



OSF[®]

HEALTHCARE SYSTEM

800 N.E. Glen Oak Avenue, Peoria, Illinois 61603-3200 Phone (309) 655-2850
February 26, 2009

ATTN: Mary Wiant
National Government Services
Medicare Audit & Reimbursement
3200 Pleasant Run Suite B
Springfield, IL 62711-6304

RE: OSF Holy Family Medical Center
Monmouth, IL
Provider No.: 14-1318, 14-Z318, 14-5528, 14-3461, 14-7627
For the Period 10/01/07 - 9/30/08

Dear Ms. Wiant:

We have prepared the Medicare cost report for the above facility. The following are enclosed:

1. 1 copy of the HCFA-2552-96
2. 1 copy of our Working Trial Balance
3. 1 copy of A-6 and A-8 adjustments work papers
4. 1 copy of our PSR Crosswalk
5. 1 copy of our Medicare Bad Debt Logs
6. 1 copy of the HCFA 339 with supporting schedules
7. 1 computer disk with HCFA-2552-96
8. 1 copy of our audited financial statement for year ended 9/30/07
9. 1 copy of our W/S A & C grouping work papers and supporting documentation
10. 1 copy of our W/S H work papers
11. 1 copy of our W/S M work papers

Please note the following:

1. **Protested Item:** In accordance with Medicare regulations, we believe The Illinois Healthcare and Family Services' hospital tax assessment is an allowable cost. National Government Services disallows this cost in their audit of hospital cost reports. In order to protect our appeal rights on this issue, we are filing the reimbursement impact as a Protested Item in our Medicare Cost Report. The reimbursement impact during our cost reporting period October 01, 2007 through September 30, 2008 is \$84,038.

If you have any questions or need further information, please contact me at (309) 655-2855.

Sincerely,

Carole M. Wahl
Reimbursement Analyst

Enclosures

Cc: Theresa Springer, OSF Holy Family Medical Center

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT
 CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
 PARTS I & II

INTERMEDIARY [] AUDITED DATE RECEIVED [] INITIAL [] RE-OPENING
 USE ONLY: [] DESK REVIEWED INTERMEDIARY NO. [] FINAL [] MCR CODE

PART I - CERTIFICATION

CHECK XX ELECTRONICALLY FILED COST REPORT DATE: 02/26/2009
 APPLICABLE BOX MANUALLY SUBMITTED COST REPORT TIME: 11:03

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 WHERE 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 OSF HOLY FAMILY MEDICAL CENTER (14-1318) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 10/01/2007 AND ENDING 09/30/2008, AND THAT 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.

ECR Encryption: 02/26/2009 11:03
 yB:6WO.:xpFsKH0lpRtfnDsRyW9.Z0
 zdRvO0mpsefk:M05WzDI13nos9SsW0
 59Cw0XELeF01qJ6k

(SIGNED) Don [Rh]
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)
Chief Financial Officer
 TITLE
February 26, 2009
 DATE

PI Encryption: 02/26/2009 11:03
 eLnkchpDLcnpHwkrvflpBvV78QP3H0
 4hlIL01BbG1SeoxapyIyWwEUd.7n
 hvBN9SP9fd0qulAZ

PART II - SETTLEMENT SUMMARY

| | TITLE V | TITLE XVIII | | TITLE XIX | |
|-----|------------------------------------|-------------|--------|-----------|-----|
| | | PART A | PART B | | |
| 1 | HOSPITAL | 140548 | 80932 | | 1 |
| 2 | SUBPROVIDER I | | | | 2 |
| 3 | SWING BED - SNF | 190297 | | | 3 |
| 4 | SWING BED - NF | | | | 4 |
| 5 | SKILLED NURSING FACILITY | | | | 5 |
| 6 | NURSING FACILITY | | | | 6 |
| 7 | HOME HEALTH AGENCY | | | | 7 |
| 8 | OUTPATIENT REHABILITATION PROVIDER | | | | 8 |
| 9 | RURAL HEALTH CLINIC I | | 68253 | | 9 |
| 100 | TOTAL | 330845 | 149185 | | 100 |

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

ECR TO COMPU-MAX FILE CONVERSION UTILITY
TRANSMITTAL #17 - CMS-2552-96

ELECTRONIC FILE NAME: C:\255296\CMTEMP\EC141318.08A
COMPU-MAX FILE NAME: C:\255296\CMTEMP\CRECTEMP
PROVIDER NUMBER: 14-1318
SOFTWARE VENDOR: N01
KPMG LLP - COMPU-MAX MICRO - DATE APPROVED: 06/28/07
CREATION DATE: 2009057 (JULIAN DATE FORMAT)
CREATION TIME:
PROVIDER NAME: OSF HOLY FAMILY MEDICAL CENTER
FISCAL YEAR BEGINNING: 10/01/2007
FISCAL YEAR ENDING: 09/30/2008
ECR FINGERPRINT:

REMARKS:

ELECTRONIC REPORTING FILE VALIDATION AND EDIT REPORT

CMS REQUIRED EDITS ARE APPLIED AT TWO LEVELS:

LEVEL I EDITS ARE THOSE WHICH TEST THE FORMAT OF THE DATA TO IDENTIFY FOR CORRECTION THOSE ERROR CONDITIONS WHICH MAY RESULT IN A COST REPORT REJECTION. INTERMEDIARIES MAY REJECT ALL ELECTRONIC COST REPORTING FILES WHICH CONTAIN ONE OR MORE LEVEL I EDIT ERRORS. LEVEL I EDITS ARE IDENTIFIED WITH NUMBERS BETWEEN 1000 AND 1999.

LEVEL II EDITS IDENTIFY POTENTIAL INCONSISTENCIES AND/OR MISSING DATA ITEMS. THESE ITEMS SHOULD BE RESOLVED AT THE PROVIDER SITE AND APPROPRIATE WORKSHEETS AND/OR DATA SUBMITTED WITH THE COST REPORT. FAILURE TO SUBMIT THE APPROPRIATE DATA WITH YOUR COST REPORT MAY RESULT IN PAYMENTS BEING WITHHELD PENDING RESOLUTION OF THE ISSUE(S). LEVEL II EDITS ARE IDENTIFIED WITH NUMBERS BETWEEN 2000 AND 2999.

WORKSHEET A COST CENTER LIST: (THE ASTERISK INDICATES THAT THERE IS NO DIRECT INPUT DATA ASSOCIATED WITH THE COST CENTER)

| CMS EDIT NO. | | | |
|--------------|--------------------------------------|------|----|
| 1 | OLD CAP REL COSTS-BLDG & FIXT | 0100 | ** |
| 2 | OLD CAP REL COSTS-MVBLE EQUIP | 0200 | ** |
| 3 | NEW CAP REL COSTS-BLDG & FIXT | 0300 | |
| 4 | NEW CAP REL COSTS-MVBLE EQUIP | 0400 | |
| 4 1 | NEW CAP REL COSTS-MVBLE EQUIP NH | 0401 | |
| 5 | EMPLOYEE BENEFITS | 0500 | |
| 6 | ADMINISTRATIVE & GENERAL | 0600 | |
| 7 | MAINTENANCE & REPAIRS | 0700 | ** |
| 8 | OPERATION OF PLANT | 0800 | |
| 9 | LAUNDRY & LINEN SERVICE | 0900 | |
| 10 | HOUSEKEEPING | 1000 | |
| 11 | DIETARY | 1100 | |
| 12 | CAFETERIA | 1200 | |
| 13 | MAINTENANCE OF PERSONNEL | 1300 | ** |
| 14 | NURSING ADMINISTRATION | 1400 | ** |
| 15 | CENTRAL SERVICES & SUPPLY | 1500 | |
| 16 | PHARMACY | 1600 | |
| 17 | MEDICAL RECORDS & LIBRARY | 1700 | |
| 18 | SOCIAL SERVICE | 1800 | ** |
| 20 | NONPHYSICIAN ANESTHETISTS | 2000 | ** |
| 21 | NURSING SCHOOL | 2100 | ** |
| 22 | I&R SERVICES-SALARY & FRINGES APPRVD | 2200 | ** |
| 23 | I&R SERVICES-OTHER PRGM COSTS APPRVD | 2300 | ** |
| 24 | PARAMED ED PRGM-(SPECIFY) | 2400 | ** |
| 25 | ADULTS & PEDIATRICS | 2500 | |
| 34 | SKILLED NURSING FACILITY | 3400 | |
| 37 | OPERATING ROOM | 3700 | |
| 40 | ANESTHESIOLOGY | 4000 | |
| 41 | RADIOLOGY-DIAGNOSTIC | 4100 | |
| 44 | LABORATORY | 4400 | |
| 4630 | BLOOD CLOTTING FACTORS ADMIN COSTS | 4650 | ** |
| 49 | RESPIRATORY THERAPY | 4900 | |
| 50 | PHYSICAL THERAPY | 5000 | |
| 51 | OCCUPATIONAL THERAPY | 5100 | |

ELECTRONIC REPORTING FILE VALIDATION AND EDIT REPORT (CONTINUED)

CMS
EDIT NO.

| | | | |
|-------|--------------------------------------|------|----|
| 52 | SPEECH PATHOLOGY | 5200 | |
| 53 | ELECTROCARDIOLOGY | 5300 | |
| 55 | MEDICAL SUPPLIES CHARGED TO PATIENTS | 5500 | |
| 56 | DRUGS CHARGED TO PATIENTS | 5600 | |
| 61 | EMERGENCY | 6100 | |
| 62 | OBSERVATION BEDS (NON-DISTINCT PART) | 6200 | |
| 6350 | RHC | 6310 | |
| 6360 | FQHC | 6320 | ** |
| 6910 | CMHC | 6910 | ** |
| 6920 | OUTPATIENT PHYSICAL THERAPY | 6920 | ** |
| 6930 | OUTPATIENT OCCUPATIONAL THERAPY | 6930 | ** |
| 6940 | OUTPATIENT SPEECH PATHOLOGY | 6940 | ** |
| 71 | HOME HEALTH AGENCY | 7100 | |
| 85 1 | PANCREAS ACQUISITION | 8510 | ** |
| 85 2 | INTESTINAL ACQUISITION | 8520 | ** |
| 85 3 | ISLET CELL ACQUISITION | 8530 | ** |
| 88 | INTEREST EXPENSE | 8800 | |
| 100 | CLINIC | 7950 | |
| 100 1 | RENTAL SPACE | 7951 | ** |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2007 TO 09/30/2008 RUN DATE: 02/26/2009

ELECTRONIC REPORTING FILE VALIDATION AND EDIT REPORT (CONTINUED)

CMS
EDIT NO.

WORKSHEET E-1 - INTERIM PAYMENT SUMMARY

| | | PART A | PART B | TOTAL |
|---|----------------------|---------|---------|---------|
| 1 | HOSPITAL | 1421665 | 1784218 | 3205883 |
| 2 | SUBPROVIDER I | | | |
| 3 | SWING-BED SNF | 1052897 | | 1052897 |
| 4 | SKILLED NURSING FAC | 39517 | | 39517 |
| 5 | HOME HEALTH AGENCY I | 20462 | 15553 | 36015 |
| 6 | CORF | | | |
| | TOTAL | 2534541 | 1799771 | 4334312 |

WORKSHEET S - SETTLEMENT SUMMARY

| | TITLE V | TITLE XVIII PART A | TITLE XVIII PART B | TITLE XIX | |
|-----|--------------------------|--------------------------|--------------------------|--------------|-----|
| | 1 | 2 | 3 | 4 | |
| 1 | HOSPITAL | | 140548 | 80932 | 1 |
| 2 | SUBPROVIDER I | | | | 2 |
| 3 | SWING BED - SNF | 190297 | | | 3 |
| 4 | SWING BED - NF | | | | 4 |
| 5 | SKILLED NURSING FACILITY | | | | 5 |
| 6 | NURSING FACILITY | | | | 6 |
| 7 | HOME HEALTH AGENCY | | | | 7 |
| 8 | CORF | | | | 8 |
| 9 | RHC | | | 68253 | 9 |
| 100 | TOTAL | 330845 | | 149185 | 100 |

*

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 1000 WEST HARLEM AVENUE
 1.01 CITY: MONMOUTH STATE: IL P.O. BOX: ZIP CODE: 61462 COUNTY: WARREN 1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

| COMPONENT 0 | COMPONENT NAME 1 | PROVIDER NUMBER 2 | DATE CERTIFIED 3 | PAYMENT SYSTEM (P, T, O OR N) | | | |
|----------------|------------------------------------|-------------------------|---------------------------------|----------------------------------|------------|----------|----|
| | | | | V 4 | XVIII 5 | XIX 6 | |
| 2 | HOSPITAL | | | | | | |
| 3 | SUBPROVIDER I | 14-1318 | 05/01/2002 | N | O | P | 2 |
| 4 | SWING BEDS - SNF | | | | | | 3 |
| 5 | SWING BEDS - NF | 14-2318 | 05/01/2002 | N | O | N | 4 |
| 6 | HOSPITAL-BASED SNF | | | | | | 5 |
| 7 | HOSPITAL-BASED NF | 14-5528 | 08/14/1985 | N | P | N | 6 |
| 8 | HOSPITAL-BASED OLTC | | | | | | 7 |
| 9 | HOSPITAL-BASED HHA | | | | | | 8 |
| 11 | SEPARATELY CERTIFIED ASC | 14-7627 | 01/01/1985 | N | P | N | 9 |
| 12 | HOSPITAL-BASED HOSPICE | | | | | | 11 |
| 14 | HOSP-BASED RHC | | | | | | 12 |
| 15 | OUTPATIENT REHABILITATION PROVID | 14-3461 | 02/05/2003 | N | O | N | 14 |
| 16 | RENAL DIALYSIS | | | | | | 15 |
| 17 | COST REPORTING PERIOD (MM/DD/YYYY) | | FROM: 10/01/2007 TO: 09/30/2008 | | | | 17 |
| 18 | TYPE OF CONTROL | | 1 2 | | | | 18 |

