY ROOM & LABOR ROOM		1,734,219	24,401	16,873	24,401		52
53	ANESTHESIOLOGY		215,368					53
54	RADIOLOGY-DIAGNOSTIC		1,554,883	34,974	16,747	34,974		54
55	RADIOLOGY-THERAPEUTIC		1,598,029	25,694	246	25,694		55
56	RADIOISOTOPE		245,410	3,282		3,282		56
57	CT SCAN		365,157	3,976	2,463	3,976		57
58	MRI		417,375	4,159		4,159		58
60	LABORATORY		8,459,393	31,087	246	31,087		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		573,463	1,257		1,257		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY		254,609	621		621		64
65	RESPIRATORY THERAPY		646,102	3,316		3,316		65
66	PHYSICAL THERAPY		1,136,414	7,218	1,450	7,218		66
67	OCCUPATIONAL THERAPY		149,448	316		316		67
68	SPEECH PATHOLOGY		188,869	459		459		68
69	ELECTROCARDIOLOGY		2,644,870	23,635	7,881	23,635		69
70	ELECTROENCEPHALOGRAPHY		337,655	4,664	3,448	4,664		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		3,219,061					71
72	IMPL. DEV. CHARGED TO PATIENTS		4,721,510					72
73	DRUGS CHARGED TO PATIENTS		6,911,514					73
74	RENAL DIALYSIS		127,789	1,298		1,298		74
75.01	CARDIAC REHAB		116,943					75.01
75.02	SLEEP LAB							75.02
75.03	INPATIENT DIALYSIS							75.03
75.04	PAIN MANAGEMENT		92,463	3,187	1,724	3,187		75.04
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		2,359,995	19,338	1,483	19,338		90
90.01	PATIENT TREATMENT CENTER		331,639	6,453	1,724	6,453		90.01
90.02	REHAB SERVICES-BLOOMINGDALE							90.02
90.03	CANTERA							90.03
90.04	MENTAL HEALTH O/P		395,195	5,436		5,436		90.04

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

	COST CENTER DESCRIPTIONS	RECON-CILIATION	ADMIN AND GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING SQUARE FEET	DIETARY (MEALS SERVED)	
		5A.60	5.60	7	8	9	10	
90.05	WOMEN'S CLINIC							90.05
90.06	WOUND CARE		61,815	1,529		1,529		90.06
91	EMERGENCY		1,945,697	41,030	26,352	41,030		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	-29,942,200	81,511,584	629,245	242,307	610,250	41,522	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		31,806					190
190.01	KOFEE KORNER							190.01
191	RESEARCH							191
192.01	WSKF							192.01
193.01	DEVELOPMENT							193.01
193.02	MARKETING							193.02
193.04	PHYSICIAN ANSWERING SERVICE							193.04
193.05	CAR SEAT SAFETY PROGRAM							193.05
193.07	JOINT VENTURE							193.07
193.08	PARKINSONS CENTER		9,116					193.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I		29,942,200	17,007,921	206,440	1,780,689	1,211,937	202
203	UNIT COST MULT-WS B PT I		0.367152	27.029092	0.851977	2.917966	29.187828	203
204	COST TO BE ALLOC PER B PT II		214,155	8,936,850	112,823	325,050	426,454	204
205	UNIT COST MULT-WS B PT II		0.002626	14.202497	0.465620	0.532651	10.270555	205

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

	COST CENTER DESCRIPTIONS	CAFETERIA (FTES SERVED)	NURSING ADMINI-STRATION (DIRECT NRSG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY GROSS REVENUE		
		11	13	14	15	16		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT TELEPHONES							5.10
5.30	PURCHASING AND STORES							5.30
5.40	ADMITTING							5.40
5.50	ACCOUNTS RECEIVABLE AND CASHIERS							5.50
5.60	ADMINISTRATION & GENERAL							5.60
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA	844,381						11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	12,039	807,302					13
14	CENTRAL SERVICES & SUPPLY	21,743		8,419,753				14
15	PHARMACY	21,380	21,380		6,939,862			15
16	MEDICAL RECORDS & LIBRARY	2,742				540,436,132		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	174,215	174,215		2,212	39,802,839		30
31	INTENSIVE CARE UNIT	44,446	44,446		802	7,917,980		31
35	NEONATAL INTENSIVE CARE UNIT	16,262	16,262			4,771,832		35
40	SUBPROVIDER - IPF	15,599			4	3,611,115		40
43	NURSERY	6,767	6,767			1,883,105		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	61,500	342,138	720,463	2,090	48,175,869		50
51	RECOVERY ROOM	16,148	61,500			10,209,668		51
52	DELIVERY ROOM & LABOR ROOM	27,523	27,523		357	5,506,285		52
53	ANESTHESIOLOGY	2,214	2,214		98	6,226,736		53
54	RADIOLOGY-DIAGNOSTIC	27,632			3,789	20,215,242		54
55	RADIOLOGY-THERAPEUTIC	22,700			1,925	8,036,938		55
56	RADIOISOTOPE	1,993	1,993		241	3,935,032		56
57	CT SCAN	6,541			664	24,124,668		57
58	MRI	6,265			37,444	11,783,851		58
60	LABORATORY	164,270			4,632	97,666,978		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,163				3,097,688		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY				743	7,097,059		64
65	RESPIRATORY THERAPY	15,746	15,746		145	7,723,849		65
66	PHYSICAL THERAPY	24,495	24,495		495	5,078,951		66
67	OCCUPATIONAL THERAPY	1,278	1,278			1,293,406		67
68	SPEECH PATHOLOGY	3,440	3,440			1,136,850		68
69	ELECTROCARDIOLOGY	24,628	24,628	162,090	2,686	15,469,439		69
70	ELECTROENCEPHALOGRAPHY	6,609	6,609			3,615,629		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			3,026,731		51,332,723		71
72	IMPL. DEV. CHARGED TO PATIENTS			4,510,469		33,478,261		72
73	DRUGS CHARGED TO PATIENTS				6,809,047	77,747,056		73
74	RENAL DIALYSIS					809,700		74
75.01	CARDIAC REHAB	2,118				404,494		75.01
75.02	SLEEP LAB							75.02
75.03	INPATIENT DIALYSIS							75.03
75.04	PAIN MANAGEMENT	1,362				1,850,300		75.04
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	63,665			62,904	5,810,454		90
90.01	PATIENT TREATMENT CENTER	6,852			36	2,331,369		90.01
90.02	REHAB SERVICES-BLOOMINGDALE							90.02

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	CAFETERIA (FTES SERVED)	NURSING ADMINI-STRATION (DIRECT NRSG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY GROSS REVENUE		
		11	13	14	15	16		
90.03	CANTERA							90.03
90.04	MENTAL HEALTH O/P	4,692				2,205,875		90.04
90.05	WOMEN'S CLINIC							90.05
90.06	WOUND CARE	1,440			130	211,050		90.06
91	EMERGENCY	32,668	32,668		9,418	25,873,841		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	844,135	807,302	8,419,753	6,939,862	540,436,132		118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33						190
190.01	KOFEE KORNER							190.01
191	RESEARCH							191
192.01	WSKF							192.01
193.01	DEVELOPMENT							193.01
193.02	MARKETING							193.02
193.04	PHYSICIAN ANSWERING SERVICE							193.04
193.05	CAR SEAT SAFETY PROGRAM							193.05
193.07	JOINT VENTURE							193.07
193.08	PARKINSONS CENTER	213						193.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	741,463	1,171,347	1,232,461	1,590,114	1,012,454		202
203	UNIT COST MULT-WS B PT I	0.878114	1.450940	0.146377	0.229128	0.001873		203
204	COST TO BE ALLOC PER B PT II	298,117	223,429	250,114	134,273	2,908		204
205	UNIT COST MULT-WS B PT II	0.353060	0.276760	0.029706	0.019348	0.000005		205