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1 19
 20 SUBPROVIDER I 20

OTHER INFORMATION

| | | | | | | | |
|-------|---|----|--|--|--|--|-------|
| 21 | INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. | | | | | | 21 |
| 21.01 | DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106? | | | | | | 21.01 |
| 21.02 | HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE. | | | | | | 21.02 |
| 21.03 | ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy) (SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. | 2 | | | | | 21.03 |
| 21.04 | FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL. | 2 | | | | | 21.04 |
| 21.05 | FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL. | 2 | | | | | 21.05 |
| 21.06 | DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER 'Y' FOR YES AND 'N' FOR NO. | NO | | | | | 21.06 |
| 22 | ARE YOU CLASSIFIED AS A REFERRAL CENTER? | NO | | | | | 22 |
| 23 | DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW | NO | | | | | 23 |
| 23.01 | IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (mm/dd/yyyy) | | | | | | 23.01 |
| 23.02 | IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (mm/dd/yyyy) | | | | | | 23.02 |
| 23.03 | IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (mm/dd/yyyy) | | | | | | 23.03 |
| 23.04 | IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (mm/dd/yyyy) | | | | | | 23.04 |
| 23.05 | IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION DATE | | | | | | 23.05 |
| 23.06 | IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CTR, ENTER THE CERT. DATE (mm/dd/yyyy) | | | | | | 23.06 |
| 23.07 | IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERT. DATE (mm/dd/yyyy) | | | | | | 23.07 |
| 24 | IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 | | | | | | 24 |
| 25 | IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R? | NO | | | | | 25 |
| 25.01 | IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4? | NO | | | | | 25.01 |
| 25.02 | IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II. | NO | | | | | 25.02 |
| 25.03 | AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9. | NO | | | | | 25.03 |
| 25.04 | ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2 | NO | | | | | 25.04 |
| 25.05 | HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS) | | | | | | 25.05 |
| 25.06 | HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS) | | | | | | 25.06 |

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

TITLE XIX INPATIENT HOSPITAL SERVICES

38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? YES 38
 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? NO 38.01
 38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? YES 38.02
 38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? NO 38.03
 38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? NO 38.04
 40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE. YES 149006 40
 40.01 NAME: OSF HEALTHCARE SYSTEM FI/CONTRACTOR'S NAME: 14-9006 FI/CONTRACTOR'S NUMBER: 52280 40.01
 40.02 STREET: 800 N.E. GLEN OAK AVENUE P.O. BOX: 40.02
 40.03 CITY: PEORIA, IL 61603 STATE: ZIP CODE: 40.03
 41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? YES 41
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? YES 42
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? NO 42.01
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? YES 42.02
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS? NO 43
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY? NO 44
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? NO 45
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.
 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS? 45.01
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? 45.02
 45.03 WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? 45.03
 46 IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE. 46

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COST OR CHARGES, ENTER A 'Y' FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION; ENTER 'N' IF NOT EXEMPT (SEE 42 CFR 413.13).

| | PART A | PART B | OUTPATIENT ASC | OUTPATIENT RADIOLOGY | OUTPATIENT DIAGNOSTIC | | | | |
|---|--------|--------|----------------|----------------------|-----------------------|--------------|----------|--------|----|
| 47 HOSPITAL | N | N | N | N | N | 47 | | | |
| 48 SUBPROVIDER I | N | N | N | N | N | 48 | | | |
| 49 SKILLED NURSING FACILITY | N | N | N | N | N | 49 | | | |
| 50 HOME HEALTH AGENCY | N | N | N | N | N | 50 | | | |
| 52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? | | | | | | 52 | | | |
| 52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV. | | | | | | 52.01 | | | |
| 53 IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. | | | | | | 53 | | | |
| 53.01 MDH PERIOD: BEGINNING: ENDING: | | | | | | 53.01 | | | |
| 54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 169600 PAID LOSSES: AND/OR SELF INSURANCE: | | | | | | 54 | | | |
| 54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. | | | | | | 54.01 | | | |
| 55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO. | | | | | | 55 | | | |
| 56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002. | | | | DATE 0 / / | Y/N 1 NO | LIMIT 2 0.00 | Y/N 3 NO | FEES 4 | 56 |
| 57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? | | | | | | 57 | | | |
| 58 ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002. | | | | | | 58 | | | |
| 58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS) | | | | | | 58.01 | | | |
| 59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS) | | | | | | 59 | | | |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2007 TO 09/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (05/2007)

VERSION: 2007.06
02/26/2009 12:14

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

| | | | |
|-------|--|----|-------|
| 60 | ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS) | NO | 60 |
| 60.01 | IF LINE 60 COLUMN 1 IS Y, DOES 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. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.) | | 60.01 |

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

| | COMPONENT | -----DISCHARGES----- | | | | TOTAL ALL PATIENTS |
|----|---|----------------------|-------------------|-----------------|-----|--------------------|
| | | TITLE V 12 | TITLE XVIII 13 | TITLE XIX 14 | 15 | |
| 1 | HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS | | 348 | 50 | 520 | 1 |
| 2 | HMO XIX | | | | | 2 |
| 3 | HOSPITAL ADULTS & PEDS - SWING BED SNF | | | | | 3 |
| 4 | HOSPITAL ADULTS & PEDS - SWING BED NF | | | | | 4 |
| 5 | TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS | | | | | 5 |
| 6 | INTENSIVE CARE UNIT | | | | | 6 |
| 7 | CORONARY CARE UNIT | | | | | 7 |
| 8 | BURN INTENSIVE CARE UNIT | | | | | 8 |
| 9 | SURGICAL INTENSIVE CARE UNIT | | | | | 9 |
| 10 | OTHER SPECIAL CARE (SPECIFY) | | | | | 10 |
| 11 | NURSERY | | | | | 11 |
| 12 | TOTAL HOSPITAL | | 348 | 50 | 520 | 12 |
| 13 | RPCH VISITS | | | | | 13 |
| 14 | SUBPROVIDER I | | | | | 14 |
| 15 | SKILLED NURSING FACILITY | | | | | 15 |
| 16 | NURSING FACILITY | | | | | 16 |
| 17 | OTHER LONG TERM CARE | | | | | 17 |
| 18 | HOME HEALTH AGENCY | | | | | 18 |
| 20 | ASC (DISTINCT PART) | | | | | 20 |
| 21 | HOSPICE (DISTINCT PART) | | | | | 21 |
| 23 | O/P REHAB PROVIDER | | | | | 23 |
| 24 | RHC I | | | | | 24 |
| 25 | TOTAL | | | | | 25 |
| 26 | OBSERVATION BED DAYS | | | | | 26 |
| 27 | AMBULANCE TRIPS | | | | | 27 |
| 28 | EMPLOYEE DISCOUNT DAYS | | | | | 28 |

HOSPITAL WAGE INDEX INFORMATION

| PART II - WAGE DATA | | AMOUNT REPORTED | RECLASS. OF SALARIES FROM WKST. A-6 | ADJUSTED SALARIES (COL.1 + COL.2) | PAID HOURS RELATED TO SALARY IN COL.3 | AVERAGE HOURLY WAGE (COL.3 / COL.4) | DATA SOURCE | WORKSHEET S-3 PART II |
|---------------------|---|-----------------|-------------------------------------|-----------------------------------|---------------------------------------|-------------------------------------|-------------|-----------------------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | |
| 1 | SALARIES | | | | | | | |
| 1 | TOTAL SALARIES | 10689735 | | | | | | 1 |
| 2 | NON-PHYSICIAN ANESTHETIST PART A | | | | | | | 2 |
| 3 | NON-PHYSICIAN ANESTHETIST PART B | | | | | | | 3 |
| 4 | PHYSICIAN - PART A | | | | | | | 4 |
| 4.01 | TEACHING PHYSICIAN SALARIES | | | | | | | 4.01 |
| 5 | PHYSICIAN - PART B | | | | | | | 5 |
| 5.01 | NON-PHYSICIAN - PART B | | | | | | | 5.01 |
| 6 | INTERNS & RESIDENTS (IN APPR PGM) | | | | | | | 6 |
| 6.01 | CONTRACT SERVICES, I&R | | | | | | | 6.01 |
| 7 | HOME OFFICE PERSONNEL | | | | | | | 7 |
| 8 | SNF | 956158 | | | | | | 8 |
| 8.01 | EXCLUDED AREA SALARIES | 636444 | -30311 | | | | | 8.01 |
| | OTHER WAGES & RELATED COSTS | | | | | | | |
| 9 | CONTRACT LABOR | | | | | | | 9 |
| 9.01 | PHARMACY SERVICES UNDER CONTRACT | | | | | | | 9.01 |
| 9.02 | LABORATORY SERVICES UNDER CONTRACT | | | | | | | 9.02 |
| 9.03 | MANAGEMENT AND ADMINISTRATIVE SERVICES' | | | | | | | 9.03 |
| 10 | CONTRACT LABOR: PHYSICIAN PART A | | | | | | | 10 |
| 10.01 | TEACHING PHYSICIAN UNDER CONTRACT | | | | | | | 10.01 |
| 11 | HOME OFFICE SALARIES & WAGE REL COSTS | | | | | | | 11 |
| 12 | HOME OFFICE: PHYSICIAN PART A | | | | | | | 12 |
| 12.01 | TEACHING PHYSICIAN SALARIES | | | | | | | 12.01 |
| | WAGE-RELATED COSTS | | | | | | | |
| 13 | WAGE RELATED COSTS (CORE) | | | | | | CMS 339 | 13 |
| 14 | WAGE RELATED COSTS (OTHER) | | | | | | CMS 339 | 14 |
| 15 | EXCLUDED AREAS | | | | | | CMS 339 | 15 |
| 16 | NON-PHYSICIAN ANESTHETIST PART A | | | | | | CMS 339 | 16 |
| 17 | NON-PHYSICIAN ANESTHETIST PART B | | | | | | CMS 339 | 17 |
| 18 | PHYSICIAN PART A | | | | | | CMS 339 | 18 |
| 18.01 | PART A TEACHING PHYSICIANS | | | | | | CMS 339 | 18.01 |
| 19 | PHYSICIAN PART B | | | | | | CMS 339 | 19 |
| 19.01 | WAGE RELATED COSTS (RHC/FQHC) | | | | | | CMS 339 | 19.01 |
| 20 | INTERNS & RESIDENTS (IN APPR PGM) | | | | | | CMS 339 | 20 |
| | OVERHEAD COSTS - DIRECT SALARIES | | | | | | | |
| 21 | EMPLOYEE BENEFITS | | | | | | | 21 |
| 22 | ADMINISTRATIVE & GENERAL | 2323334 | 324627 | | | | | 22 |
| 22.01 | ADMINISTRATIVE & GENERAL UNDER CONTACT | | | | | | | 22.01 |
| 23 | MAINTENANCE & REPAIRS | | | | | | | 23 |
| 24 | OPERATION OF PLANT | 418919 | | | | | | 24 |
| 25 | LAUNDRY & LINEN SERVICE | 18531 | | | | | | 25 |
| 26 | HOUSEKEEPING | 350409 | | | | | | 26 |
| 26.01 | HOUSEKEEPING UNDER CONTRACT | | | | | | | 26.01 |
| 27 | DIETARY | 338678 | | | | | | 27 |
| 27.01 | DIETARY UNDER CONTRACT | | | | | | | 27.01 |
| 28 | CAFETERIA | | | | | | | 28 |
| 29 | MAINTENANCE OF PERSONNEL | | | | | | | 29 |
| 30 | NURSING ADMINISTRATION | | | | | | | 30 |
| 31 | CENTRAL SERVICES AND SUPPLY | 18526 | | | | | | 31 |
| 32 | PHARMACY | 251557 | | | | | | 32 |
| 33 | MEDICAL RECORDS & MEDICAL RECORDS LIBR | 177663 | | | | | | 33 |
| 34 | SOCIAL SERVICE | | | | | | | 34 |
| 35 | OTHER GENERAL SERVICE | | | | | | | 35 |

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART III

| PART III - HOSPITAL WAGE INDEX SUMMARY | | AMOUNT REPORTED | RECLASS. OF SALARIES FROM WKST. A-6 | ADJUSTED SALARIES (COL.1 + COL.2) | PAID HOURS RELATED TO SALARY IN COL.3 | AVERAGE HOURLY WAGE (COL.3 / COL.4) | |
|--|---|-----------------|-------------------------------------|-----------------------------------|---------------------------------------|-------------------------------------|----|
| | | 1 | 2 | 3 | 4 | 5 | |
| 1 | NET SALARIES | 10689735 | | 10689735 | | | 1 |
| 2 | EXCLUDED AREA SALARIES | 1592602 | -30311 | 1562291 | | | 2 |
| 3 | SUBTOTAL SALARIES (LINE 1 MINUS LINE 2) | 9097133 | 30311 | 9127444 | | | 3 |
| 4 | SUBTOTAL OTHER WAGES & REL COSTS | | | | | | 4 |
| 5 | SUBTOTAL WAGE-RELATED COSTS | | | | | | 5 |
| 6 | TOTAL (SUM OF LINES 3 THRU 5) | 9097133 | 30311 | 9127444 | | | 6 |
| 7 | NET SALARIES | | | | | | 7 |
| 8 | EXCLUDED AREA SALARIES | | | | | | 8 |
| 9 | SUBTOTAL SALARIES (LINE 7 MINUS LINE 8) | | | | | | 9 |
| 10 | SUBTOTAL OTHER WAGES & REL COSTS | | | | | | 10 |
| 11 | SUBTOTAL WAGE-RELATED COSTS | | | | | | 11 |
| 12 | TOTAL (SUM OF LINES 9 THRU 11) | | | | | | 12 |
| 13 | TOTAL OVERHEAD COSTS | 3897617 | 324627 | 4222244 | | | 13 |

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7627

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY: WARREN

| DESCRIPTION | TITLE V 1 | TITLE XVIII 2 | TITLE XIX 3 | OTHER 4 | TOTAL 5 | |
|-----------------------------|--------------|------------------|----------------|------------|------------|---|
| 1 HOME HEALTH AIDE HOURS | | 19 | | | 19 | 1 |
| 2 UNDUPLICATED CENSUS COUNT | | 16.00 | 1.00 | 2.00 | 19.00 | 2 |

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

| ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: 40.00 | STAFF 1 | CONTRACT 2 | TOTAL 3 | |
|--|------------|---------------|------------|----|
| 3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S) | | | | 3 |
| 4 DIRECTORS AND ASSISTANT DIRECTOR(S) | .04 | | .04 | 4 |
| 5 OTHER ADMINISTRATIVE PERSONNEL | | | | 5 |
| 6 DIRECT NURSING SERVICE | .20 | | .20 | 6 |
| 7 NURSING SUPERVISOR | | | | 7 |
| 8 PHYSICAL THERAPY SERVICE | | | | 8 |
| 9 PHYSICAL THERAPY SUPERVISOR | | | | 9 |
| 10 OCCUPATIONAL THERAPY SERVICE | .01 | | .01 | 10 |
| 11 OCCUPATIONAL THERAPY SUPERVISOR | | | | 11 |
| 12 SPEECH PATHOLOGY SERVICE | | | | 12 |
| 13 SPEECH PATHOLOGY SUPERVISOR | | | | 13 |
| 14 MEDICAL SOCIAL SERVICE | | | | 14 |
| 15 MEDICAL SOCIAL SERVICE SUPERVISOR | | | | 15 |
| 16 HOME HEALTH AIDE | .01 | | .01 | 16 |
| 17 HOME HEALTH AIDE SUPERVISOR | | | | 17 |
| 18 OTHER (SPECIFY) | | | | 18 |

HOME HEALTH AGENCY MSA CODES

| | | | | |
|--|------|---|-------|----|
| 19 HOW MANY MSAs IN COLUMN 1 OR CBSAs IN COLUMN 1.01 DID YOU PROVIDE SERVICES TO DURING THIS COST REPORTING PERIOD | 1 | 1 | 1.01 | 19 |
| 20 LIST THOSE MSA CODE(S) IN COLUMN 1 AND CBSA CODE(S) IN COLUMN 1.01 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE) | 9914 | | 19340 | 20 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2007 TO 09/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2007.06
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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7627

WORKSHEET S-4
 (CONTINUED)

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 2000

| | FULL EPISODES | | LUPA EPISODES 3 | PEP ONLY EPISODES 4 | SCIC WITHIN A PEP 5 | SCIC ONLY EPISODES 6 | TOTAL 7 | |
|----|--------------------------------------|-----------------------|-----------------------|---------------------------|------------------------------|----------------------------|------------|----|
| | WITHOUT OUTLIERS 1 | WITH OUTLIERS 2 | | | | | | |
| 21 | SKILLED NURSING VISITS | 79 | | 4 | 42 | | 125 | 21 |
| 22 | SKILLED NURSING VISIT CHARGES | 11929 | 604 | | 6342 | | 18875 | 22 |
| 23 | PHYSICAL THERAPY VISITS | 59 | | | 14 | | 73 | 23 |
| 24 | PHYSICAL THERAPY VISIT CHARGES | 10974 | | | 2604 | | 13578 | 24 |
| 25 | OCCUPATIONAL THERAPY VISITS | 14 | | | 4 | | 18 | 25 |
| 26 | OCCUPATIONAL THERAPY VISIT CHARGES | 2604 | | | 744 | | 3348 | 26 |
| 27 | SPEECH PATHOLOGY VISITS | | | | | | | 27 |
| 28 | SPEECH PATHOLOGY VISIT CHARGES | | | | | | | 28 |
| 29 | MEDICAL SOCIAL SERVICE VISITS | | | | | | | 29 |
| 30 | MEDICAL SOCIAL SERVICE VISIT CHARGES | | | | | | | 30 |
| 31 | HOME HEALTH AIDE VISITS | 9 | | | 9 | | 18 | 31 |
| 32 | HOME HEALTH AIDE VISIT CHARGES | 720 | | | 720 | | 1440 | 32 |
| 33 | TOTAL VISITS | 161 | | 4 | 69 | | 234 | 33 |
| 34 | OTHER CHARGES | | | | | | | 34 |
| 35 | TOTAL CHARGES | 26227 | 604 | | 10410 | | 37241 | 35 |
| 36 | TOTAL NUMBER OF EPISODES | 10 | 1 | | 5 | | 16 | 36 |
| 37 | TOTAL NUMBER OF OUTLIER EPISODES | | | | | | | 37 |
| 38 | TOTAL MEDICAL SUPPLY CHARGES | 158 | 6 | | 84 | | 248 | 38 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2007 TO 09/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (4/2005)

VERSION: 2007.06
 02/26/2009 12:14

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

| GROUP (1) | M3PI REVENUE CODE | SERVICES PRIOR TO OCTOBER 1st | | SERVICES ON OR AFTER OCTOBER 1st | | SERVICES THROUGH 4/1/2001 - 9/30/2001 | | SWING BED SNF DAYS | TOTAL |
|-----------|-------------------------|----------------------------------|------|-------------------------------------|------|--|------|--------------------------|-------|
| | | RATE | DAYS | RATE | DAYS | RATE | DAYS | | |
| 1 | 2 | 3 | 3.01 | 4 | 4.01 | 4.02 | 4.03 | 4.06 | 5 |
| 1 | RUC | | | | | | | | 1 |
| 2 | RUB | | | | | | | | 2 |
| 3 | RUA | | | | | | | | 3 |
| 3.01 | RUX | | | | | | | | 3.01 |
| 3.02 | RUL | | | | | | | | 3.02 |
| 4 | RVC | | | | | | | | 4 |
| 5 | RVB | | | | | | | | 5 |
| 6 | RVA | | | | | | | | 6 |
| 6.01 | RVX | | | | | | | | 6.01 |
| 6.02 | RVL | | | | | | | | 6.02 |
| 7 | RHC | | 27 | | | | | | 7 |
| 8 | RHB | | 15 | | | | | | 8 |
| 9 | RHA | | | | | | | | 9 |
| 9.01 | RHX | | | | | | | | 9.01 |
| 9.02 | RHL | | | | | | | | 9.02 |
| 10 | RMC | | 15 | | | | | | 10 |
| 11 | RMB | | 47 | | | | | | 11 |
| 12 | RMA | | | | | | | | 12 |
| 12.01 | RMX | | | | | | | | 12.01 |
| 12.02 | RML | | | | | | | | 12.02 |
| 13 | RLB | | | | | | | | 13 |
| 14 | RLA | | | | | | | | 14 |
| 14.01 | RLX | | | | | | | | 14.01 |
| 15 | SE3 | | 7 | | | | | | 15 |
| 16 | SE2 | | 16 | | | | | | 16 |
| 17 | SE1 | | 11 | | | | | | 17 |
| 18 | SSC | | 31 | | | | | | 18 |
| 19 | SSB | | | | | | | | 19 |
| 20 | SSA | | 45 | | | | | | 20 |
| 21 | CC2 | | | | | | | | 21 |
| 22 | CC1 | | | | | | | | 22 |
| 23 | CB2 | | | | | | | | 23 |
| 24 | CB1 | | | | | | | | 24 |
| 25 | CA2 | | | | | | | | 25 |
| 26 | CA1 | | 21 | | | | | | 26 |
| 27 | IB2 | | | | | | | | 27 |
| 28 | IB1 | | 13 | | | | | | 28 |
| 29 | IA2 | | | | | | | | 29 |
| 30 | IA1 | | | | | | | | 30 |
| 31 | BB2 | | | | | | | | 31 |
| 32 | BB1 | | | | | | | | 32 |
| 33 | BA2 | | | | | | | | 33 |
| 34 | BA1 | | | | | | | | 34 |
| 35 | PE2 | | | | | | | | 35 |
| 36 | PE1 | | | | | | | | 36 |
| 37 | PD2 | | | | | | | | 37 |
| 38 | PD1 | | | | | | | | 38 |
| 39 | PC2 | | | | | | | | 39 |
| 40 | PC1 | | | | | | | | 40 |
| 41 | PB2 | | | | | | | | 41 |
| 42 | PB1 | | | | | | | | 42 |
| 43 | PA2 | | | | | | | | 43 |
| 44 | PA1 | | | | | | | | 44 |
| 45 | DEFAULT RATE | | | | | | | | 45 |
| 46 | TOTAL | | 248 | | | | | | 46 |

PROVIDER-BASED RURAL HEALTH CLINIC/
 FEDERALLY QUALIFIED HEALTH CENTER
 PROVIDER STATISTICAL DATA

RHC I
 COMPONENT NO: 14-3461

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 1000 WEST HARLEM AVENUE 1
 1.01 CITY: MONMOUTH STATE: IL ZIP CODE: 61462 COUNTY: WARREN 1.01
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 2

SOURCE OF FEDERAL FUNDS:

| | GRANT AWARD | DATE | |
|---|--|------|---|
| | 1 | 2 | |
| 3 | COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT) | / / | 3 |
| 4 | MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT) | / / | 4 |
| 5 | HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT) | / / | 5 |
| 6 | APPALACHIAN REGIONAL COMMISSION | / / | 6 |
| 7 | LOOK-ALIKES | / / | 7 |
| 8 | OTHER | / / | 8 |

PHYSICIAN INFORMATION:

| | PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT | PHYSICIAN NAME | BILLING NO. | |
|------|---|---------------------------|-------------|------|
| 9 | PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT | KALIVODA POPELA, VICTORIA | E30152 | 9 |
| 9.01 | | MEDRANO, RUBEN | G48235 | 9.01 |
| 9.02 | | BATTENBURG, JAMES | E18972 | 9.02 |
| 9.03 | | PADGETT, ROBERT | H53293 | 9.03 |
| 9.04 | | POTTER, ORIE R. | R78392 | 9.04 |
| 9.05 | | CARLSON, WADE | I12816 | 9.05 |
| 9.06 | | WAKELAND, JUDITH | Q63859 | 9.06 |
| 9.07 | | MITCHELL, ROBERT | S42765 | 9.07 |
| 9.08 | | KUSLER, KEVIN | P77500 | 9.08 |
| 9.09 | | JENNETT, GARY | E42646 | 9.09 |
| 9.10 | | CREE, BARBARA | S37111 | 9.10 |
| 9.11 | | LASALA, FRANK | E42646 | 9.11 |

10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD PHYSICIAN NAME HOURS 10

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? NO 11
 IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2
 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS)

FACILITY HOURS OF OPERATIONS (1)

| | TYPE OPERATION | SUNDAY | | MONDAY | | TUESDAY | | WEDNESDAY | | THURSDAY | | FRIDAY | | SATURDAY | | | | |
|----|----------------|--------|----|--------|------|---------|------|-----------|------|----------|------|--------|------|----------|------|-----|------|----|
| | | FROM | TO | FROM | TO | FROM | TO | FROM | TO | FROM | TO | FROM | TO | FROM | TO | | | |
| 12 | CLINIC | 0 | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 12 |
| | | | | 700 | 2200 | 700 | 2200 | 700 | 2200 | 700 | 2200 | 700 | 2200 | 700 | 2200 | 700 | 2200 | |

(1) ENTER CLINIC HRS OF OPERATION ON LNE 12 & OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LNE 12 (BOTH TYPE & HRS OF OPERATION)
 LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? NO 13
 14 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB 27, SECTION 508(D)? NO 14
 IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT.
 LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.

15 PROVIDER NAME: PROVIDER NUMBER: - V XVIII XIX 15

16 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS? IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF MEDICARE VISITS PERFORMED BY INTERNS AND RESIDENTS. NO 16

17 HAS THE HOSPITAL'S BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, SEE INSTRUCTIONS. NO 17

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

| COST CENTER | | SALARIES 1 | OTHER 2 | TOTAL 3 | RECLASSI- FICATIONS 4 | RECLASS. TRIAL BALANCE 5 | ADJUST- MENTS 6 | NET EXP FOR ALLOCATION 7 | |
|-------------------------------------|-------|---------------|------------|------------|-----------------------------|-----------------------------------|-----------------------|-----------------------------------|--------|
| GENERAL SERVICE COST CENTERS | | | | | | | | | |
| 1 | 0100 | | | | | | | | 1 |
| 2 | 0200 | | | | | | | | 2 |
| 3 | 0300 | | | | | | | | 3 |
| 4 | 0400 | | 149554 | 149554 | 2300 | 151854 | | 151854 | 4 |
| 4.01 | 0401 | | 1017521 | 1017521 | 85759 | 1103280 | -16179 | 1087101 | 4.01 |
| 5 | 0500 | | 21725 | 21725 | 456 | 22181 | | 22181 | 5 |
| 6 | 0600 | 2323334 | 2748655 | 2748655 | | 2748655 | -89943 | 2658712 | 6 |
| 7 | 0700 | | 2250486 | 4573820 | 376043 | 4949863 | 1238679 | 6188542 | 7 |
| 8 | 0800 | | | | | | | | 8 |
| 9 | 0900 | 418919 | 753644 | 1172563 | | 1172563 | | 1172563 | 9 |
| 10 | 1000 | 18531 | 118126 | 136657 | | 136657 | | 136657 | 10 |
| 11 | 1100 | 350409 | 67280 | 417689 | | 417689 | | 417689 | 11 |
| 12 | 1200 | 338678 | 282766 | 621444 | | 621444 | -34336 | 587108 | 12 |
| 13 | 1300 | | | | | | | | 13 |
| 14 | 1400 | | | | | | | | 14 |
| 15 | 1500 | | | | | | | | 15 |
| 16 | 1600 | 18526 | 61289 | 79815 | -44020 | 35795 | | 35795 | 16 |
| 17 | 1700 | 251557 | 406735 | 658292 | -658292 | | | | 17 |
| 18 | 1800 | 177663 | 35009 | 212672 | | 212672 | -6325 | 206347 | 18 |
| 20 | 2000 | | | | | | | | 20 |
| 21 | 2100 | | | | | | | | 21 |
| 22 | 2200 | | | | | | | | 22 |
| 23 | 2300 | | | | | | | | 23 |
| 24 | 2400 | | | | | | | | 24 |
| INPATIENT ROUTINE SERV COST CENTERS | | | | | | | | | |
| 25 | 2500 | 875495 | 90550 | 966045 | -27953 | 938092 | | 938092 | 25 |
| 34 | 3400 | 956158 | 65605 | 1021763 | | 1021763 | | 1021763 | 34 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 37 | 3700 | 329779 | 310253 | 640032 | -200526 | 439506 | | 439506 | 37 |
| 40 | 4000 | 287017 | 30794 | 317811 | -9137 | 308674 | -291157 | 17517 | 40 |
| 41 | 4100 | 437811 | 819077 | 1256888 | -104711 | 1152177 | -67682 | 1084495 | 41 |
| 44 | 4400 | 347051 | 693149 | 1040200 | | 1040200 | -15000 | 1025200 | 44 |
| 46.30 | 4650 | | | | | | | | 46.30 |
| 49 | 4900 | 16164 | 37556 | 53720 | -19580 | 34140 | | 34140 | 49 |
| 50 | 5000 | 204834 | 97205 | 302039 | -4223 | 297816 | -11277 | 286539 | 50 |
| 51 | 5100 | 70740 | 3271 | 74011 | -709 | 73302 | | 73302 | 51 |
| 52 | 5200 | | 13840 | 13840 | | 13840 | | 13840 | 52 |
| 53 | 5300 | | 6533 | 102117 | -223 | 101894 | | 101894 | 53 |
| 55 | 5500 | | | | 335359 | 335359 | | 335359 | 55 |
| 56 | 5600 | | | | 762887 | 762887 | | 762887 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 61 | 6100 | 610194 | 222576 | 832770 | -4367 | 828403 | -216003 | 612400 | 61 |
| 62 | 6200 | | | | | | | | 62 |
| 63.50 | 6310 | 1924847 | 303247 | 2228094 | -361631 | 1866463 | -12425 | 1854038 | 63.50 |
| 63.60 | 6320 | | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 69.10 | 6910 | | | | | | | | 69.10 |
| 69.20 | 6920 | | | | | | | | 69.20 |
| 69.30 | 6930 | | | | | | | | 69.30 |
| 69.40 | 6940 | | | | | | | | 69.40 |
| 71 | 7100 | 10247 | 8250 | 18497 | -173 | 18324 | | 18324 | 71 |
| SPECIAL PURPOSE COST CENTERS | | | | | | | | | |
| 85.01 | 8510 | | | | | | | | 85.01 |
| 85.02 | 8520 | | | | | | | | 85.02 |
| 85.03 | 8530 | | | | | | | | 85.03 |
| 88 | 8800 | | 69269 | 69269 | -69269 | | | | 88 |
| 95 | | | | | | | | | 95 |
| SUBTOTALS | | 10063538 | 10683965 | 20747503 | 57990 | 20805493 | 478352 | 21283845 | |
| NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 100 | 7950 | 626197 | 150324 | 776521 | -57990 | 718531 | | 718531 | 100 |
| 100.01 | 7951 | | | | | | | | 100.01 |
| 101 | TOTAL | 10689735 | 10834289 | 21524024 | | 21524024 | 478352 | 22002376 | 101 |