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

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 DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	21,787,549		21,787,549	63	21,787,612	30
31	INTENSIVE CARE UNIT	4,452,785		4,452,785		4,452,785	31
35	NEONATAL INTENSIVE CARE UNIT	1,679,519		1,679,519		1,679,519	35
40	SUBPROVIDER - IPF	1,895,429		1,895,429		1,895,429	40
43	NURSERY	1,108,054		1,108,054		1,108,054	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	11,473,502		11,473,502	2,640	11,476,142	50
51	RECOVERY ROOM	1,669,004		1,669,004		1,669,004	51
52	DELIVERY ROOM & LABOR ROOM	3,190,551		3,190,551		3,190,551	52
53	ANESTHESIOLOGY	311,282		311,282		311,282	53
54	RADIOLOGY-DIAGNOSTIC	3,250,392		3,250,392		3,250,392	54
55	RADIOLOGY-THERAPEUTIC	2,989,845		2,989,845	6,392	2,996,237	55
56	RADIOISOTOPE	445,866		445,866		445,866	56
57	CT SCAN	671,475		671,475		671,475	57
58	MRI	731,316		731,316		731,316	58
60	LABORATORY	12,824,904		12,824,904		12,824,904	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	830,234		830,234		830,234	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	380,149		380,149		380,149	64
65	RESPIRATORY THERAPY	1,033,798		1,033,798		1,033,798	65
66	PHYSICAL THERAPY	1,837,720		1,837,720		1,837,720	66
67	OCCUPATIONAL THERAPY	219,180		219,180		219,180	67
68	SPEECH PATHOLOGY	282,099		282,099		282,099	68
69	ELECTROCARDIOLOGY	4,441,127		4,441,127		4,441,127	69
70	ELECTROENCEPHALOGRAPHY	626,401		626,401	1,000	627,401	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,940,136		4,940,136		4,940,136	71
72	IMPL. DEV. CHARGED TO PATIENTS	7,177,959		7,177,959		7,177,959	72
73	DRUGS CHARGED TO PATIENTS	11,154,853		11,154,853		11,154,853	73
74	RENAL DIALYSIS	215,096		215,096		215,096	74
75.01	CARDIAC REHAB	162,497		162,497		162,497	75.01
75.02	SLEEP LAB						75.02
75.03	INPATIENT DIALYSIS						75.03
75.04	PAIN MANAGEMENT	227,984		227,984		227,984	75.04
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	3,888,053		3,888,053		3,888,053	90
90.01	PATIENT TREATMENT CENTER	658,511		658,511		658,511	90.01
90.02	REHAB SERVICES-BLOOMINGDALE						90.02
90.03	CANTERA						90.03
90.04	MENTAL HEALTH O/P	711,336		711,336		711,336	90.04
90.05	WOMEN'S CLINIC						90.05
90.06	WOUND CARE	131,989		131,989		131,989	90.06
91	EMERGENCY	4,037,948		4,037,948	2,392	4,040,340	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,787,353		2,787,353		2,787,353	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	114,225,896		114,225,896	12,487	114,238,383	200
201	LESS OBSERVATION BEDS	2,787,353		2,787,353		2,787,353	201
202	TOTAL (SEE INSTRUCTIONS)	111,438,543		111,438,543		111,451,030	202

KPMG LLP

COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

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 SERV COST CENTERS							
30	ADULTS & PEDIATRICS	36,112,804		36,112,804				30
31	INTENSIVE CARE UNIT	7,917,980		7,917,980				31
35	NEONATAL INTENSIVE CARE UNIT	4,771,832		4,771,832				35
40	SUBPROVIDER - IPF	3,611,115		3,611,115				40
43	NURSERY	1,883,105		1,883,105				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	23,750,023	24,425,846	48,175,869	0.238159	0.238159	0.238213	50
51	RECOVERY ROOM	3,086,514	7,123,154	10,209,668	0.163473	0.163473	0.163473	51
52	DELIVERY ROOM & LABOR ROOM	5,498,597	7,688	5,506,285	0.579438	0.579438	0.579438	52
53	ANESTHESIOLOGY	3,059,848	3,166,888	6,226,736	0.049991	0.049991	0.049991	53
54	RADIOLOGY-DIAGNOSTIC	5,828,414	14,386,828	20,215,242	0.160789	0.160789	0.160789	54
55	RADIOLOGY-THERAPEUTIC	434,935	7,602,003	8,036,938	0.372013	0.372013	0.372808	55
56	RADIOISOTOPE	962,031	2,973,001	3,935,032	0.113307	0.113307	0.113307	56
57	CT SCAN	7,802,758	16,321,910	24,124,668	0.027834	0.027834	0.027834	57
58	MRI	2,983,107	8,800,744	11,783,851	0.062061	0.062061	0.062061	58
60	LABORATORY	16,332,448	81,334,530	97,666,978	0.131313	0.131313	0.131313	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,011,841	2,085,847	3,097,688	0.268017	0.268017	0.268017	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	2,933,219	4,163,840	7,097,059	0.053564	0.053564	0.053564	64
65	RESPIRATORY THERAPY	7,010,936	712,913	7,723,849	0.133845	0.133845	0.133845	65
66	PHYSICAL THERAPY	1,140,560	3,938,391	5,078,951	0.361831	0.361831	0.361831	66
67	OCCUPATIONAL THERAPY	640,225	653,181	1,293,406	0.169460	0.169460	0.169460	67
68	SPEECH PATHOLOGY	586,741	550,109	1,136,850	0.248141	0.248141	0.248141	68
69	ELECTROCARDIOLOGY	6,974,291	8,495,148	15,469,439	0.287090	0.287090	0.287090	69
70	ELECTROENCEPHALOGRAPHY	1,183,049	2,432,580	3,615,629	0.173248	0.173248	0.173525	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,648,719	17,684,004	51,332,723	0.096238	0.096238	0.096238	71
72	IMPL. DEV. CHARGED TO PATIENTS	25,463,295	8,014,966	33,478,261	0.214407	0.214407	0.214407	72
73	DRUGS CHARGED TO PATIENTS	34,269,929	43,477,127	77,747,056	0.143476	0.143476	0.143476	73
74	RENAL DIALYSIS	809,700		809,700	0.265649	0.265649	0.265649	74
75.01	CARDIAC REHAB	44,458	360,036	404,494	0.401729	0.401729	0.401729	75.01
75.02	SLEEP LAB							75.02
75.03	INPATIENT DIALYSIS							75.03
75.04	PAIN MANAGEMENT	341,297	1,509,003	1,850,300	0.123215	0.123215	0.123215	75.04
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	18,412	5,792,042	5,810,454	0.669148	0.669148	0.669148	90
90.01	PATIENT TREATMENT CENTER	1,375,238	956,131	2,331,369	0.282457	0.282457	0.282457	90.01
90.02	REHAB SERVICES-BLOOMINGDALE							90.02
90.03	CANTERA							90.03
90.04	MENTAL HEALTH O/P	523,618	1,682,257	2,205,875	0.322473	0.322473	0.322473	90.04
90.05	WOMEN'S CLINIC							90.05
90.06	WOUND CARE	3,605	207,445	211,050	0.625392	0.625392	0.625392	90.06
91	EMERGENCY	7,692,046	18,181,795	25,873,841	0.156063	0.156063	0.156155	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		3,690,035	3,690,035	0.755373	0.755373	0.755373	92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	249,706,690	290,729,442	540,436,132				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	249,706,690	290,729,442	540,436,132				202

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] TITLE XVIII, PART A** **[ ] TITLE XIX** **[XX] PPS** **[ ] TEFRA**

		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 SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	4,021,208		4,021,208	14,109	285.01	4,644	1,323,586	30
31	INTENSIVE CARE UNIT	714,201		714,201	1,395	511.97	650	332,781	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	NEONATAL INTENSIVE CARE UNIT	175,568		175,568	1,013	173.31			35
40	SUBPROVIDER - IPF	543,480		543,480	1,680	323.50	235	76,023	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	314,932		314,932	1,211	260.06			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	5,769,389		5,769,389	19,408		5,529	1,732,390	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0242** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) | [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26) 1	TOTAL CHARGES (from Wkst. C, Part I, (col. 8) 2	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL COSTS (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,011,799	48,175,869	0.041759	8,892,952	371,361	50
51	RECOVERY ROOM	307,335	10,209,668	0.030102	1,146,120	34,501	51
52	DELIVERY ROOM & LABOR ROOM	601,638	5,506,285	0.109264	8,974	981	52
53	ANESTHESIOLOGY	1,997	6,226,736	0.000321	881,737	283	53
54	RADIOLOGY-DIAGNOSTIC	841,457	20,215,242	0.041625	2,457,104	102,277	54
55	RADIOLOGY-THERAPEUTIC	614,558	8,036,938	0.076467	208,900	15,974	55
56	RADIOISOTOPE	78,842	3,935,032	0.020036	403,371	8,082	56
57	CT SCAN	97,737	24,124,668	0.004051	3,368,266	13,645	57
58	MRI	101,562	11,783,851	0.008619	889,571	7,667	58
60	LABORATORY	809,672	97,666,978	0.008290	6,813,857	56,487	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	32,098	3,097,688	0.010362	364,345	3,775	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	15,275	7,097,059	0.002152	720,710	1,551	64
65	RESPIRATORY THERAPY	89,375	7,723,849	0.011571	3,045,267	35,237	65
66	PHYSICAL THERAPY	188,281	5,078,951	0.037071	523,373	19,402	66
67	OCCUPATIONAL THERAPY	8,610	1,293,406	0.006657	296,077	1,971	67
68	SPEECH PATHOLOGY	13,426	1,136,850	0.011810	313,167	3,699	68
69	ELECTROCARDIOLOGY	584,979	15,469,439	0.037815	2,751,137	104,034	69
70	ELECTROENCEPHALOGRAPHY	115,976	3,615,629	0.032076	285,943	9,172	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	98,656	51,332,723	0.001922	12,957,379	24,904	71
72	IMPL. DEV. CHARGED TO PATIENTS	146,576	33,478,261	0.004378	9,532,284	41,732	72
73	DRUGS CHARGED TO PATIENTS	150,314	77,747,056	0.001933	14,140,923	27,334	73
74	RENAL DIALYSIS	30,761	809,700	0.037991	611,477	23,231	74
75.01	CARDIAC REHAB	1,057	404,494	0.002613	15,611	41	75.01
75.02	SLEEP LAB						75.02
75.03	INPATIENT DIALYSIS						75.03
75.04	PAIN MANAGEMENT	76,225	1,850,300	0.041196	118,597	4,886	75.04
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	483,811	5,810,454	0.083266	7,670	639	90
90.01	PATIENT TREATMENT CENTER	155,337	2,331,369	0.066629	596,695	39,757	90.01
90.02	REHAB SERVICES-BLOOMINGDALE						90.02
90.03	CANTERA						90.03
90.04	MENTAL HEALTH O/P	130,103	2,205,875	0.058980	26,108	1,540	90.04
90.05	WOMEN'S CLINIC						90.05
90.06	WOUND CARE	36,507	211,050	0.172978			90.06
91	EMERGENCY	999,839	25,873,841	0.038643	2,956,791	114,259	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	514,445	3,690,035	0.139415			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	9,338,248	486,139,296		74,334,406	1,068,422	200

(A) Worksheet A line numbers

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS; [XX] TITLE XVIII, PART A [ ] TEFRA; [ ] TITLE XIX

		NURSING SCHOOL	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	1	2	3	4	5	
	INPATIENT ROUTINE SERV 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	NEONATAL INTENSIVE CARE UNIT						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

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] PPS [ ] TEFRA

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	14,109		4,644		30
31	INTENSIVE CARE UNIT	1,395		650		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	NEONATAL INTENSIVE CARE UNIT	1,013				35
40	SUBPROVIDER - IPF	1,680		235		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	1,211				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	19,408		5,529		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0242** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	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	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75.01	CARDIAC REHAB							75.01
75.02	SLEEP LAB							75.02
75.03	INPATIENT DIALYSIS							75.03
75.04	PAIN MANAGEMENT							75.04
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	PATIENT TREATMENT CENTER							90.01
90.02	REHAB SERVICES-BLOOMINGDALE							90.02
90.03	CANTERA							90.03
90.04	MENTAL HEALTH O/P							90.04
90.05	WOMEN'S CLINIC							90.05
90.06	WOUND CARE							90.06
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0242** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		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	48,175,869			8,892,952		5,996,495		50
51	RECOVERY ROOM	10,209,668			1,146,120		1,448,255		51
52	DELIVERY ROOM & LABOR ROOM	5,506,285			8,974				52
53	ANESTHESIOLOGY	6,226,736			881,737		562,142		53
54	RADIOLOGY-DIAGNOSTIC	20,215,242			2,457,104		2,593,513		54
55	RADIOLOGY-THERAPEUTIC	8,036,938			208,900		2,733,210		55
56	RADIOISOTOPE	3,935,032			403,371		1,145,163		56
57	CT SCAN	24,124,668			3,368,266		4,693,418		57
58	MRI	11,783,851			889,571		2,322,691		58
60	LABORATORY	97,666,978			6,813,857		2,695,670		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,097,688			364,345		295,584		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	7,097,059			720,710		1,101,833		64
65	RESPIRATORY THERAPY	7,723,849			3,045,267		151,788		65
66	PHYSICAL THERAPY	5,078,951			523,373				66
67	OCCUPATIONAL THERAPY	1,293,406			296,077				67
68	SPEECH PATHOLOGY	1,136,850			313,167				68
69	ELECTROCARDIOLOGY	15,469,439			2,751,137		2,407,584		69
70	ELECTROENCEPHALOGRAPHY	3,615,629			285,943		539,286		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,332,723			12,957,379		4,099,631		71
72	IMPL. DEV. CHARGED TO PATIENTS	33,478,261			9,532,284		3,512,317		72
73	DRUGS CHARGED TO PATIENTS	77,747,056			14,140,923		11,250,191		73
74	RENAL DIALYSIS	809,700			611,477				74
75.01	CARDIAC REHAB	404,494			15,611		178,324		75.01
75.02	SLEEP LAB								75.02
75.03	INPATIENT DIALYSIS								75.03
75.04	PAIN MANAGEMENT	1,850,300			118,597		662,478		75.04
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	5,810,454			7,670		303,467		90
90.01	PATIENT TREATMENT CENTER	2,331,369			596,695		132,969		90.01
90.02	REHAB SERVICES-BLOOMINGDALE								90.02
90.03	CANTERA								90.03
90.04	MENTAL HEALTH O/P	2,205,875			26,108		72,229		90.04
90.05	WOMEN'S CLINIC								90.05
90.06	WOUND CARE	211,050							90.06
91	EMERGENCY	25,873,841			2,956,791		3,221,227		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,690,035					1,100,482		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	486,139,296			74,334,406		53,219,947		200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0242** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.238159	5,996,495			1,428,119			50
51	RECOVERY ROOM	0.163473	1,448,255			236,751			51
52	DELIVERY ROOM & LABOR ROOM	0.579438							52
53	ANESTHESIOLOGY	0.049991	562,142			28,102			53
54	RADIOLOGY-DIAGNOSTIC	0.160789	2,593,513			417,008			54
55	RADIOLOGY-THERAPEUTIC	0.372013	2,733,210			1,016,790			55
56	RADIOISOTOPE	0.113307	1,145,163			129,755			56
57	CT SCAN	0.027834	4,693,418			130,637			57
58	MRI	0.062061	2,322,691			144,149			58
60	LABORATORY	0.131313	2,695,670			353,977			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.268017	295,584			79,222			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	0.053564	1,101,833			59,019			64
65	RESPIRATORY THERAPY	0.133845	151,788			20,316			65
66	PHYSICAL THERAPY	0.361831							66
67	OCCUPATIONAL THERAPY	0.169460							67
68	SPEECH PATHOLOGY	0.248141							68
69	ELECTROCARDIOLOGY	0.287090	2,407,584			691,193			69
70	ELECTROENCEPHALOGRAPHY	0.173248	539,286			93,430			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.096238	4,099,631			394,540			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.214407	3,512,317			753,065			72
73	DRUGS CHARGED TO PATIENTS	0.143476	11,250,191		13,912	1,614,132		1,996	73
74	RENAL DIALYSIS	0.265649							74
75.01	CARDIAC REHAB	0.401729	178,324			71,638			75.01
75.02	SLEEP LAB								75.02
75.03	INPATIENT DIALYSIS								75.03
75.04	PAIN MANAGEMENT	0.123215	662,478			81,627			75.04
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.669148	303,467			203,064			90
90.01	PATIENT TREATMENT CENTER	0.282457	132,969			37,558			90.01
90.02	REHAB SERVICES-BLOOMINGDALE								90.02
90.03	CANTERA								90.03
90.04	MENTAL HEALTH O/P	0.322473	72,229			23,292			90.04
90.05	WOMEN'S CLINIC								90.05
90.06	WOUND CARE	0.625392							90.06
91	EMERGENCY	0.156063	3,221,227			502,714			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.755373	1,100,482			831,274			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		53,219,947		13,912	9,341,372		1,996	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		53,219,947		13,912	9,341,372		1,996	202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S242** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [ ] HOSPITAL [XX] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26) 1	TOTAL CHARGES (from Wkst. C, Part I, (col. 8) 2	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL COSTS (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,011,799	48,175,869	0.041759			50
51	RECOVERY ROOM	307,335	10,209,668	0.030102			51
52	DELIVERY ROOM & LABOR ROOM	601,638	5,506,285	0.109264			52
53	ANESTHESIOLOGY	1,997	6,226,736	0.000321			53
54	RADIOLOGY-DIAGNOSTIC	841,457	20,215,242	0.041625	2,374	99	54
55	RADIOLOGY-THERAPEUTIC	614,558	8,036,938	0.076467			55
56	RADIOISOTOPE	78,842	3,935,032	0.020036			56
57	CT SCAN	97,737	24,124,668	0.004051	4,734	19	57
58	MRI	101,562	11,783,851	0.008619			58
60	LABORATORY	809,672	97,666,978	0.008290	47,473	394	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	32,098	3,097,688	0.010362			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	15,275	7,097,059	0.002152			64
65	RESPIRATORY THERAPY	89,375	7,723,849	0.011571	191	2	65
66	PHYSICAL THERAPY	188,281	5,078,951	0.037071	1,236	46	66
67	OCCUPATIONAL THERAPY	8,610	1,293,406	0.006657	505	3	67
68	SPEECH PATHOLOGY	13,426	1,136,850	0.011810			68
69	ELECTROCARDIOLOGY	584,979	15,469,439	0.037815	3,030	115	69
70	ELECTROENCEPHALOGRAPHY	115,976	3,615,629	0.032076			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	98,656	51,332,723	0.001922	8,508	16	71
72	IMPL. DEV. CHARGED TO PATIENTS	146,576	33,478,261	0.004378	1,544	7	72
73	DRUGS CHARGED TO PATIENTS	150,314	77,747,056	0.001933	143,124	277	73
74	RENAL DIALYSIS	30,761	809,700	0.037991			74
75.01	CARDIAC REHAB	1,057	404,494	0.002613			75.01
75.02	SLEEP LAB						75.02
75.03	INPATIENT DIALYSIS						75.03
75.04	PAIN MANAGEMENT	76,225	1,850,300	0.041196	18	1	75.04
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	483,811	5,810,454	0.083266			90