RECLASSIFICATIONS

| EXPLANATION OF RECLASSIFICATION ENTRY | CODE | ----- INCREASE ----- | | | |
|--|------|-------------------------------|-------------|-------------|------------|
| | | COST CENTER 2 | LINE # 3 | SALARY 4 | OTHER 5 |
| 1 TO RECLASS INTEREST EXPENSE | A | NEW CAP REL COSTS-MVBLE EQUIP | 4 | | 69269 1 |
| 2 TO RECLASS CHARGEABLE DRUGS | B | DRUGS CHARGED TO PATIENTS | 56 | | 303003 2 |
| 3 TO RECLASS MEDICAL SUPPLIES | C | MEDICAL SUPPLIES CHARGED TO P | 55 | | 335359 3 |
| 4 | C | DRUGS CHARGED TO PATIENTS | 56 | | 459884 4 |
| 5 | C | | | | 5 |
| 6 | C | | | | 6 |
| 7 | C | | | | 7 |
| 8 | C | | | | 8 |
| 9 | C | | | | 9 |
| 10 | C | | | | 10 |
| 11 | C | | | | 11 |
| 12 | C | | | | 12 |
| 13 | C | | | | 13 |
| 14 | C | | | | 14 |
| 15 TO RECLASS HHA THERAPY COSTS | D | | | | 15 |
| 16 | D | OCCUPATIONAL THERAPY | 51 | 157 | 48 16 |
| 17 TO RECLASS RT SALARIES | E | RESPIRATORY THERAPY | 49 | 3898 | 17 |
| 18 | E | | | | 18 |
| 19 | E | | | | 19 |
| 20 TO RECLASS A&G EXPENSES | F | ADMINISTRATIVE & GENERAL | 6 | 324627 | 90601 20 |
| 21 | F | | | | 21 |
| 22 TO RECLASS RHC PHYSICIAN RECRUITMEN | H | RHC | 63.50 | | 19939 22 |
| 23 TO RECLASS PROPERTY INSURANCE | I | NEW CAP REL COSTS-BLDG & FIXT | 3 | | 2300 23 |
| 24 | I | NEW CAP REL COSTS-MVBLE EQUIP | 4 | | 16490 24 |
| 25 | I | NEW CAP REL COSTS-MVBLE EQUIP | 4.01 | | 456 25 |
| 26 | | | | | 26 |
| 27 | | | | | 27 |
| 28 | | | | | 28 |
| 29 | | | | | 29 |
| 30 | | | | | 30 |
| 31 | | | | | 31 |
| 32 | | | | | 32 |
| 33 | | | | | 33 |
| 34 | | | | | 34 |
| 35 | | | | | 35 |
| 36 TOTAL RECLASSIFICATIONS | | | | 328682 | 1297349 36 |

RECLASSIFICATIONS

| 1 | EXPLANATION OF RECLASSIFICATION ENTRY | CODE | ----- COST CENTER 6 | DECREASE LINE # 7 | SALARY 8 | OTHER 9 | WKST A-7 | |
|----|---------------------------------------|------|---------------------------|-------------------------|-------------|------------|------------|-------|
| | | | | | | | REF. 10 | |
| 1 | TO RECLASS INTEREST EXPENSE | A | INTEREST EXPENSE | 88 | | 69269 | 11 | 1 |
| 2 | TO RECLASS CHARGEABLE DRUGS | B | PHARMACY | 16 | | 303003 | | 2 |
| 3 | TO RECLASS MEDICAL SUPPLIES | C | CENTRAL SERVICES & SUPPLY | 15 | | 44020 | | 3 |
| 4 | | C | PHARMACY | 16 | | 355289 | | 4 |
| 5 | | C | ADULTS & PEDIATRICS | 25 | | 24342 | | 5 |
| 6 | | C | OPERATING ROOM | 37 | | 200526 | | 6 |
| 7 | | C | ANESTHESIOLOGY | 40 | | 9137 | | 7 |
| 8 | | C | RADIOLOGY-DIAGNOSTIC | 41 | | 104711 | | 8 |
| 9 | | C | RESPIRATORY THERAPY | 49 | | 23478 | | 9 |
| 10 | | C | PHYSICAL THERAPY | 50 | | 4191 | | 10 |
| 11 | | C | OCCUPATIONAL THERAPY | 51 | | 914 | | 11 |
| 12 | | C | EMERGENCY | 61 | | 4303 | | 12 |
| 13 | | C | RHC | 63.50 | | 1495 | | 13 |
| 14 | | C | CLINIC | 100 | | 22837 | | 14 |
| 15 | TO RECLASS HHA THERAPY COSTS | D | PHYSICAL THERAPY | 50 | 32 | | | 15 |
| 16 | | D | HOME HEALTH AGENCY | 71 | 125 | | 48 | 16 |
| 17 | TO RECLASS RT SALARIES | E | ADULTS & PEDIATRICS | 25 | 3611 | | | 17 |
| 18 | | E | ELECTROCARDIOLOGY | 53 | 223 | | | 18 |
| 19 | | E | EMERGENCY | 61 | 64 | | | 19 |
| 20 | TO RECLASS A&G EXPENSES | F | RHC | 63.50 | 294441 | 85634 | | 20 |
| 21 | | F | CLINIC | 100 | 30186 | 4967 | | 21 |
| 22 | TO RECLASS RHC PHYSICIAN RECRUITM | H | ADMINISTRATIVE & GENERAL | 6 | | 19939 | | 22 |
| 23 | TO RECLASS PROPERTY INSURANCE | I | ADMINISTRATIVE & GENERAL | 6 | | 19246 | | 11 23 |
| 24 | | I | | | | | | 11 24 |
| 25 | | I | | | | | | 11 25 |
| 26 | | | | | | | | 26 |
| 27 | | | | | | | | 27 |
| 28 | | | | | | | | 28 |
| 29 | | | | | | | | 29 |
| 30 | | | | | | | | 30 |
| 31 | | | | | | | | 31 |
| 32 | | | | | | | | 32 |
| 33 | | | | | | | | 33 |
| 34 | | | | | | | | 34 |
| 35 | | | | | | | | 35 |
| 36 | TOTAL RECLASSIFICATIONS | | | | 328682 | 1297349 | | 36 |

ANALYSIS OF CHANGES DURING COST REPORTING
 PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED
 TO PARTICIPATE IN HEALTH CARE PROGRAMS

WORKSHEET A-7
 PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

| DESCRIPTION | BEGINNING BALANCES 1 | ----- ACQUISITIONS ----- | | | DISPOSALS AND RETIREMENTS 5 | ENDING BALANCE 6 | FULLY DEPRECIATED ASSETS 7 | |
|--------------------------|----------------------------|--------------------------|---------------|------------|--------------------------------------|------------------------|-------------------------------------|---|
| | | PURCHASE 2 | DONATION 3 | TOTAL 4 | | | | |
| 1 LAND | | | | | | | | 1 |
| 2 LAND IMPROVEMENTS | | | | | | | | 2 |
| 3 BUILDINGS AND FIXTURES | | | | | | | | 3 |
| 4 BUILDING IMPROVEMENTS | | | | | | | | 4 |
| 5 FIXED EQUIPMENT | | | | | | | | 5 |
| 6 MOVABLE EQUIPMENT | | | | | | | | 6 |
| 7 SUBTOTAL | | | | | | | | 7 |
| 8 RECONCILING ITEMS | | | | | | | | 8 |
| 9 TOTAL | | | | | | | | 9 |

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

| DESCRIPTION | BEGINNING BALANCES 1 | ----- ACQUISITIONS ----- | | | DISPOSALS AND RETIREMENTS 5 | ENDING BALANCE 6 | FULLY DEPRECIATED ASSETS 7 | |
|--------------------------|----------------------------|--------------------------|---------------|------------|--------------------------------------|------------------------|-------------------------------------|---|
| | | PURCHASE 2 | DONATION 3 | TOTAL 4 | | | | |
| 1 LAND | 325000 | | | | | 325000 | | 1 |
| 2 LAND IMPROVEMENTS | 146120 | | | | | 146120 | | 2 |
| 3 BUILDINGS AND FIXTURES | 2217660 | 156180 | | 156180 | | 2373840 | | 3 |
| 4 BUILDING IMPROVEMENTS | | | | | | | | 4 |
| 5 FIXED EQUIPMENT | | | | | | | | 5 |
| 6 MOVABLE EQUIPMENT | 2337229 | 408095 | | 408095 | | 2745324 | | 6 |
| 7 SUBTOTAL | 5026009 | 564275 | | 564275 | | 5590284 | | 7 |
| 8 RECONCILING ITEMS | | | | | | | | 8 |
| 9 TOTAL | 5026009 | 564275 | | 564275 | | 5590284 | | 9 |

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS III & IV

| DESCRIPTION | COMPUTATION OF RATIOS | | | | ALLOCATION OF OTHER CAPITAL | | | TOTAL |
|--------------------------------------|-----------------------|--------------------|------------------------|----------|-----------------------------|-------|-----------------------------|-------|
| | GROSS ASSETS | CAPITALIZED LEASES | GROSS ASSETS FOR RATIO | RATIO | INSURANCE | TAXES | OTHER CAPITAL-RELATED COSTS | |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 1 OLD CAP REL COSTS-BLDG & FIXT | | | | .000000 | | | | 1 |
| 2 OLD CAP REL COSTS-MVBLE EQUIP | | | | .000000 | | | | 2 |
| 3 NEW CAP REL COSTS-BLDG & FIXT | 2648209 | | 2648209 | .529972 | | | | 3 |
| 4 NEW CAP REL COSTS-MVBLE EQUIP | 2348675 | | 2348675 | .470028 | | | | 4 |
| 4.01 NEW CAP REL COSTS-MVBLE EQUIP N | | | | .000000 | | | | 4.01 |
| 5 TOTAL | 4996884 | | 4996884 | 1.000000 | | | | 5 |

| DESCRIPTION | SUMMARY OF OLD AND NEW CAPITAL | | | | | | | TOTAL |
|---------------------------------------|--------------------------------|-------|----------|-----------|-------|-----------------------------|---------|-------|
| | DEPREC-IATION | LEASE | INTEREST | INSURANCE | TAXES | OTHER CAPITAL-RELATED COSTS | | |
| | 9 | 10 | 11 | 12 | 13 | 14 | 15 | |
| 1 OLD CAP REL COSTS-BLDG & FIXT | | | | | | | | 1 |
| 2 OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | | 2 |
| 3 NEW CAP REL COSTS-BLDG & FIXT | 149554 | | 2300 | | | | 151854 | 3 |
| 4 NEW CAP REL COSTS-MVBLE EQUIP | 1017521 | | 69580 | | | | 1087101 | 4 |
| 4.01 NEW CAP REL COSTS-MVBLE EQUIP NH | 21725 | | 456 | | | | 22181 | 4.01 |
| 5 TOTAL | 1188800 | | 72336 | | | | 1261136 | 5 |

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

| DESCRIPTION | SUMMARY OF OLD AND NEW CAPITAL | | | | | | | TOTAL |
|---------------------------------------|--------------------------------|-------|----------|-----------|-------|-----------------------------|---------|-------|
| | DEPREC-IATION | LEASE | INTEREST | INSURANCE | TAXES | OTHER CAPITAL-RELATED COSTS | | |
| | 9 | 10 | 11 | 12 | 13 | 14 | 15 | |
| 1 OLD CAP REL COSTS-BLDG & FIXT | | | | | | | | 1 |
| 2 OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | | 2 |
| 3 NEW CAP REL COSTS-BLDG & FIXT | 149554 | | | | | | 149554 | 3 |
| 4 NEW CAP REL COSTS-MVBLE EQUIP | 1017521 | | | | | | 1017521 | 4 |
| 4.01 NEW CAP REL COSTS-MVBLE EQUIP NH | 21725 | | | | | | 21725 | 4.01 |
| 5 TOTAL | 1188800 | | | | | | 1188800 | 5 |

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

| DESCRIPTION | BASIS 1 | AMOUNT 2 | EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED | | WKST A-7 REF 5 |
|---|------------|-------------|--|---------------|----------------------|
| | | | COST CENTER 3 | LINE NO. 4 | |
| 1 INVESTMENT INCOME-OLD BLDGS & FIXTURES | | | OLD CAP REL COSTS-BLDG & FIXT | 1 | 1 |
| 2 INVESTMENT INCOME-OLD MOVABLE EQUIPMENT | | | OLD CAP REL COSTS-MVBLE EQUIP | 2 | 2 |
| 3 INVESTMENT INCOME-NEW BLDGS & FIXTURES | | | NEW CAP REL COSTS-BLDG & FIXT | 3 | 3 |
| 4 INVESTMENT INCOME-NEW MOVABLE EQUIPMENT | B | -16179 | NEW CAP REL COSTS-MVBLE EQUIP | 4 | 11 4 |
| 5 INVESTMENT INCOME-OTHER | | | | | 5 |
| 6 TRADE, QUANTITY, AND TIME DISCOUNTS | | | | | 6 |
| 7 REFUNDS AND REBATES OF EXPENSES | | | | | 7 |
| 8 RENTAL OF PROVIDER SPACE BY SUPPLIERS | | | | | 8 |
| 9 TELEPHONE SERVICES (PAY STATIONS EXCL) | A | -3609 | ADMINISTRATIVE & GENERAL | 6 | 9 |
| 10 TELEVISION AND RADIO SERVICE | A | -4116 | ADMINISTRATIVE & GENERAL | 6 | 10 |
| 11 PARKING LOT | | | | | 11 |
| 12 PROVIDER-BASED PHYSICIAN ADJUSTMENT | WKST | | | | |
| | A-8-2 | -203000 | | | 12 |
| 13 SALE OF SCRAP, WASTE, ETC. | | | | | 13 |
| 14 RELATED ORGANIZATION TRANSACTIONS | WKST | | | | |
| | A-8-1 | 1387238 | | | 14 |
| 15 LAUNDRY AND LINEN SERVICE | | | | | 15 |
| 16 CAFETERIA - EMPLOYEES AND GUESTS | B | -34084 | DIETARY | 11 | 16 |
| 17 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS | | | | | 17 |
| 18 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS | | | | | 18 |
| 19 SALE OF DRUGS TO OTHER THAN PATIENTS | | | | | 19 |
| 20 SALE OF MEDICAL RECORDS AND ABSTRACTS | B | -6325 | MEDICAL RECORDS & LIBRARY | 17 | 20 |
| 21 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.) | | | | | 21 |
| 22 VENDING MACHINES | | | | | 22 |
| 23 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES | | | | | 23 |
| 24 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT | | | | | 24 |
| 25 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL | WKST | | | | |
| | A-8-4 | | RESPIRATORY THERAPY | 49 | 25 |
| 26 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL | WKST | | | | |
| | A-8-4 | -11007 | PHYSICAL THERAPY | 50 | 26 |
| 27 ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION | WKST | | | | |
| | A-8-3 | | HOME HEALTH AGENCY | 71 | 27 |
| 28 UTIL REVIEW-PHYSICIANS' COMPENSATION | | | UTILIZATION REVIEW-SNF | 89 | 28 |
| 29 DEPRECIATION--OLD BUILDINGS & FIXTURES | | | OLD CAP REL COSTS-BLDG & FIXT | 1 | 29 |
| 30 DEPRECIATION--OLD MOVABLE EQUIPMENT | | | OLD CAP REL COSTS-MVBLE EQUIP | 2 | 30 |
| 31 DEPRECIATION--NEW BUILDINGS & FIXTURES | | | NEW CAP REL COSTS-BLDG & FIXT | 3 | 31 |
| 32 DEPRECIATION--NEW MOVABLE EQUIPMENT | | | NEW CAP REL COSTS-MVBLE EQUIP | 4 | 32 |
| 33 NON-PHYSICIAN ANESTHETIST | | | NONPHYSICIAN ANESTHETISTS | 20 | 33 |
| 34 PHYSICIANS' ASSISTANT | | | | | 34 |
| 35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL | WKST | | | | |
| | WKST A-8-4 | | | | 35 |
| 36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL | WKST | | | | |
| | WKST A-8-4 | | SPEECH PATHOLOGY | 52 | 36 |
| 37 MARKETING & DEVELOPMENT SALARIES | A | -52851 | ADMINISTRATIVE & GENERAL | 6 | 37 |
| 38 MARKETING & DEVELOPMENT FRINGE BE | A | -16142 | EMPLOYEE BENEFITS | 5 | 38 |
| 39 MARKETING & DEVELOPMENT OTHER EXP | A | -46581 | ADMINISTRATIVE & GENERAL | 6 | 39 |
| 40 MARKETING & DEVELOPMENT OTHER EXP | A | -252 | DIETARY | 11 | 40 |
| 41 ADVERTISING EXPENSE | A | -178468 | ADMINISTRATIVE & GENERAL | 6 | 41 |
| 42 MISCELLANEOUS INCOME | B | -57574 | ADMINISTRATIVE & GENERAL | 6 | 42 |
| 43 LOBBYING | A | -9460 | ADMINISTRATIVE & GENERAL | 6 | 43 |
| 44 PHYSICIAN RECRUITMENT | A | -35095 | ADMINISTRATIVE & GENERAL | 6 | 44 |
| 45 CAR ALLOWANCE | A | -7200 | ADMINISTRATIVE & GENERAL | 6 | 45 |
| 46 COUNTRY CLUB DUES | A | -4250 | ADMINISTRATIVE & GENERAL | 6 | 46 |
| 47 CRNA PROFESSIONAL FEES | A | -4140 | ANESTHESIOLOGY | 40 | 47 |
| 48 PROVIDER TAX IDPA | A | -185584 | ADMINISTRATIVE & GENERAL | 6 | 48 |
| 49 CRNA SALARIES | A | -287017 | ANESTHESIOLOGY | 40 | 49 |
| 49.01 CRNA BENEFITS | A | -73801 | EMPLOYEE BENEFITS | 5 | 49.01 |
| 49.02 CIA COMPLIANCE | A | -19693 | ADMINISTRATIVE & GENERAL | 6 | 49.02 |
| 49.03 PROPERTY TAXES | A | -4800 | ADMINISTRATIVE & GENERAL | 6 | 49.03 |
| 49.04 RHC OTHER INCOME | B | -12425 | RHC | 63.50 | 49.04 |
| 49.05 ER BENEFITS | A | -28003 | EMERGENCY | 61 | 49.05 |
| 49.06 MISCELLANEOUS INCOME | B | -270 | PHYSICAL THERAPY | 50 | 49.06 |
| 49.07 ALCOHOLIC BEVERAGES | A | -927 | ADMINISTRATIVE & GENERAL | 6 | 49.07 |
| 49.08 ASSET RETIREMENT OBLIGATION | A | -7200 | ADMINISTRATIVE & GENERAL | 6 | 49.08 |
| 49.10 GOODWILL | A | 401167 | ADMINISTRATIVE & GENERAL | 6 | 49.10 |
| 50 TOTAL | | 478352 | | | 50 |

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 THE CLAIMING OF HOME OFFICE COSTS:

| LINE NO. | COST CENTER | EXPENSE ITEMS | AMOUNT OF ALLOWABLE COST | AMOUNT (INCL IN WKST A, COL 5) | NET ADJUSTMENTS | WKST A-7 REF | |
|----------|-------------|--------------------------|--------------------------|--------------------------------|-----------------|--------------|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 1 | 6 | ADMINISTRATIVE & GENERAL | A&G | 1270127 | 400395 | 869732 | 1 |
| 2 | 6 | ADMINISTRATIVE & GENERAL | INTEREST EXP CORP OFFICE | 585188 | | 585188 | 2 |
| 3 | 41 | RADIOLOGY-DIAGNOSTIC | MOBILE MRI | 159841 | 192584 | -32743 | 3 |
| 4 | 41 | RADIOLOGY-DIAGNOSTIC | ET MAINTENANCE AGREEMENT | 76131 | 111070 | -34939 | 4 |
| 5 | | TOTALS | | 2091287 | 704049 | 1387238 | 5 |

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

THE SECRETARY, BY VIRTUE OF 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.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES 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.

| SYMBOL (1) | NAME | ----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE ----- | | | |
|------------|-------------------------|--|------|----------------------|------------------|
| | | PERCENT OF OWNERSHIP | NAME | PERCENT OF OWNERSHIP | TYPE OF BUSINESS |
| 1 | 2 | 3 | 4 | 5 | 6 |
| 1 | B OSF HEALTHCARE SYSTEM | 100.00 | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |

1
2
3
4
5

- (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:

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2007 TO 09/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/96)

VERSION: 2007.06
 02/26/2009 12:14

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

| WKST | A | COST CENTER/ PHYSICIAN IDENTIFIER | | TOTAL REMUNERA- TION INCL FRINGES | PROFES- SIONAL COMPONENT | PROVIDER COMPONENT | RCE AMOUNT | PHYSICIAN/ PROVIDER COMPONENT HOURS | UNAD- JUSTED RCE LIMIT | PERCENT OF UNAD- JUSTED RCE LIMIT |
|-------------|----|--------------------------------------|-----------|--|--------------------------------|-----------------------|---------------|--|---------------------------------|--|
| LINE NO. | 1 | 2 | | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 1 | 61 | EMERGENCY | AGGREGATE | 296908 | 188000 | 108908 | | | | |
| 2 | 44 | LABORATORY | AGGREGATE | 15000 | 15000 | | | | | |
| 101 | | TOTAL | | 311908 | 203000 | 108908 | | | | |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2007 TO 09/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2007.06
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
 PARTS I & II

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

| | | | | | | | |
|-------|--|-------------|------------|------------|-------|----------|-------|
| 1 | TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) | | | | | 25 | 1 |
| 2 | LINE 1 MULTIPLIED BY 15 HOURS PER WEEK | | | | | 375 | 2 |
| 3 | NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE | | | | | 125 | 3 |
| 4 | NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE | | | | | | 4 |
| 5 | NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS | | | | | | 5 |
| 6 | NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS | | | | | | 6 |
| 7 | STANDARD TRAVEL EXPENSE RATE | | | | | 3.45 | 7 |
| 8 | OPTIONAL TRAVEL EXPENSE RATE PER MILE | | | | | | 8 |
| | | SUPERVISORS | THERAPISTS | ASSISTANTS | AIDES | TRAINEES | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 9 | TOTAL HOURS WORKED | | 909.75 | | | | 9 |
| 10 | AHSEA | | 66.31 | | | | 10 |
| 11 | STANDARD TRAVEL ALLOWANCE | 33.16 | 33.16 | | | | 11 |
| 12 | NO OF TRAVEL HRS (PROV SITE) | | | | | | 12 |
| 12.01 | NO OF TRAVEL HRS (OFFSITE) | | | | | | 12.01 |
| 13 | MILES DRIVEN (PROV SITE) | | | | | | 13 |
| 13.01 | MILES DRIVEN (OFFSITE) | | | | | | 13.01 |

PART II - SALARY EQUIVALENCY COMPUTATION

| | | | | | | | |
|----|--|--|--|--|--|-------|----|
| 14 | SUPERVISORS | | | | | | 14 |
| 15 | THERAPISTS | | | | | | 15 |
| 16 | ASSISTANTS | | | | | 60326 | 16 |
| 17 | SUBTOTAL ALLOWANCE AMOUNT | | | | | | 17 |
| 18 | AIDES | | | | | 60326 | 18 |
| 19 | TRAINEES | | | | | | 19 |
| 20 | TOTAL ALLOWANCE AMOUNT | | | | | 60326 | 20 |
| 21 | WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES | | | | | | 21 |
| 22 | WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES | | | | | | 22 |
| 23 | TOTAL SALARY EQUIVALENCY | | | | | 60326 | 23 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2007 TO 09/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS III & IV

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

| | | | |
|---|--|------|----|
| STANDARD TRAVEL ALLOWANCE | | | |
| 24 | THERAPISTS | | 24 |
| 25 | ASSISTANTS | 4145 | 25 |
| 26 | SUBTOTAL | | 25 |
| 27 | STANDARD TRAVEL EXPENSE | 4145 | 26 |
| 28 | TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE | 431 | 27 |
| | | 4576 | 28 |
| OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | | | |
| 29 | THERAPISTS | | 29 |
| 30 | ASSISTANTS | | 30 |
| 31 | SUBTOTAL | | 31 |
| 32 | OPTIONAL TRAVEL EXPENSE | | 32 |
| 33 | STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | | 32 |
| 34 | OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | 4576 | 33 |
| 35 | OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | | 34 |
| | | | 35 |

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

| | | | |
|--|---|--|----|
| STANDARD TRAVEL EXPENSE | | | |
| 36 | THERAPISTS | | 36 |
| 37 | ASSISTANTS | | 37 |
| 38 | SUBTOTAL | | 38 |
| 39 | STANDARD TRAVEL EXPENSE | | 39 |
| OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | | | |
| 40 | THERAPISTS | | 40 |
| 41 | ASSISTANTS | | 41 |
| 42 | SUBTOTAL | | 42 |
| 43 | OPTIONAL TRAVEL EXPENSE | | 43 |
| TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES | | | |
| 44 | STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | | 44 |
| 45 | OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | | 45 |
| 46 | OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | | 46 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2007 TO 09/30/2008

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
 PARTS V, VI & VII

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

| | THERAPISTS 1 | ASSISTANTS 2 | AIDES 3 | TRAINEES 4 | TOTAL 5 | |
|----|-----------------|-----------------|------------|---------------|------------|----|
| 47 | | | | | | 47 |
| | | | | | | |
| 48 | | | | | | 48 |
| 49 | | | | | | 49 |
| 50 | | | | | | 50 |
| 51 | | | | | | 51 |
| 52 | | | | | | 52 |
| 53 | | | | | | 53 |
| 54 | | | | | | 54 |
| 55 | | | | | | 55 |
| 56 | | | | | | 56 |

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

| | | | | | | |
|----|--|--|--|--|-------|----|
| 57 | | | | | | 57 |
| 58 | | | | | 60326 | 58 |
| 59 | | | | | 4576 | 59 |
| 60 | | | | | | 60 |
| 61 | | | | | | 61 |
| 62 | | | | | | 62 |
| 63 | | | | | | 63 |
| 64 | | | | | 64902 | 64 |
| 65 | | | | | 75909 | 65 |
| | | | | | 11007 | 65 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2007 TO 09/30/2008

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS V,VI & VII

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

| | | | |
|----|---|----------|----|
| 66 | COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL | 75909 | 66 |
| 67 | TOTAL COST | 75909 | 67 |
| 68 | RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL | 1.000000 | 68 |
| 69 | EXCESS OF COST OVER LIMITATION - HOSPITAL | 11007 | 69 |
| 70 | TOTAL EXCESS OF COST OVER LIMITATION | 11007 | 70 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2007 TO 09/30/2008