90.01	PATIENT TREATMENT CENTER	155,337	2,331,369	0.066629			90.01
90.02	REHAB SERVICES-BLOOMINGDALE						90.02
90.03	CANTERA						90.03
90.04	MENTAL HEALTH O/P	130,103	2,205,875	0.058980	45,542	2,686	90.04
90.05	WOMEN'S CLINIC						90.05
90.06	WOUND CARE	36,507	211,050	0.172978			90.06
91	EMERGENCY	999,839	25,873,841	0.038643	52,568	2,031	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		3,690,035				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	8,823,803	486,139,296		310,847	5,696	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S242** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH-ETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (sum of col. 1 through col. 4) 5	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4) 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	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75.01	CARDIAC REHAB							75.01
75.02	SLEEP LAB							75.02
75.03	INPATIENT DIALYSIS							75.03
75.04	PAIN MANAGEMENT							75.04
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	PATIENT TREATMENT CENTER							90.01
90.02	REHAB SERVICES-BLOOMINGDALE							90.02
90.03	CANTERA							90.03
90.04	MENTAL HEALTH O/P							90.04
90.05	WOMEN'S CLINIC							90.05
90.06	WOUND CARE							90.06
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S242** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		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	48,175,869							50
51	RECOVERY ROOM	10,209,668							51
52	DELIVERY ROOM & LABOR ROOM	5,506,285							52
53	ANESTHESIOLOGY	6,226,736							53
54	RADIOLOGY-DIAGNOSTIC	20,215,242			2,374				54
55	RADIOLOGY-THERAPEUTIC	8,036,938							55
56	RADIOISOTOPE	3,935,032							56
57	CT SCAN	24,124,668			4,734				57
58	MRI	11,783,851							58
60	LABORATORY	97,666,978			47,473				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,097,688							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	7,097,059							64
65	RESPIRATORY THERAPY	7,723,849			191				65
66	PHYSICAL THERAPY	5,078,951			1,236				66
67	OCCUPATIONAL THERAPY	1,293,406			505				67
68	SPEECH PATHOLOGY	1,136,850							68
69	ELECTROCARDIOLOGY	15,469,439			3,030				69
70	ELECTROENCEPHALOGRAPHY	3,615,629							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,332,723			8,508				71
72	IMPL. DEV. CHARGED TO PATIENTS	33,478,261			1,544				72
73	DRUGS CHARGED TO PATIENTS	77,747,056			143,124				73
74	RENAL DIALYSIS	809,700							74
75.01	CARDIAC REHAB	404,494							75.01
75.02	SLEEP LAB								75.02
75.03	INPATIENT DIALYSIS								75.03
75.04	PAIN MANAGEMENT	1,850,300			18				75.04
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	5,810,454							90
90.01	PATIENT TREATMENT CENTER	2,331,369							90.01
90.02	REHAB SERVICES-BLOOMINGDALE								90.02
90.03	CANTERA								90.03
90.04	MENTAL HEALTH O/P	2,205,875			45,542				90.04
90.05	WOMEN'S CLINIC								90.05
90.06	WOUND CARE	211,050							90.06
91	EMERGENCY	25,873,841			52,568				91
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,690,035							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	486,139,296			310,847				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S242** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.238159							50
51	RECOVERY ROOM	0.163473							51
52	DELIVERY ROOM & LABOR ROOM	0.579438							52
53	ANESTHESIOLOGY	0.049991							53
54	RADIOLOGY-DIAGNOSTIC	0.160789							54
55	RADIOLOGY-THERAPEUTIC	0.372013							55
56	RADIOISOTOPE	0.113307							56
57	CT SCAN	0.027834							57
58	MRI	0.062061							58
60	LABORATORY	0.131313							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.268017							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	0.053564							64
65	RESPIRATORY THERAPY	0.133845							65
66	PHYSICAL THERAPY	0.361831							66
67	OCCUPATIONAL THERAPY	0.169460							67
68	SPEECH PATHOLOGY	0.248141							68
69	ELECTROCARDIOLOGY	0.287090							69
70	ELECTROENCEPHALOGRAPHY	0.173248							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.096238							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.214407							72
73	DRUGS CHARGED TO PATIENTS	0.143476							73
74	RENAL DIALYSIS	0.265649							74
75.01	CARDIAC REHAB	0.401729							75.01
75.02	SLEEP LAB								75.02
75.03	INPATIENT DIALYSIS								75.03
75.04	PAIN MANAGEMENT	0.123215							75.04
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.669148							90
90.01	PATIENT TREATMENT CENTER	0.282457							90.01
90.02	REHAB SERVICES-BLOOMINGDALE								90.02
90.03	CANTERA								90.03
90.04	MENTAL HEALTH O/P	0.322473							90.04
90.05	WOMEN'S CLINIC								90.05
90.06	WOUND CARE	0.625392							90.06
91	EMERGENCY	0.156063							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.755373							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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES:
[ ] TITLE V
[ ] TITLE XVIII, PART A
[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 SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	4,021,208		4,021,208	14,109	285.01	2,733	778,932	30
31	INTENSIVE CARE UNIT	714,201		714,201	1,395	511.97	116	59,389	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	NEONATAL INTENSIVE CARE UNIT	175,568		175,568	1,013	173.31	352	61,005	35
40	SUBPROVIDER - IPF	543,480		543,480	1,680	323.50	562	181,807	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	314,932		314,932	1,211	260.06	196	50,972	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	5,769,389		5,769,389	19,408		3,959	1,132,105	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0242** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [ ] TITLE XVIII, PART A [ ] IPF [XX] 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	2,011,799	48,175,869	0.041759			50
51	RECOVERY ROOM	307,335	10,209,668	0.030102			51
52	DELIVERY ROOM & LABOR ROOM	601,638	5,506,285	0.109264			52
53	ANESTHESIOLOGY	1,997	6,226,736	0.000321			53
54	RADIOLOGY-DIAGNOSTIC	841,457	20,215,242	0.041625			54
55	RADIOLOGY-THERAPEUTIC	614,558	8,036,938	0.076467			55
56	RADIOISOTOPE	78,842	3,935,032	0.020036			56
57	CT SCAN	97,737	24,124,668	0.004051			57
58	MRI	101,562	11,783,851	0.008619			58
60	LABORATORY	809,672	97,666,978	0.008290			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	32,098	3,097,688	0.010362			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	15,275	7,097,059	0.002152			64
65	RESPIRATORY THERAPY	89,375	7,723,849	0.011571			65
66	PHYSICAL THERAPY	188,281	5,078,951	0.037071			66
67	OCCUPATIONAL THERAPY	8,610	1,293,406	0.006657			67
68	SPEECH PATHOLOGY	13,426	1,136,850	0.011810			68
69	ELECTROCARDIOLOGY	584,979	15,469,439	0.037815			69
70	ELECTROENCEPHALOGRAPHY	115,976	3,615,629	0.032076			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	98,656	51,332,723	0.001922			71
72	IMPL. DEV. CHARGED TO PATIENTS	146,576	33,478,261	0.004378			72
73	DRUGS CHARGED TO PATIENTS	150,314	77,747,056	0.001933			73
74	RENAL DIALYSIS	30,761	809,700	0.037991			74
75.01	CARDIAC REHAB	1,057	404,494	0.002613			75.01
75.02	SLEEP LAB						75.02
75.03	INPATIENT DIALYSIS						75.03
75.04	PAIN MANAGEMENT	76,225	1,850,300	0.041196			75.04
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	483,811	5,810,454	0.083266			90
90.01	PATIENT TREATMENT CENTER	155,337	2,331,369	0.066629			90.01
90.02	REHAB SERVICES-BLOOMINGDALE						90.02
90.03	CANTERA						90.03
90.04	MENTAL HEALTH O/P	130,103	2,205,875	0.058980			90.04
90.05	WOMEN'S CLINIC						90.05
90.06	WOUND CARE	36,507	211,050	0.172978			90.06
91	EMERGENCY	999,839	25,873,841	0.038643			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	514,445	3,690,035	0.139415			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	9,338,248	486,139,296				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES:
[ ] TITLE V
[ ] TITLE XVIII, PART A
[XX] TITLE XIX

		NURSING SCHOOL	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	1	2	3	4	5	
	INPATIENT ROUTINE SERV 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	NEONATAL INTENSIVE CARE UNIT						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

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES:
[ ] TITLE V
[ ] TITLE XVIII, PART A
[XX] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	14,109		2,733		30
31	INTENSIVE CARE UNIT	1,395		116		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	NEONATAL INTENSIVE CARE UNIT	1,013		352		35
40	SUBPROVIDER - IPF	1,680		562		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	1,211		196		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	19,408		3,959		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0242** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	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	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75.01	CARDIAC REHAB							75.01
75.02	SLEEP LAB							75.02
75.03	INPATIENT DIALYSIS							75.03
75.04	PAIN MANAGEMENT							75.04
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	PATIENT TREATMENT CENTER							90.01
90.02	REHAB SERVICES-BLOOMINGDALE							90.02
90.03	CANTERA							90.03
90.04	MENTAL HEALTH O/P							90.04
90.05	WOMEN'S CLINIC							90.05
90.06	WOUND CARE							90.06
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0242** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR
[ ] TITLE XVIII, PART A [ ] IPF [ ] SNF
[XX] TITLE XIX [ ] IRF [ ] NF

		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	48,175,869							50
51	RECOVERY ROOM	10,209,668							51
52	DELIVERY ROOM & LABOR ROOM	5,506,285							52
53	ANESTHESIOLOGY	6,226,736							53
54	RADIOLOGY-DIAGNOSTIC	20,215,242							54
55	RADIOLOGY-THERAPEUTIC	8,036,938							55
56	RADIOISOTOPE	3,935,032							56
57	CT SCAN	24,124,668							57
58	MRI	11,783,851							58
60	LABORATORY	97,666,978							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,097,688							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	7,097,059							64
65	RESPIRATORY THERAPY	7,723,849							65
66	PHYSICAL THERAPY	5,078,951							66
67	OCCUPATIONAL THERAPY	1,293,406							67
68	SPEECH PATHOLOGY	1,136,850							68
69	ELECTROCARDIOLOGY	15,469,439							69
70	ELECTROENCEPHALOGRAPHY	3,615,629							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,332,723							71
72	IMPL. DEV. CHARGED TO PATIENTS	33,478,261							72
73	DRUGS CHARGED TO PATIENTS	77,747,056							73
74	RENAL DIALYSIS	809,700							74
75.01	CARDIAC REHAB	404,494							75.01
75.02	SLEEP LAB								75.02
75.03	INPATIENT DIALYSIS								75.03
75.04	PAIN MANAGEMENT	1,850,300							75.04
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	5,810,454							90
90.01	PATIENT TREATMENT CENTER	2,331,369							90.01
90.02	REHAB SERVICES-BLOOMINGDALE								90.02
90.03	CANTERA								90.03
90.04	MENTAL HEALTH O/P	2,205,875							90.04
90.05	WOMEN'S CLINIC								90.05
90.06	WOUND CARE	211,050							90.06
91	EMERGENCY	25,873,841							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,690,035							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	486,139,296							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0242** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XIX - O/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.238159							50
51	RECOVERY ROOM	0.163473							51
52	DELIVERY ROOM & LABOR ROOM	0.579438							52
53	ANESTHESIOLOGY	0.049991							53
54	RADIOLOGY-DIAGNOSTIC	0.160789							54
55	RADIOLOGY-THERAPEUTIC	0.372013							55
56	RADIOISOTOPE	0.113307							56
57	CT SCAN	0.027834							57
58	MRI	0.062061							58
60	LABORATORY	0.131313							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.268017							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	0.053564							64
65	RESPIRATORY THERAPY	0.133845							65
66	PHYSICAL THERAPY	0.361831							66
67	OCCUPATIONAL THERAPY	0.169460							67
68	SPEECH PATHOLOGY	0.248141							68
69	ELECTROCARDIOLOGY	0.287090							69
70	ELECTROENCEPHALOGRAPHY	0.173248							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.096238							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.214407							72
73	DRUGS CHARGED TO PATIENTS	0.143476							73
74	RENAL DIALYSIS	0.265649							74
75.01	CARDIAC REHAB	0.401729							75.01
75.02	SLEEP LAB								75.02
75.03	INPATIENT DIALYSIS								75.03
75.04	PAIN MANAGEMENT	0.123215							75.04
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.669148							90
90.01	PATIENT TREATMENT CENTER	0.282457							90.01
90.02	REHAB SERVICES-BLOOMINGDALE								90.02
90.03	CANTERA								90.03
90.04	MENTAL HEALTH O/P	0.322473							90.04
90.05	WOMEN'S CLINIC								90.05
90.06	WOUND CARE	0.625392							90.06
91	EMERGENCY	0.156063							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.755373							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

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S242** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [ ] TITLE XVIII, PART A [XX] IPF [XX] TITLE XIX [ ] IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26) 1	TOTAL CHARGES (from Wkst. C, Part I, (col. 8) 2	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL COSTS (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,011,799	48,175,869	0.041759			50
51	RECOVERY ROOM	307,335	10,209,668	0.030102			51
52	DELIVERY ROOM & LABOR ROOM	601,638	5,506,285	0.109264			52
53	ANESTHESIOLOGY	1,997	6,226,736	0.000321			53
54	RADIOLOGY-DIAGNOSTIC	841,457	20,215,242	0.041625			54
55	RADIOLOGY-THERAPEUTIC	614,558	8,036,938	0.076467			55
56	RADIOISOTOPE	78,842	3,935,032	0.020036			56
57	CT SCAN	97,737	24,124,668	0.004051			57
58	MRI	101,562	11,783,851	0.008619			58
60	LABORATORY	809,672	97,666,978	0.008290			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	32,098	3,097,688	0.010362			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	15,275	7,097,059	0.002152			64
65	RESPIRATORY THERAPY	89,375	7,723,849	0.011571			65
66	PHYSICAL THERAPY	188,281	5,078,951	0.037071			66
67	OCCUPATIONAL THERAPY	8,610	1,293,406	0.006657			67
68	SPEECH PATHOLOGY	13,426	1,136,850	0.011810			68
69	ELECTROCARDIOLOGY	584,979	15,469,439	0.037815			69
70	ELECTROENCEPHALOGRAPHY	115,976	3,615,629	0.032076			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	98,656	51,332,723	0.001922			71
72	IMPL. DEV. CHARGED TO PATIENTS	146,576	33,478,261	0.004378			72
73	DRUGS CHARGED TO PATIENTS	150,314	77,747,056	0.001933			73
74	RENAL DIALYSIS	30,761	809,700	0.037991			74
75.01	CARDIAC REHAB	1,057	404,494	0.002613			75.01
75.02	SLEEP LAB						75.02
75.03	INPATIENT DIALYSIS						75.03
75.04	PAIN MANAGEMENT	76,225	1,850,300	0.041196			75.04
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	483,811	5,810,454	0.083266			90
90.01	PATIENT TREATMENT CENTER	155,337	2,331,369	0.066629			90.01
90.02	REHAB SERVICES-BLOOMINGDALE						90.02
90.03	CANTERA						90.03
90.04	MENTAL HEALTH O/P	130,103	2,205,875	0.058980			90.04
90.05	WOMEN'S CLINIC						90.05
90.06	WOUND CARE	36,507	211,050	0.172978			90.06
91	EMERGENCY	999,839	25,873,841	0.038643			91
92	OBSERVATION BEDS (NON-DISTINCT PART)		3,690,035				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	8,823,803	486,139,296				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S242** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR
[ ] TITLE XVIII, PART A [XX] IPF [ ] SNF
[XX] TITLE XIX [ ] IRF [ ] NF

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	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	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75.01	CARDIAC REHAB							75.01
75.02	SLEEP LAB							75.02
75.03	INPATIENT DIALYSIS							75.03
75.04	PAIN MANAGEMENT							75.04
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	PATIENT TREATMENT CENTER							90.01
90.02	REHAB SERVICES-BLOOMINGDALE							90.02
90.03	CANTERA							90.03
90.04	MENTAL HEALTH O/P							90.04
90.05	WOMEN'S CLINIC							90.05
90.06	WOUND CARE							90.06
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S242** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR
[ ] TITLE XVIII, PART A [XX] IPF [ ] SNF
[XX] TITLE XIX [ ] IRF [ ] NF