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
 PARTS I & II

[] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

| | | | | | | | |
|-------|--|-------------|------------|------------|-------|----------|-------|
| 1 | TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) | | | | | 29 | 1 |
| 2 | LINE 1 MULTIPLIED BY 15 HOURS PER WEEK | | | | | 435 | 2 |
| 3 | NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE | | | | | 117 | 3 |
| 4 | NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE | | | | | | 4 |
| 5 | NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS | | | | | | 5 |
| 6 | NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS | | | | | | 6 |
| 7 | STANDARD TRAVEL EXPENSE RATE | | | | | 3.45 | 7 |
| 8 | OPTIONAL TRAVEL EXPENSE RATE PER MILE | | | | | | 8 |
| | | SUPERVISORS | THERAPISTS | ASSISTANTS | AIDES | TRAINEES | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 9 | TOTAL HOURS WORKED | | 82.33 | | | | 9 |
| 10 | AHSEA | | 60.39 | | | | 10 |
| 11 | STANDARD TRAVEL ALLOWANCE | 30.20 | 30.20 | | | | 11 |
| 12 | NO OF TRAVEL HRS (PROV SITE) | | | | | | 12 |
| 12.01 | NO OF TRAVEL HRS (OFFSITE) | | | | | | 12.01 |
| 13 | MILES DRIVEN (PROV SITE) | | | | | | 13 |
| 13.01 | MILES DRIVEN (OFFSITE) | | | | | | 13.01 |

PART II - SALARY EQUIVALENCY COMPUTATION

| | | | | | | | |
|----|--|--|--|--|--|-------|----|
| 14 | SUPERVISORS | | | | | | 14 |
| 15 | THERAPISTS | | | | | 4972 | 15 |
| 16 | ASSISTANTS | | | | | | 16 |
| 17 | SUBTOTAL ALLOWANCE AMOUNT | | | | | 4972 | 17 |
| 18 | AIDES | | | | | | 18 |
| 19 | TRAINEES | | | | | | 19 |
| 20 | TOTAL ALLOWANCE AMOUNT | | | | | 4972 | 20 |
| 21 | WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES | | | | | 60.39 | 21 |
| 22 | WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES | | | | | 26270 | 22 |
| 23 | TOTAL SALARY EQUIVALENCY | | | | | 26270 | 23 |

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WORKSHEET A-8-4
PARTS III & IV

[] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

| | | | |
|---|--|------|----|
| STANDARD TRAVEL ALLOWANCE | | | |
| 24 | THERAPISTS | 3533 | 24 |
| 25 | ASSISTANTS | | 25 |
| 26 | SUBTOTAL | 3533 | 26 |
| 27 | STANDARD TRAVEL EXPENSE | 404 | 27 |
| 28 | TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE | 3937 | 28 |
| OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | | | |
| 29 | THERAPISTS | | 29 |
| 30 | ASSISTANTS | | 30 |
| 31 | SUBTOTAL | | 31 |
| 32 | OPTIONAL TRAVEL EXPENSE | | 32 |
| 33 | STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | 3937 | 33 |
| 34 | OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | | 34 |
| 35 | OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | | 35 |

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

| | | | |
|--|---|--|----|
| STANDARD TRAVEL EXPENSE | | | |
| 36 | THERAPISTS | | 36 |
| 37 | ASSISTANTS | | 37 |
| 38 | SUBTOTAL | | 38 |
| 39 | STANDARD TRAVEL EXPENSE | | 39 |
| OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | | | |
| 40 | THERAPISTS | | 40 |
| 41 | ASSISTANTS | | 41 |
| 42 | SUBTOTAL | | 42 |
| 43 | OPTIONAL TRAVEL EXPENSE | | 43 |
| TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES | | | |
| 44 | STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | | 44 |
| 45 | OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | | 45 |
| 46 | OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | | 46 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2007 TO 09/30/2008

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FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS V, VI & VII

[] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

| | THERAPISTS 1 | ASSISTANTS 2 | AIDES 3 | TRAINEES 4 | TOTAL 5 | |
|----|-----------------|-----------------|------------|---------------|------------|----|
| 47 | | | | | | 47 |
| | | | | | | |
| 48 | | | | | | 48 |
| 49 | | | | | | 49 |
| | | | | | | |
| 50 | | | | | | 50 |
| | | | | | | |
| 51 | | | | | | 51 |
| | | | | | | |
| 52 | | | | | | 52 |
| | | | | | | |
| 53 | | | | | | 53 |
| 54 | | | | | | 54 |
| 55 | | | | | | 55 |
| | | | | | | |
| 56 | | | | | | 56 |

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

| | | | | | | |
|----|--|--|--|--|-------|----|
| 57 | | | | | 26270 | 57 |
| 58 | | | | | 3937 | 58 |
| 59 | | | | | | 59 |
| 60 | | | | | | 60 |
| 61 | | | | | | 61 |
| 62 | | | | | | 62 |
| 63 | | | | | 30207 | 63 |
| 64 | | | | | 13790 | 64 |
| 65 | | | | | | 65 |

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WORKSHEET A-8-4
PARTS V,VI & VII

[] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

| | | | |
|----|---|----------|----|
| 66 | COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL | 13790 | 66 |
| 67 | TOTAL COST | 13790 | 67 |
| 68 | RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL | 1.000000 | 68 |
| 69 | EXCESS OF COST OVER LIMITATION - HOSPITAL | 0 | 69 |
| 70 | TOTAL EXCESS OF COST OVER LIMITATION | 0 | 70 |

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

| COST CENTER DESCRIPTION | NET EXP FOR COST ALLOCATION 0 | NEW CAP BLDGS & FIXTURES 3 | NEW CAP MOVABLE EQUIPMENT 4 | NEW CAP MVBLE EQUIP NH 4.01 | EMPLOYEE BENEFITS 5 | SUBTOTAL 5A | ADMINIS-TRATIVE + GENERAL 6 | OPERATION OF PLANT 8 | |
|--|----------------------------------|-------------------------------|--------------------------------|--------------------------------|------------------------|----------------|--------------------------------|-------------------------|--------|
| GENERAL SERVICE COST CENTERS | | | | | | | | | |
| 1 OLD CAP REL COSTS-BLDG & FIXT | | | | | | | | | 1 |
| 2 OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | | | 2 |
| 3 NEW CAP REL COSTS-BLDG & FIXT | 151854 | 151854 | | | | | | | 3 |
| 4 NEW CAP REL COSTS-MVBLE EQUIP | 1087101 | | 1087101 | | | | | | 4 |
| 4.01 NEW CAP REL COSTS-MVBLE EQUIP N | 22181 | | | 22181 | | | | | 4.01 |
| 5 EMPLOYEE BENEFITS | 2658712 | | | | 2658712 | | | | 5 |
| 6 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS | 6188542 | 16446 | 137171 | | 683920 | 7026079 | 7026079 | | 6 |
| 7 OPERATION OF PLANT | 1172563 | 17976 | 149928 | | 108200 | 1448667 | 679638 | 2128305 | 7 |
| 9 LAUNDRY & LINEN SERVICE | 136657 | | | | 4786 | 141443 | 66358 | | 9 |
| 10 HOUSEKEEPING | 417689 | 1578 | 13158 | | 90505 | 522930 | 245331 | 28592 | 10 |
| 11 DIETARY | 587108 | 10945 | 91290 | | 87475 | 776818 | 364442 | 198369 | 11 |
| 12 CAFETERIA | | | | | | | | | 12 |
| 13 MAINTENANCE OF PERSONNEL | | | | | | | | | 13 |
| 14 NURSING ADMINISTRATION | | | | | | | | | 14 |
| 15 CENTRAL SERVICES & SUPPLY | 35795 | 5853 | 48814 | | 4785 | 95247 | 44685 | 106070 | 15 |
| 16 PHARMACY | | 1843 | 15372 | | 64973 | 82188 | 38558 | 33402 | 16 |
| 17 MEDICAL RECORDS & LIBRARY | 206347 | 4351 | 36292 | | 45887 | 292877 | 137402 | 78861 | 17 |
| 18 SOCIAL SERVICE | | | | | | | | | 18 |
| 20 NONPHYSICIAN ANESTHETISTS | | | | | | | | | 20 |
| 21 NURSING SCHOOL | | | | | | | | | 21 |
| 22 I&R SERVICES-SALARY & FRINGES A | | | | | | | | | 22 |
| 23 I&R SERVICES-OTHER PRGM COSTS A | | | | | | | | | 23 |
| 24 PARAMED ED PRGM-(SPECIFY) | | | | | | | | | 24 |
| INPATIENT ROUTINE SERV COST CENTERS | | | | | | | | | |
| 25 ADULTS & PEDIATRICS | 938092 | 18158 | 151451 | | | | | | 25 |
| 34 SKILLED NURSING FACILITY | 1021763 | 21515 | | 22181 | 225193 | 1332894 | 625323 | 329092 | 34 |
| ANCILLARY SERVICE COST CENTERS | | | | | 246959 | 1312418 | 615717 | 389944 | |
| 37 OPERATING ROOM | 439506 | 8067 | 67285 | | 85176 | 600034 | 281504 | 146206 | 37 |
| 40 ANESTHESIOLOGY | 17517 | 383 | 3196 | | | 21096 | 9897 | 6945 | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 1084495 | 7241 | 60394 | | 113079 | 1265209 | 593569 | 131234 | 41 |
| 44 LABORATORY | 1025200 | 3217 | 26828 | | 89637 | 1144882 | 537118 | 58296 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | 34140 | | | | 5182 | 39322 | 18448 | | 49 |
| 50 PHYSICAL THERAPY | 286539 | 5388 | 44940 | | 52897 | 389764 | 182857 | 97651 | 50 |
| 51 OCCUPATIONAL THERAPY | 73302 | | | | 18311 | 91613 | 42980 | | 51 |
| 52 SPEECH PATHOLOGY | 13840 | 58 | 484 | | | 14382 | 6747 | 1052 | 52 |
| 53 ELECTROCARDIOLOGY | 101894 | 2414 | 20131 | | 24630 | 149069 | 69935 | 43745 | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | 335359 | | | | | 335359 | 157333 | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | 762887 | | | | | 762887 | 357906 | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 61 EMERGENCY | 612400 | 8450 | 70481 | | 129457 | 820788 | 385070 | 153151 | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | | | | | | | | | 62 |
| 63.50 RHC | 1854038 | 13852 | 115531 | | 421106 | 2404527 | 1128071 | 251043 | 63.50 |
| 63.60 FQHC | | | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 69.10 CMHC | | | | | | | | | 69.10 |
| 69.20 OUTPATIENT PHYSICAL THERAPY | | | | | | | | | 69.20 |
| 69.30 OUTPATIENT OCCUPATIONAL THERAPY | | | | | | | | | 69.30 |
| 69.40 OUTPATIENT SPEECH PATHOLOGY | | | | | | | | | 69.40 |
| 71 HOME HEALTH AGENCY | 18324 | 126 | 1052 | | 2614 | 22116 | 10376 | 2285 | 71 |
| SPECIAL PURPOSE COST CENTERS | | | | | | | | | |
| 85.01 PANCREAS ACQUISITION | | | | | | | | | 85.01 |
| 85.02 INTESTINAL ACQUISITION | | | | | | | | | 85.02 |
| 85.03 ISLET CELL ACQUISITION | | | | | | | | | 85.03 |
| 95 SUBTOTALS | 21283845 | 147861 | 1053798 | 22181 | 2504772 | 21092609 | 6599265 | 2055938 | 95 |
| NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 100 CLINIC | 718531 | 3993 | 33303 | | 153940 | 909767 | 426814 | 72367 | 100 |
| 100.01 RENTAL SPACE | | | | | | | | | 100.01 |
| 101 CROSS FOOT ADJUSTMENTS | | | | | | | | | 101 |
| 102 NEGATIVE COST CENTER | | | | | | | | | 102 |
| 103 TOTAL | 22002376 | 151854 | 1087101 | 22181 | 2658712 | 22002376 | 7026079 | 2128305 | 103 |