		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	48,175,869							50
51	RECOVERY ROOM	10,209,668							51
52	DELIVERY ROOM & LABOR ROOM	5,506,285							52
53	ANESTHESIOLOGY	6,226,736							53
54	RADIOLOGY-DIAGNOSTIC	20,215,242							54
55	RADIOLOGY-THERAPEUTIC	8,036,938							55
56	RADIOISOTOPE	3,935,032							56
57	CT SCAN	24,124,668							57
58	MRI	11,783,851							58
60	LABORATORY	97,666,978							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,097,688							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	7,097,059							64
65	RESPIRATORY THERAPY	7,723,849							65
66	PHYSICAL THERAPY	5,078,951							66
67	OCCUPATIONAL THERAPY	1,293,406							67
68	SPEECH PATHOLOGY	1,136,850							68
69	ELECTROCARDIOLOGY	15,469,439							69
70	ELECTROENCEPHALOGRAPHY	3,615,629							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,332,723							71
72	IMPL. DEV. CHARGED TO PATIENTS	33,478,261							72
73	DRUGS CHARGED TO PATIENTS	77,747,056							73
74	RENAL DIALYSIS	809,700							74
75.01	CARDIAC REHAB	404,494							75.01
75.02	SLEEP LAB								75.02
75.03	INPATIENT DIALYSIS								75.03
75.04	PAIN MANAGEMENT	1,850,300							75.04
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	5,810,454							90
90.01	PATIENT TREATMENT CENTER	2,331,369							90.01
90.02	REHAB SERVICES-BLOOMINGDALE								90.02
90.03	CANTERA								90.03
90.04	MENTAL HEALTH O/P	2,205,875							90.04
90.05	WOMEN'S CLINIC								90.05
90.06	WOUND CARE	211,050							90.06
91	EMERGENCY	25,873,841							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,690,035							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	486,139,296							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S242** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [XX] TITLE XIX - O/P | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.238159							50
51	RECOVERY ROOM	0.163473							51
52	DELIVERY ROOM & LABOR ROOM	0.579438							52
53	ANESTHESIOLOGY	0.049991							53
54	RADIOLOGY-DIAGNOSTIC	0.160789							54
55	RADIOLOGY-THERAPEUTIC	0.372013							55
56	RADIOISOTOPE	0.113307							56
57	CT SCAN	0.027834							57
58	MRI	0.062061							58
60	LABORATORY	0.131313							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.268017							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	0.053564							64
65	RESPIRATORY THERAPY	0.133845							65
66	PHYSICAL THERAPY	0.361831							66
67	OCCUPATIONAL THERAPY	0.169460							67
68	SPEECH PATHOLOGY	0.248141							68
69	ELECTROCARDIOLOGY	0.287090							69
70	ELECTROENCEPHALOGRAPHY	0.173248							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.096238							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.214407							72
73	DRUGS CHARGED TO PATIENTS	0.143476							73
74	RENAL DIALYSIS	0.265649							74
75.01	CARDIAC REHAB	0.401729							75.01
75.02	SLEEP LAB								75.02
75.03	INPATIENT DIALYSIS								75.03
75.04	PAIN MANAGEMENT	0.123215							75.04
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.669148							90
90.01	PATIENT TREATMENT CENTER	0.282457							90.01
90.02	REHAB SERVICES-BLOOMINGDALE								90.02
90.03	CANTERA								90.03
90.04	MENTAL HEALTH O/P	0.322473							90.04
90.05	WOMEN'S CLINIC								90.05
90.06	WOUND CARE	0.625392							90.06
91	EMERGENCY	0.156063							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.755373							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

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0242** **WORKSHEET D-1 PART I**

CHECK	**[ ] TITLE V - I/P**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[XX] PPS**
APPLICABLE	**[XX] 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)	14,109	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	14,109	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)	12,304	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	4,644	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	21,787,612	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	21,787,612	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	21,787,612	37

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0242** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) | [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,544.24	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					7,171,451	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)					7,171,451	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	4,452,785	1,395	3,191.96	650	2,074,774	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	NEONATAL INTENSIVE CARE UNIT	1,679,519	1,013	1,657.97			47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					11,764,766	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					21,010,991	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					1,656,367	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					1,068,422	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					2,724,789	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					18,286,202	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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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0242** **WORKSHEET D-1 PARTS III & IV**

CHECK APPLICABLE BOXES:	**[ ] TITLE V - I/P**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[XX] PPS**	
	[XX] TITLE XVIII, PART A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[ ] TITLE XIX - I/P	**[ ] IRF**	**[ ] NF**		**[ ] OTHER**	

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					1,805	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,544.24	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					2,787,353	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	4,021,208	21,787,612	0.184564	2,787,353	514,445	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S242** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES:	**[ ] TITLE V - I/P**	**[ ] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[XX] PPS**
	[XX] TITLE XVIII, PART A	**[XX] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[ ] 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)	1,680	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	1,680	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)	1,680	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	235	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	1,895,429	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	1,895,429	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	1,895,429	37

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S242** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) | [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	1,128.23	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	265,134	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)	265,134	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	52,759	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	317,893	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	76,023	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	5,696	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	81,719	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	236,174	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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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0242** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [ ] PPS [ ] TEFRA [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	14,109	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	14,109	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)	12,304	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	2,733	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 Title XIX only)	1,211	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	196	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)	21,787,549	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	21,787,549	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	21,787,549	37

KPMG LLP COMPU-MAX

CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0242** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] PPS [ ] TEFRA [XX] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,544.23	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					4,220,381	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)					4,220,381	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)	1,108,054	1,211	914.99	196	179,338	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	4,452,785	1,395	3,191.96	116	370,267	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	NEONATAL INTENSIVE CARE UNIT	1,679,519	1,013	1,657.97	352	583,605	47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					5,353,591	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					950,298	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					950,298	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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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0242** **WORKSHEET D-1**
PARTS III & IV

CHECK APPLICABLE BOXES:	**[ ] TITLE V - I/P**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[ ] PPS**	
	[ ] TITLE XVIII, PART A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[XX] TITLE XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] OTHER**	

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					1,805	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S242** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES:	**[ ] TITLE V - I/P**	**[ ] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[ ] PPS**	
	[ ] TITLE XVIII, PART A	**[XX] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[XX] TITLE XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] OTHER**	

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	1,680	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	1,680	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)	1,680	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	562	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	1,895,429	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	1,895,429	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	1,895,429	37

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S242** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [ ] TITLE XVIII, PART A [XX] TITLE XIX - I/P | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) | [ ] PPS [ ] TEFRA [XX] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	1,128.23	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	634,065	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)	634,065	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)		48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	634,065	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	181,807	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)		51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	181,807	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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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0242** **WORKSHEET D-3**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] SWING BED SNF**	**[XX] PPS**
	[XX] TITLE XVIII, PART A	**[ ] IPF**	**[ ] SNF**	**[ ] SWING BED NF**	**[ ] TEFRA**
	[ ] TITLE XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/MR**	**[ ] 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		13,559,365		30
31	INTENSIVE CARE UNIT		3,308,394		31
35	NEONATAL INTENSIVE CARE UNIT				35
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.238213	8,892,952	2,118,417	50
51	RECOVERY ROOM	0.163473	1,146,120	187,360	51
52	DELIVERY ROOM & LABOR ROOM	0.579438	8,974	5,200	52
53	ANESTHESIOLOGY	0.049991	881,737	44,079	53
54	RADIOLOGY-DIAGNOSTIC	0.160789	2,457,104	395,075	54
55	RADIOLOGY-THERAPEUTIC	0.372808	208,900	77,880	55
56	RADIOISOTOPE	0.113307	403,371	45,705	56
57	CT SCAN	0.027834	3,368,266	93,752	57
58	MRI	0.062061	889,571	55,208	58
60	LABORATORY	0.131313	6,813,857	894,748	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.268017	364,345	97,651	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.053564	720,710	38,604	64
65	RESPIRATORY THERAPY	0.133845	3,045,267	407,594	65
66	PHYSICAL THERAPY	0.361831	523,373	189,373	66
67	OCCUPATIONAL THERAPY	0.169460	296,077	50,173	67
68	SPEECH PATHOLOGY	0.248141	313,167	77,710	68
69	ELECTROCARDIOLOGY	0.287090	2,751,137	789,824	69
70	ELECTROENCEPHALOGRAPHY	0.173525	285,943	49,618	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.096238	12,957,379	1,246,992	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.214407	9,532,284	2,043,788	72
73	DRUGS CHARGED TO PATIENTS	0.143476	14,140,923	2,028,883	73
74	RENAL DIALYSIS	0.265649	611,477	162,438	74
75.01	CARDIAC REHAB	0.401729	15,611	6,271	75.01
75.02	SLEEP LAB				75.02
75.03	INPATIENT DIALYSIS				75.03
75.04	PAIN MANAGEMENT	0.123215	118,597	14,613	75.04
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.669148	7,670	5,132	90
90.01	PATIENT TREATMENT CENTER	0.282457	596,695	168,541	90.01
90.02	REHAB SERVICES-BLOOMINGDALE				90.02
90.03	CANTERA				90.03
90.04	MENTAL HEALTH O/P	0.322473	26,108	8,419	90.04
90.05	WOMEN'S CLINIC				90.05
90.06	WOUND CARE	0.625392			90.06
91	EMERGENCY	0.156155	2,956,791	461,718	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.755373			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		74,334,406	11,764,766	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		74,334,406		202