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

| COST CENTER DESCRIPTION | LAUNDRY + LINEN SERVICE 9 | HOUSE- KEEPING 10 | DIETARY 11 | CAFETERIA 12 | CENTRAL SERVICES + SUPPLY 15 | PHARMACY 16 | MEDICAL RECORDS + LIBRARY 17 | SUBTOTAL 25 |
|--|------------------------------------|-------------------------|---------------|-----------------|---------------------------------------|----------------|---------------------------------------|----------------|
| GENERAL SERVICE COST CENTERS | | | | | | | | |
| 1 OLD CAP REL COSTS-BLDG & FIXT | | | | | | | | 1 |
| 2 OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | | 2 |
| 3 NEW CAP REL COSTS-BLDG & FIXT | | | | | | | | 3 |
| 4 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | | | 4 |
| 4.01 NEW CAP REL COSTS-MVBLE EQUIP N | | | | | | | | 4.01 |
| 5 EMPLOYEE BENEFITS | | | | | | | | 5 |
| 6 ADMINISTRATIVE & GENERAL | | | | | | | | 6 |
| 7 MAINTENANCE & REPAIRS | | | | | | | | 7 |
| 8 OPERATION OF PLANT | | | | | | | | 8 |
| 9 LAUNDRY & LINEN SERVICE | 207801 | | | | | | | 9 |
| 10 HOUSEKEEPING | 29294 | 826147 | | | | | | 10 |
| 11 DIETARY | | 78050 | 1417679 | | | | | 11 |
| 12 CAFETERIA | | | 793512 | 793512 | | | | 12 |
| 13 MAINTENANCE OF PERSONNEL | | | | | | | | 13 |
| 14 NURSING ADMINISTRATION | | | | | | | | 14 |
| 15 CENTRAL SERVICES & SUPPLY | | 41734 | | | 287736 | | | 15 |
| 16 PHARMACY | | 13142 | | 16990 | 254 | 184534 | | 16 |
| 17 MEDICAL RECORDS & LIBRARY | | 31028 | | 27628 | | | 567796 | 17 |
| 18 SOCIAL SERVICE | | | | | | | | 18 |
| 20 NONPHYSICIAN ANESTHETISTS | | | | | | | | 20 |
| 21 NURSING SCHOOL | | | | | | | | 21 |
| 22 I&R SERVICES-SALARY & FRINGES A | | | | | | | | 22 |
| 23 I&R SERVICES-OTHER PRGM COSTS A | | | | | | | | 23 |
| 24 PARAMED ED PRGM-(SPECIFY) | | | | | | | | 24 |
| 25 INPATIENT ROUTINE SERV COST CENTERS | | | | | | | | |
| 34 ADULTS & PEDIATRICS | 44966 | 129484 | 155644 | 120943 | 27325 | | 35849 | 2801520 25 |
| SKILLED NURSING FACILITY | 76243 | 153425 | 468523 | 150636 | 4986 | | 19883 | 3191775 34 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | |
| 37 OPERATING ROOM | 13829 | 57526 | | 60471 | 122525 | | 41201 | 1323296 37 |
| 40 ANESTHESIOLOGY | | 2733 | | 10586 | 6461 | | 1360 | 59078 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 11733 | 51635 | | 57218 | 7729 | | 138624 | 2256951 41 |
| 44 LABORATORY | 250 | 22937 | | 57425 | 20429 | | 105496 | 1946833 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | | | | | |
| 49 RESPIRATORY THERAPY | | | | 1859 | 16264 | | 5388 | 81281 49 |
| 50 PHYSICAL THERAPY | 15011 | 38422 | | 26750 | 2934 | | 28525 | 781914 50 |
| 51 OCCUPATIONAL THERAPY | | | | 5164 | 538 | | 5741 | 146036 51 |
| 52 SPEECH PATHOLOGY | | 414 | | | | | 747 | 23342 52 |
| 53 ELECTROCARDIOLOGY | 201 | 17212 | | 10896 | 1237 | | 9395 | 301690 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | | | | | 29875 | | 33540 | 556107 55 |
| 56 DRUGS CHARGED TO PATIENTS | | | | | | 184534 | 40204 | 1345531 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 61 EMERGENCY | 13310 | 60258 | | 27679 | 6881 | | 37321 | 1504458 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | | | | | | | | |
| 63.50 RHC | 2012 | 98775 | | 188593 | 24117 | | 44083 | 4141221 63.50 |
| 63.60 FQHC | | | | | | | | |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | |
| 69.10 CMHC | | | | | | | | |
| 69.20 OUTPATIENT PHYSICAL THERAPY | | | | | | | | 69.10 |
| 69.30 OUTPATIENT OCCUPATIONAL THERAPY | | | | | | | | 69.20 |
| 69.40 OUTPATIENT SPEECH PATHOLOGY | | | | | | | | 69.30 |
| 71 HOME HEALTH AGENCY | | 899 | | 1239 | | | 136 | 37051 71 |
| SPECIAL PURPOSE COST CENTERS | | | | | | | | |
| 85.01 PANCREAS ACQUISITION | | | | | | | | 85.01 |
| 85.02 INTESTINAL ACQUISITION | | | | | | | | 85.02 |
| 85.03 ISLET CELL ACQUISITION | | | | | | | | 85.03 |
| 95 SUBTOTALS | 206849 | 797674 | 1417679 | 764077 | 271555 | 184534 | 547493 | 20498084 95 |
| NONREIMBURSABLE COST CENTERS | | | | | | | | |
| 100 CLINIC | 952 | 28473 | | 29435 | 16181 | | 20303 | 1504292 100 |
| 100.01 RENTAL SPACE | | | | | | | | |
| 101 CROSS FOOT ADJUSTMENTS | | | | | | | | 100.01 |
| 102 NEGATIVE COST CENTER | | | | | | | | 101 |
| 103 TOTAL | 207801 | 826147 | 1417679 | 793512 | 287736 | 184534 | 567796 | 22002376 103 |

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

| COST CENTER DESCRIPTION | I&R COST & POST STEP- DOWN ADJS 26 | TOTAL 27 | |
|---------------------------------------|---|-------------|--------|
| GENERAL SERVICE COST CENTERS | | | |
| 1 OLD CAP REL COSTS-BLDG & FIXT | | | 1 |
| 2 OLD CAP REL COSTS-MVBLE EQUIP | | | 2 |
| 3 NEW CAP REL COSTS-BLDG & FIXT | | | 3 |
| 4 NEW CAP REL COSTS-MVBLE EQUIP | | | 4 |
| 4.01 NEW CAP REL COSTS-MVBLE EQUIP N | | | 4.01 |
| 5 EMPLOYEE BENEFITS | | | 5 |
| 6 ADMINISTRATIVE & GENERAL | | | 6 |
| 7 MAINTENANCE & REPAIRS | | | 7 |
| 8 OPERATION OF PLANT | | | 8 |
| 9 LAUNDRY & LINEN SERVICE | | | 9 |
| 10 HOUSEKEEPING | | | 10 |
| 11 DIETARY | | | 11 |
| 12 CAFETERIA | | | 12 |
| 13 MAINTENANCE OF PERSONNEL | | | 13 |
| 14 NURSING ADMINISTRATION | | | 14 |
| 15 CENTRAL SERVICES & SUPPLY | | | 15 |
| 16 PHARMACY | | | 16 |
| 17 MEDICAL RECORDS & LIBRARY | | | 17 |
| 18 SOCIAL SERVICE | | | 18 |
| 20 NONPHYSICIAN ANESTHETISTS | | | 20 |
| 21 NURSING SCHOOL | | | 21 |
| 22 I&R SERVICES-SALARY & FRINGES A | | | 22 |
| 23 I&R SERVICES-OTHER PRGM COSTS A | | | 23 |
| 24 PARAMED ED PRGM-(SPECIFY) | | | 24 |
| INPATIENT ROUTINE SERV COST CENTERS | | | |
| 25 ADULTS & PEDIATRICS | 2801520 | | 25 |
| 34 SKILLED NURSING FACILITY | 3191775 | | 34 |
| ANCILLARY SERVICE COST CENTERS | | | |
| 37 OPERATING ROOM | 1323296 | | 37 |
| 40 ANESTHESIOLOGY | 59078 | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 2256951 | | 41 |
| 44 LABORATORY | 1946833 | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | 46.30 |
| 49 RESPIRATORY THERAPY | 81281 | | 49 |
| 50 PHYSICAL THERAPY | 781914 | | 50 |
| 51 OCCUPATIONAL THERAPY | 146036 | | 51 |
| 52 SPEECH PATHOLOGY | 23342 | | 52 |
| 53 ELECTROCARDIOLOGY | 301690 | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | 556107 | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | 1345531 | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | |
| 61 EMERGENCY | 1504458 | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | | | 62 |
| 63.50 RHC | 4141221 | | 63.50 |
| 63.60 FQHC | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | |
| 69.10 CMHC | | | 69.10 |
| 69.20 OUTPATIENT PHYSICAL THERAPY | | | 69.20 |
| 69.30 OUTPATIENT OCCUPATIONAL THERAPY | | | 69.30 |
| 69.40 OUTPATIENT SPEECH PATHOLOGY | | | 69.40 |
| 71 HOME HEALTH AGENCY | 37051 | | 71 |
| SPECIAL PURPOSE COST CENTERS | | | |
| 85.01 PANCREAS ACQUISITION | | | 85.01 |
| 85.02 INTESTINAL ACQUISITION | | | 85.02 |
| 85.03 ISLET CELL ACQUISITION | | | 85.03 |
| 95 SUBTOTALS | 20498084 | | 95 |
| NONREIMBURSABLE COST CENTERS | | | |
| 100 CLINIC | 1504292 | | 100 |
| 100.01 RENTAL SPACE | | | 100.01 |
| 101 CROSS FOOT ADJUSTMENTS | | | 101 |
| 102 NEGATIVE COST CENTER | | | 102 |
| 103 TOTAL | 22002376 | | 103 |

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

| COST CENTER DESCRIPTION | DIR ASSGND CAP-REL COSTS 0 | NEW CAP BLDGS & FIXTURES 3 | NEW CAP MOVABLE EQUIPMENT 4 | NEW CAP MVBLE EQUIP NH 4.01 | CAP REL COST TO BE ALLOC 4A | ADMINIS- TRATIVE + GENERAL 6 | OPERATION OF PLANT 8 | LAUNDRY + LINEN SERVICE 9 | |
|---------------------------------------|-------------------------------------|-------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|---------------------------------------|----------------------------|------------------------------------|--------|
| GENERAL SERVICE COST CENTERS | | | | | | | | | |
| 1 OLD CAP REL COSTS-BLDG & FIXT | | | | | | | | | 1 |
| 2 OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | | | 2 |
| 3 NEW CAP REL COSTS-BLDG & FIXT | | | | | | | | | 3 |
| 4 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | | | | 4 |
| 4.01 NEW CAP REL COSTS-MVBLE EQUIP N | | | | | | | | | 4.01 |
| 5 EMPLOYEE BENEFITS | | | | | | | | | 5 |
| 6 ADMINISTRATIVE & GENERAL | 241626 | 16446 | 137171 | | 395243 | 395243 | | | 6 |
| 7 MAINTENANCE & REPAIRS | | | | | | | | | 7 |
| 8 OPERATION OF PLANT | | 17976 | 149928 | | 167904 | 38232 | 206136 | | 8 |
| 9 LAUNDRY & LINEN SERVICE | | | | | | 3733 | | 3733 | 9 |
| 10 HOUSEKEEPING | | 1578 | 13158 | | 14736 | 13801 | 2769 | 526 | 10 |
| 11 DIETARY | | 10945 | 91290 | | 102235 | 20501 | 19213 | | 11 |
| 12 CAFETERIA | | | | | | | | | 12 |
| 13 MAINTENANCE OF PERSONNEL | | | | | | | | | 13 |
| 14 NURSING ADMINISTRATION | | | | | | | | | 14 |
| 15 CENTRAL SERVICES & SUPPLY | | 5853 | 48814 | | 54667 | 2514 | 10273 | | 15 |
| 16 PHARMACY | | 1843 | 15372 | | 17215 | 2169 | 3235 | | 16 |
| 17 MEDICAL RECORDS & LIBRARY | | 4351 | 36292 | | 40643 | 7729 | 7638 | | 17 |
| 18 SOCIAL SERVICE | | | | | | | | | 18 |
| 20 NONPHYSICIAN ANESTHETISTS | | | | | | | | | 20 |
| 21 NURSING SCHOOL | | | | | | | | | 21 |
| 22 I&R SERVICES-SALARY & FRINGES A | | | | | | | | | 22 |
| 23 I&R SERVICES-OTHER PRGM COSTS A | | | | | | | | | 23 |
| 24 PARAMED ED PRGM-(SPECIFY) | | | | | | | | | 24 |
| INPATIENT ROUTINE SERV COST CENTERS | | | | | | | | | |
| 25 ADULTS & PEDIATRICS | | 18158 | 151451 | | 169609 | 35176 | 31874 | 808 | 25 |
| 34 SKILLED NURSING FACILITY | | 21515 | | 22181 | 43696 | 34636 | 37768 | 1370 | 34 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 37 OPERATING ROOM | | 8067 | 67285 | | 75352 | 15835 | 14161 | 248 | 37 |
| 40 ANESTHESIOLOGY | | 383 | 3196 | | 3579 | 557 | 673 | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | | 7241 | 60394 | | 67635 | 33390 | 12711 | 211 | 41 |
| 44 LABORATORY | | 3217 | 26828 | | 30045 | 30215 | 5646 | 4 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | | | | | | 1038 | | | 49 |
| 50 PHYSICAL THERAPY | | 5388 | 44940 | | 50328 | 10286 | 9458 | 270 | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | 2418 | | | 51 |
| 52 SPEECH PATHOLOGY | | 58 | 484 | | 542 | 380 | 102 | | 52 |
| 53 ELECTROCARDIOLOGY | | 2414 | 20131 | | 22545 | 3934 | 4237 | 4 | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | | | | | | 8850 | | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | | | | | 20133 | | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 61 EMERGENCY | | 8450 | 70481 | | 78931 | 21661 | 14833 | 239 | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | | | | | | | | | 62 |
| 63.50 RHC | | 13852 | 115531 | | 129383 | 63461 | 24315 | 36 | 63.50 |
| 63.60 FQHC | | | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 69.10 CMHC | | | | | | | | | 69.10 |
| 69.20 OUTPATIENT PHYSICAL THERAPY | | | | | | | | | 69.20 |
| 69.30 OUTPATIENT OCCUPATIONAL THERAPY | | | | | | | | | 69.30 |
| 69.40 OUTPATIENT SPEECH PATHOLOGY | | | | | | | | | 69.40 |
| 71 HOME HEALTH AGENCY | | 126 | 1052 | | 1178 | 584 | 221 | | 71 |
| SPECIAL PURPOSE COST CENTERS | | | | | | | | | |
| 85.01 PANCREAS ACQUISITION | | | | | | | | | 85.01 |
| 85.02 INTESTINAL ACQUISITION | | | | | | | | | 85.02 |
| 85.03 ISLET CELL ACQUISITION | | | | | | | | | 85.03 |
| 95 SUBTOTALS | 241626 | 147861 | 1053798 | 22181 | 1465466 | 371233 | 199127 | 3716 | 95 |
| NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 100 CLINIC | | 3993 | 33303 | | 37296 | 24010 | 7009 | 17 | 100 |
| 100.01 RENTAL SPACE | | | | | | | | | 100.01 |
| 101 CROSS FOOT ADJUSTMENTS | | | | | | | | | 101 |
| 102 NEGATIVE COST CENTER | | | | | | | | | 102 |
| 103 TOTAL | 241626 | 151854 | 1087101 | 22181 | 1502762 | 395243 | 206136 | 3733 | 103 |