(A) Worksheet A line numbers

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S242** **WORKSHEET D-3**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[ ] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] SWING BED SNF**	**[XX] PPS**
	[XX] TITLE XVIII, PART A	**[XX] IPF**	**[ ] SNF**	**[ ] SWING BED NF**	**[ ] TEFRA**
	[ ] TITLE XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/MR**	**[ ] 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
35	NEONATAL INTENSIVE CARE UNIT				35
40	SUBPROVIDER - IPF		783,799		40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.238213			50
51	RECOVERY ROOM	0.163473			51
52	DELIVERY ROOM & LABOR ROOM	0.579438			52
53	ANESTHESIOLOGY	0.049991			53
54	RADIOLOGY-DIAGNOSTIC	0.160789	2,374	382	54
55	RADIOLOGY-THERAPEUTIC	0.372808			55
56	RADIOISOTOPE	0.113307			56
57	CT SCAN	0.027834	4,734	132	57
58	MRI	0.062061			58
60	LABORATORY	0.131313	47,473	6,234	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.268017			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.053564			64
65	RESPIRATORY THERAPY	0.133845	191	26	65
66	PHYSICAL THERAPY	0.361831	1,236	447	66
67	OCCUPATIONAL THERAPY	0.169460	505	86	67
68	SPEECH PATHOLOGY	0.248141			68
69	ELECTROCARDIOLOGY	0.287090	3,030	870	69
70	ELECTROENCEPHALOGRAPHY	0.173525			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.096238	8,508	819	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.214407	1,544	331	72
73	DRUGS CHARGED TO PATIENTS	0.143476	143,124	20,535	73
74	RENAL DIALYSIS	0.265649			74
75.01	CARDIAC REHAB	0.401729			75.01
75.02	SLEEP LAB				75.02
75.03	INPATIENT DIALYSIS				75.03
75.04	PAIN MANAGEMENT	0.123215	18	2	75.04
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.669148			90
90.01	PATIENT TREATMENT CENTER	0.282457			90.01
90.02	REHAB SERVICES-BLOOMINGDALE				90.02
90.03	CANTERA				90.03
90.04	MENTAL HEALTH O/P	0.322473	45,542	14,686	90.04
90.05	WOMEN'S CLINIC				90.05
90.06	WOUND CARE	0.625392			90.06
91	EMERGENCY	0.156155	52,568	8,209	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.755373			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		310,847	52,759	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		310,847		202

(A) Worksheet A line numbers

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0242** **WORKSHEET D-3**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] SWING BED SNF**	**[ ] PPS**
	[ ] TITLE XVIII, PART A	**[ ] IPF**	**[ ] SNF**	**[ ] SWING BED NF**	**[ ] TEFRA**
	[XX] TITLE XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/MR**	**[XX] 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
35	NEONATAL INTENSIVE CARE UNIT				35
40	SUBPROVIDER - IPF				40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.238159			50
51	RECOVERY ROOM	0.163473			51
52	DELIVERY ROOM & LABOR ROOM	0.579438			52
53	ANESTHESIOLOGY	0.049991			53
54	RADIOLOGY-DIAGNOSTIC	0.160789			54
55	RADIOLOGY-THERAPEUTIC	0.372013			55
56	RADIOISOTOPE	0.113307			56
57	CT SCAN	0.027834			57
58	MRI	0.062061			58
60	LABORATORY	0.131313			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.268017			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.053564			64
65	RESPIRATORY THERAPY	0.133845			65
66	PHYSICAL THERAPY	0.361831			66
67	OCCUPATIONAL THERAPY	0.169460			67
68	SPEECH PATHOLOGY	0.248141			68
69	ELECTROCARDIOLOGY	0.287090			69
70	ELECTROENCEPHALOGRAPHY	0.173248			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.096238			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.214407			72
73	DRUGS CHARGED TO PATIENTS	0.143476			73
74	RENAL DIALYSIS	0.265649			74
75.01	CARDIAC REHAB	0.401729			75.01
75.02	SLEEP LAB				75.02
75.03	INPATIENT DIALYSIS				75.03
75.04	PAIN MANAGEMENT	0.123215			75.04
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.669148			90
90.01	PATIENT TREATMENT CENTER	0.282457			90.01
90.02	REHAB SERVICES-BLOOMINGDALE				90.02
90.03	CANTERA				90.03
90.04	MENTAL HEALTH O/P	0.322473			90.04
90.05	WOMEN'S CLINIC				90.05
90.06	WOUND CARE	0.625392			90.06
91	EMERGENCY	0.156063			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.755373			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S242** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR | [ ] PPS [ ] TEFRA [XX] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
35	NEONATAL INTENSIVE CARE UNIT				35
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.238159			50
51	RECOVERY ROOM	0.163473			51
52	DELIVERY ROOM & LABOR ROOM	0.579438			52
53	ANESTHESIOLOGY	0.049991			53
54	RADIOLOGY-DIAGNOSTIC	0.160789			54
55	RADIOLOGY-THERAPEUTIC	0.372013			55
56	RADIOISOTOPE	0.113307			56
57	CT SCAN	0.027834			57
58	MRI	0.062061			58
60	LABORATORY	0.131313			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.268017			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.053564			64
65	RESPIRATORY THERAPY	0.133845			65
66	PHYSICAL THERAPY	0.361831			66
67	OCCUPATIONAL THERAPY	0.169460			67
68	SPEECH PATHOLOGY	0.248141			68
69	ELECTROCARDIOLOGY	0.287090			69
70	ELECTROENCEPHALOGRAPHY	0.173248			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.096238			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.214407			72
73	DRUGS CHARGED TO PATIENTS	0.143476			73
74	RENAL DIALYSIS	0.265649			74
75.01	CARDIAC REHAB	0.401729			75.01
75.02	SLEEP LAB				75.02
75.03	INPATIENT DIALYSIS				75.03
75.04	PAIN MANAGEMENT	0.123215			75.04
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.669148			90
90.01	PATIENT TREATMENT CENTER	0.282457			90.01
90.02	REHAB SERVICES-BLOOMINGDALE				90.02
90.03	CANTERA				90.03
90.04	MENTAL HEALTH O/P	0.322473			90.04
90.05	WOMEN'S CLINIC				90.05
90.06	WOUND CARE	0.625392			90.06
91	EMERGENCY	0.156063			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.755373			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	10,488,291			1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)				1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)				1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	1,373,929			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	1,643,079			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	319.89			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)				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) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 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 LINES (8, 8.01 AND 8.02) (see instructions)				9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)				12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR				13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT				18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)				20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				21
22	IME PAYMENT ADJUSTMENT (see instructions)				22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0242			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.1845			31
32	SUM OF LINES 30 AND 31	0.2087			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0643			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	168,599			34
		PRIOR TO	ON OR AFTER		

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)	3,530,919			35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)	599,772			35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	599,772			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
41.01	TOTAL ESRD MEDICARE COVERED AND PAID DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41.01
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41.01 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41.01)				46
47	SUBTOTAL (see instructions)	12,630,591			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 SCH AND MDH ONLY (see instructions)	12,630,591			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	1,168,798			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES	1,588			54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	13,800,977			59
60	PRIMARY PAYER PAYMENTS				60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	13,800,977			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	997,120			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	16,720			63
64	ALLOWABLE BAD DEBTS (see instructions)				64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	12,787,137			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.01	OTHER ADJUSTMENT PER PS&R				70.01
70.02	SEQUESTRATION ADJUSTMENT				70.02
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	19,843			70.93
71	AMOUNT DUE PROVIDER (see instructions)	12,806,980			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	256,140			71.01
72	INTERIM PAYMENTS	12,422,865			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	127,975			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	118,518			75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART 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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (see instructions)				95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (see instructions)				96

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0242** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [XX] 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)	1,996			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	9,341,372			2
3	PPS PAYMENTS	6,528,810			3
4	OUTLIER PAYMENT (see instructions)	80,517			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	1,996			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	13,912			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	13,912			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)	13,912			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	11,916			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	1,996			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	6,609,327			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	1,309,704			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	5,301,619			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)	5,301,619			30
31	PRIMARY PAYER PAYMENTS	54			31
32	SUBTOTAL (line 30 minus line 31)	5,301,565			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)	5,301,565			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	5,301,565			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	106,031			40.01
41	INTERIM PAYMENTS	5,216,080			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-20,546			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (sse instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S242** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [ ] HOSPITAL [XX] 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	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART 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, line 69, col. 4)				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 (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 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 - 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
40	SUBTOTAL (see instructions)				40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)				40.01
41	INTERIM PAYMENTS				41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (sse 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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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0242** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[XX] HOSPITAL [ ] SUB (OTHER) [ ] IPF [ ] SNF [ ] 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				12,422,865		5,216,080	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)				12,422,865		5,216,080	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		384,115		85,485	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				12,806,980		5,301,565	7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-S242** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[ ] HOSPITAL [XX] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] 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				186,450			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)				186,450			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		3,806			6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				190,256			7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT **WORKSHEET E-1**
PART II

CHECK APPLICABLE BOX: **[XX] HOSPITAL [ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	3,694	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	5,294	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	831	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	14,712	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	540,436,132	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	31,320,572	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)		8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S242** **WORKSHEET E-3 PART II**

CHECK APPLICABLE BOX: **[ ] HOSPITAL** **[XX] SUBPROVIDER IPF**

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (excluding outlier, ECT, and medical education payments)	201,471	1
2	NET IPF PPS OUTLIER PAYMENT	16,975	2
3	NET IPF PPS ECT PAYMENT		3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004		4
4.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)		8
9	AVERAGE DAILY CENSUS (see instructions)	27.096774	9
10	TEACHING ADJUSTMENT FACTOR {((1 + (line 8/line 9)) raised to the power of .5150 -1}		10
11	TEACHING ADJUSTMENT (line 1 multiplied by line 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (sum of lines 1, 2, 3 and 11)	218,446	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		15
16	SUBTOTAL (see instructions)	218,446	16
17	PRIMARY PAYER PAYMENTS	1,438	17
18	SUBTOTAL (line 16 less line 17)	217,008	18
19	DEDUCTIBLES	26,752	19
20	SUBTOTAL (line 18 minus line 19)	190,256	20
21	COINSURANCE		21
22	SUBTOTAL (line 20 minus line 21)	190,256	22
23	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)		23
24	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)		24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		25
26	SUBTOTAL (sum of lines 22 and 24)	190,256	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IPF only)		27
28	OTHER PASS THROUGH COSTS (see instructions)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	190,256	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	3,805	31.01
32	INTERIM PAYMENTS	186,450	32
33	TENTATIVE SETTLEMENT (for contractor use only)		33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)	1	34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART II, LINE 2 (see instructions)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)		52
53	TIME VALUE OF MONEY (see instructions)		53

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0242** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[XX] HOSPITAL**	**[ ] NF**	**[ ] PPS**
	[XX] TITLE XIX	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[ ] TEFRA**
		[ ] SNF		**[XX] 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	5,353,591		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	5,353,591		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	5,353,591		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 CHARGE 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	1	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)	5,353,591		18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			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	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)	5,353,591		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 Worksheet 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 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S242** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XIX [ ] HOSPITAL [XX] SUBPROVIDER IPF [ ] SNF [ ] NF [ ] ICF/MR [ ] PPS [ ] TEFRA [XX] OTHER

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	634,065		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	634,065		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	634,065		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 CHARGE 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	1	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)	634,065		18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			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	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)	634,065		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 Worksheet 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 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

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	29,941,000				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	285,456,000				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-186,151,000				6
7	INVENTORY	3,332,000				7
8	PREPAID EXPENSES	13,634,000				8
9	OTHER CURRENT ASSETS	59,177,000				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	205,389,000				11
	FIXED ASSETS					
12	LAND	4,917,000				12
13	LAND IMPROVEMENTS	24,448,000				13
14	ACCUMULATED DEPRECIATION	-12,133,000				14
15	BUILDINGS	478,521,000				15
16	ACCUMULATED DEPRECIATION	-164,762,000				16
17	LEASEHOLD IMPROVEMENTS	1,046,000				17
18	ACCUMULATED AMORTIZATION	-356,000				18
19	FIXED EQUIPMENT	110,485,000				19
20	ACCUMULATED DEPRECIATION	-40,607,000				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	210,205,000				23
24	ACCUMULATED DEPRECIATION	-146,376,000				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE	13,001,000				29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	478,389,000				30
	OTHER ASSETS					
31	INVESTMENTS	355,658,000				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	8,917,000				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	364,575,000				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	1,048,353,000				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	11,433,000				37
38	SALARIES, WAGES & FEES PAYABLE					38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	105,311,000				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	116,744,000				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	28,556,000				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	28,556,000				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	145,300,000				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	903,053,000				52
53	SPECIFIC PURPOSE FUND BALANCE					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

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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	
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	903,053,000				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	1,048,353,000				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		865,841,772			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		37,148,228			2
3	TOTAL (sun of line 1 and line 2)		902,990,000			3
4	ADDITIONS (credit adjustments)					4
5	NET ASSETS RELEASED	63,000				5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)		63,000			10
11	SUBTOTAL (line 3 plus line 10)		903,053,000			11
12	DEDUCTIONS (debit adjustments)					12
13	NET EQUITY TRANSFERS					13
14	CHANGE INNET UNREALIZED G & L					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)		903,053,000			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 (sun of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5	NET ASSETS RELEASED					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)					12
13	NET EQUITY TRANSFERS					13
14	CHANGE INNET UNREALIZED G & L					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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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	37,998,909		37,998,909	1
2	SUBPROVIDER IPF	3,611,115		3,611,115	2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	41,610,024		41,610,024	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	7,917,980		7,917,980	11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	NEONATAL INTENSIVE CARE UNIT	4,771,832		4,771,832	15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)	12,689,812		12,689,812	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	54,299,836		54,299,836	17
18	ANCILLARY SERVICES	195,406,854		195,406,854	18
19	OUTPATIENT SERVICES		290,729,442	290,729,442	19
20	RHC				20
21	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)	249,706,690	290,729,442	540,436,132	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		107,969,786	29
30	BAD DEBTS	12,323,000		30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)		12,323,000	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)		120,292,786	43

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	540,436,132	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	386,266,118	2
3	NET PATIENT REVENUES (line 1 minus line 2)	154,170,014	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	120,292,786	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	33,877,228	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	288,000	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	485,000	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER 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, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	15,000	21
22	RENTAL OF HOSPITAL SPACE	547,000	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (PATIENT MEAL REVENUE)		24
24.01	OTHER (DUES REV)		24.01
24.02	OTHER (INSTYMEDS REV)	65,000	24.02
24.03	OTHER (INTEREST INCOME MISC)		24.03
24.04	OTHER (OTHER INCOME)	1,838,000	24.04
24.05	OTHER (NET NON OPERATING INCOME)		24.05
24.07	OTHER (RESEARCH INCOME)	33,000	24.07
25	TOTAL OTHER INCOME (sum of lines 6-24)	3,271,000	25
26	TOTAL (line 5 plus line 25)	37,148,228	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	37,148,228	29

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CENTRAL DUPAGE HOSPITAL Provider CCN: 14-0242	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/28/2015 Run Time: 11:44 Version: 2014.10

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0242** **WORKSHEET L**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS [ ] COST METHOD

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	838,146	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	294,444	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)	237.29	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.0242	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.1845	8
9	SUM OF LINES 7 AND 8	0.2087	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0432	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	36,208	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	1,168,798	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
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT TELEPHONES							5.10
5.30	PURCHASING AND STORES							5.30
5.40	ADMITTING							5.40
5.50	ACCOUNTS RECEIVABLE AND CASHIERS							5.50
5.60	ADMINISTRATION & GENERAL							5.60
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
35	NEONATAL INTENSIVE CARE UNIT							35
40	SUBPROVIDER - IPF							40
43	NURSERY							43
	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	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75.01	CARDIAC REHAB							75.01
75.02	SLEEP LAB							75.02
75.03	INPATIENT DIALYSIS							75.03
75.04	PAIN MANAGEMENT							75.04
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	PATIENT TREATMENT CENTER							90.01
90.02	REHAB SERVICES-BLOOMINGDALE							90.02
90.03	CANTERA							90.03
90.04	MENTAL HEALTH O/P							90.04
90.05	WOMEN'S CLINIC							90.05

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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		
90.06	WOUND CARE							90.06
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
190.01	KOFEE KORNER							190.01
191	RESEARCH							191
192.01	WSKF							192.01
193.01	DEVELOPMENT							193.01
193.02	MARKETING							193.02
193.04	PHYSICIAN ANSWERING SERVICE							193.04
193.05	CAR SEAT SAFETY PROGRAM							193.05
193.07	JOINT VENTURE							193.07
193.08	PARKINSONS CENTER							193.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202