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

| COST CENTER DESCRIPTION | HOUSE-KEEPING 10 | DIETARY 11 | CAFETERIA 12 | CENTRAL SERVICES + SUPPLY 15 | PHARMACY 16 | MEDICAL RECORDS + LIBRARY 17 | SUBTOTAL 25 | I&R COST & POST STEP-DOWN ADJS 26 |
|---------------------------------------|---------------------|---------------|-----------------|---------------------------------|----------------|---------------------------------|----------------|--------------------------------------|
| GENERAL SERVICE COST CENTERS | | | | | | | | |
| 1 OLD CAP REL COSTS-BLDG & FIXT | | | | | | | | 1 |
| 2 OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | | 2 |
| 3 NEW CAP REL COSTS-BLDG & FIXT | | | | | | | | 3 |
| 4 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | | | 4 |
| 4.01 NEW CAP REL COSTS-MVBLE EQUIP N | | | | | | | | 4.01 |
| 5 EMPLOYEE BENEFITS | | | | | | | | 5 |
| 6 ADMINISTRATIVE & GENERAL | | | | | | | | 6 |
| 7 MAINTENANCE & REPAIRS | | | | | | | | 7 |
| 8 OPERATION OF PLANT | | | | | | | | 8 |
| 9 LAUNDRY & LINEN SERVICE | | | | | | | | 9 |
| 10 HOUSEKEEPING | 31832 | | | | | | | 10 |
| 11 DIETARY | 3007 | 144956 | | | | | | 11 |
| 12 CAFETERIA | | 81136 | 81136 | | | | | 12 |
| 13 MAINTENANCE OF PERSONNEL | | | | | | | | 13 |
| 14 NURSING ADMINISTRATION | | | | | | | | 14 |
| 15 CENTRAL SERVICES & SUPPLY | 1608 | | | 69062 | | | | 15 |
| 16 PHARMACY | 506 | | 1737 | 61 | 24923 | | | 16 |
| 17 MEDICAL RECORDS & LIBRARY | 1196 | | 2825 | | | 60031 | | 17 |
| 18 SOCIAL SERVICE | | | | | | | | 18 |
| 20 NONPHYSICIAN ANESTHETISTS | | | | | | | | 20 |
| 21 NURSING SCHOOL | | | | | | | | 21 |
| 22 I&R SERVICES-SALARY & FRINGES A | | | | | | | | 22 |
| 23 I&R SERVICES-OTHER PRGM COSTS A | | | | | | | | 23 |
| 24 PARAMED ED PRGM-(SPECIFY) | | | | | | | | 24 |
| INPATIENT ROUTINE SERV COST CENTERS | | | | | | | | |
| 25 ADULTS & PEDIATRICS | 4989 | 15914 | 12366 | 6559 | | 3791 | 281086 | 25 |
| 34 SKILLED NURSING FACILITY | 5911 | 47906 | 15402 | 1197 | | 2103 | 189989 | 34 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | |
| 37 OPERATING ROOM | 2217 | | 6183 | 29408 | | 4357 | 147761 | 37 |
| 40 ANESTHESIOLOGY | 105 | | 1082 | 1551 | | 144 | 7691 | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 1990 | | 5850 | 1855 | | 14643 | 138285 | 41 |
| 44 LABORATORY | 884 | | 5872 | 4903 | | 11157 | 88726 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | | | 190 | 3904 | | 570 | 5702 | 49 |
| 50 PHYSICAL THERAPY | 1480 | | 2735 | 704 | | 3017 | 78278 | 50 |
| 51 OCCUPATIONAL THERAPY | | | 528 | 129 | | 607 | 3682 | 51 |
| 52 SPEECH PATHOLOGY | 16 | | | | | 79 | 1119 | 52 |
| 53 ELECTROCARDIOLOGY | 663 | | 1114 | 297 | | 994 | 33788 | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | | | | 7170 | | 3547 | 19567 | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | | | | 24923 | 4252 | 49308 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 61 EMERGENCY | 2322 | | 2830 | 1652 | | 3947 | 126415 | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | | | | | | | | 62 |
| 63.50 RHC | 3806 | | 19285 | 5788 | | 4662 | 250736 | 63.50 |
| 63.60 FQHC | | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | |
| 69.10 CMHC | | | | | | | | 69.10 |
| 69.20 OUTPATIENT PHYSICAL THERAPY | | | | | | | | 69.20 |
| 69.30 OUTPATIENT OCCUPATIONAL THERAPY | | | | | | | | 69.30 |
| 69.40 OUTPATIENT SPEECH PATHOLOGY | | | | | | | | 69.40 |
| 71 HOME HEALTH AGENCY | 35 | | 127 | | | 14 | 2159 | 71 |
| SPECIAL PURPOSE COST CENTERS | | | | | | | | |
| 85.01 PANCREAS ACQUISITION | | | | | | | | 85.01 |
| 85.02 INTESTINAL ACQUISITION | | | | | | | | 85.02 |
| 85.03 ISLET CELL ACQUISITION | | | | | | | | 85.03 |
| 95 SUBTOTALS | 30735 | 144956 | 78126 | 65178 | 24923 | 57884 | 1424292 | 95 |
| NONREIMBURSABLE COST CENTERS | | | | | | | | |
| 100 CLINIC | 1097 | | 3010 | 3884 | | 2147 | 78470 | 100 |
| 100.01 RENTAL SPACE | | | | | | | | 100.01 |
| 101 CROSS FOOT ADJUSTMENTS | | | | | | | | 101 |
| 102 NEGATIVE COST CENTER | | | | | | | | 102 |
| 103 TOTAL | 31832 | 144956 | 81136 | 69062 | 24923 | 60031 | 1502762 | 103 |

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

| COST CENTER DESCRIPTION | | TOTAL | |
|-------------------------------------|---------------------------------|---------|--------|
| | | 27 | |
| GENERAL SERVICE COST CENTERS | | | |
| 1 | OLD CAP REL COSTS-BLDG & FIXT | | 1 |
| 2 | OLD CAP REL COSTS-MVBLE EQUIP | | 2 |
| 3 | NEW CAP REL COSTS-BLDG & FIXT | | 3 |
| 4 | NEW CAP REL COSTS-MVBLE EQUIP | | 4 |
| 4.01 | NEW CAP REL COSTS-MVBLE EQUIP N | | 4.01 |
| 5 | EMPLOYEE BENEFITS | | 5 |
| 6 | ADMINISTRATIVE & GENERAL | | 6 |
| 7 | MAINTENANCE & REPAIRS | | 7 |
| 8 | OPERATION OF PLANT | | 8 |
| 9 | LAUNDRY & LINEN SERVICE | | 9 |
| 10 | HOUSEKEEPING | | 10 |
| 11 | DIETARY | | 11 |
| 12 | CAFETERIA | | 12 |
| 13 | MAINTENANCE OF PERSONNEL | | 13 |
| 14 | NURSING ADMINISTRATION | | 14 |
| 15 | CENTRAL SERVICES & SUPPLY | | 15 |
| 16 | PHARMACY | | 16 |
| 17 | MEDICAL RECORDS & LIBRARY | | 17 |
| 18 | SOCIAL SERVICE | | 18 |
| 20 | NONPHYSICIAN ANESTHETISTS | | 20 |
| 21 | NURSING SCHOOL | | 21 |
| 22 | I&R SERVICES-SALARY & FRINGES A | | 22 |
| 23 | I&R SERVICES-OTHER PRGM COSTS A | | 23 |
| 24 | PARAMED ED PRGM-(SPECIFY) | | 24 |
| INPATIENT ROUTINE SERV COST CENTERS | | | |
| 25 | ADULTS & PEDIATRICS | 281086 | 25 |
| 34 | SKILLED NURSING FACILITY | 189989 | 34 |
| ANCILLARY SERVICE COST CENTERS | | | |
| 37 | OPERATING ROOM | 147761 | 37 |
| 40 | ANESTHESIOLOGY | 7691 | 40 |
| 41 | RADIOLOGY-DIAGNOSTIC | 138285 | 41 |
| 44 | LABORATORY | 88726 | 44 |
| 46.30 | BLOOD CLOTTING FACTORS ADMIN CO | | 46.30 |
| 49 | RESPIRATORY THERAPY | 5702 | 49 |
| 50 | PHYSICAL THERAPY | 78278 | 50 |
| 51 | OCCUPATIONAL THERAPY | 3682 | 51 |
| 52 | SPEECH PATHOLOGY | 1119 | 52 |
| 53 | ELECTROCARDIOLOGY | 33788 | 53 |
| 55 | MEDICAL SUPPLIES CHARGED TO PAT | 19567 | 55 |
| 56 | DRUGS CHARGED TO PATIENTS | 49308 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | |
| 61 | EMERGENCY | 126415 | 61 |
| 62 | OBSERVATION BEDS (NON-DISTINCT | | 62 |
| 63.50 | RHC | 250736 | 63.50 |
| 63.60 | FQHC | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | |
| 69.10 | CMHC | | 69.10 |
| 69.20 | OUTPATIENT PHYSICAL THERAPY | | 69.20 |
| 69.30 | OUTPATIENT OCCUPATIONAL THERAPY | | 69.30 |
| 69.40 | OUTPATIENT SPEECH PATHOLOGY | | 69.40 |
| 71 | HOME HEALTH AGENCY | 2159 | 71 |
| SPECIAL PURPOSE COST CENTERS | | | |
| 85.01 | PANCREAS ACQUISITION | | 85.01 |
| 85.02 | INTESTINAL ACQUISITION | | 85.02 |
| 85.03 | ISLET CELL ACQUISITION | | 85.03 |
| 95 | SUBTOTALS | 1424292 | 95 |
| NONREIMBURSABLE COST CENTERS | | | |
| 100 | CLINIC | 78470 | 100 |
| 100.01 | RENTAL SPACE | | 100.01 |
| 101 | CROSS FOOT ADJUSTMENTS | | 101 |
| 102 | NEGATIVE COST CENTER | | 102 |
| 103 | TOTAL | 1502762 | 103 |

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

| COST CENTER DESCRIPTION | LAUNDRY + LINEN SERVICE POUNDS OF LAUNDRY 9 | HOUSE-KEEPING SQUARE FEET 10 | DIETARY MEALS SERVED 11 | CAFETERIA FTE'S 12 | CENTRAL SERVICES + SUPPLY COSTED REQUIS. 15 | PHARMACY COSTED REQUIS. 16 | MEDICAL RECORDS + LIBRARY GROSS REVENUE 17 | |
|------------------------------|---|------------------------------------|-------------------------------|--------------------------|---|----------------------------------|--|----------|
| GENERAL SERVICE COST CENTERS | | | | | | | | |
| 1 | OLD CAP REL COSTS-BLDG & FIXT | | | | | | | 1 |
| 2 | OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | 2 |
| 3 | NEW CAP REL COSTS-BLDG & FIXT | | | | | | | 3 |
| 4 | NEW CAP REL COSTS-MVBLE EQUIP | | | | | | | 4 |
| 4.01 | NEW CAP REL COSTS-MVBLE EQUIP | | | | | | | 4.01 |
| 5 | EMPLOYEE BENEFITS | | | | | | | 5 |
| 6 | ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS | | | | | | | 6 |
| 7 | OPERATION OF PLANT | | | | | | | 7 |
| 8 | LAUNDRY & LINEN SERVICE | 245877 | | | | | | 8 |
| 9 | HOUSEKEEPING | 34662 | 69839 | | | | | 9 |
| 10 | DIETARY | | 6598 | 82878 | | | | 10 |
| 11 | CAFETERIA | | | 46389 | 15366 | | | 11 |
| 12 | MAINTENANCE OF PERSONNEL | | | | | | | 12 |
| 13 | NURSING ADMINISTRATION | | | | | | | 13 |
| 14 | CENTRAL SERVICES & SUPPLY | | 3528 | | | 522042 | | 14 |
| 15 | PHARMACY | | 1111 | | | 461 | | 15 |
| 16 | MEDICAL RECORDS & LIBRARY | | 2623 | | | | 100 | 16 |
| 17 | SOCIAL SERVICE | | | | 535 | | | 17 |
| 18 | NONPHYSICIAN ANESTHETISTS | | | | | | 39979015 | 18 |
| 19 | NURSING SCHOOL | | | | | | | 19 |
| 20 | I&R SERVICES-SALARY & FRINGES | | | | | | | 20 |
| 21 | I&R SERVICES-OTHER PRGM COSTS | | | | | | | 21 |
| 22 | PARAMED ED PRGM-(SPECIFY) | | | | | | | 22 |
| 23 | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | 23 |
| 24 | ADULTS & PEDIATRICS | 53205 | 10946 | 9099 | 2342 | 49576 | 2524199 | 24 |
| 25 | SKILLED NURSING FACILITY | 90211 | 12970 | 27390 | 2917 | 9046 | 1400027 | 25 |
| 26 | ANCILLARY SERVICE COST CENTERS | | | | | | | 26 |
| 27 | OPERATING ROOM | 16363 | 4863 | | 1171 | 222300 | 2901048 | 27 |
| 28 | ANESTHESIOLOGY | | 231 | | 205 | 11722 | 95790 | 28 |
| 29 | RADIOLOGY-DIAGNOSTIC | 13883 | 4365 | | 1108 | 14022 | 9759735 | 29 |
| 30 | LABORATORY | 296 | 1939 | | 1112 | 37064 | 7428274 | 30 |
| 31 | BLOOD CLOTTING FACTORS ADMIN | | | | | | | 31 |
| 32 | RESPIRATORY THERAPY | | | | 36 | 29508 | 379354 | 32 |
| 33 | PHYSICAL THERAPY | 17762 | 3248 | | 518 | 5323 | 2008537 | 33 |
| 34 | OCCUPATIONAL THERAPY | | | | 100 | 977 | 404242 | 34 |
| 35 | SPEECH PATHOLOGY | | 35 | | | | 52596 | 35 |
| 36 | ELECTROCARDIOLOGY | 238 | 1455 | | 211 | 2245 | 661552 | 36 |
| 37 | MEDICAL SUPPLIES CHARGED TO P | | | | | 54202 | 261668 | 37 |
| 38 | DRUGS CHARGED TO PATIENTS | | | | | | 2830878 | 38 |
| 39 | OUTPATIENT SERVICE COST CENTERS | | | | | | | 39 |
| 40 | EMERGENCY | 15749 | 5094 | | 536 | 12484 | 2627888 | 40 |
| 41 | OBSERVATION BEDS (NON-DISTINC | | | | | | | 41 |
| 42 | RHC | 2381 | 8350 | | 3652 | 43755 | 3104029 | 42 |
| 43 | FQHC | | | | | | | 43 |
| 44 | OTHER REIMBURSABLE COST CENTERS | | | | | | | 44 |
| 45 | CMHC | | | | | | | 45 |
| 46 | OUTPATIENT PHYSICAL THERAPY | | 76 | | 24 | | 9593 | 46 |
| 47 | OUTPATIENT OCCUPATIONAL THERA | | | | | | | 47 |
| 48 | OUTPATIENT SPEECH PATHOLOGY | | | | | | | 48 |
| 49 | HOME HEALTH AGENCY | | | | | | | 49 |
| 50 | SPECIAL PURPOSE COST CENTERS | | | | | | | 50 |
| 51 | PANCREAS ACQUISITION | | | | | | | 51 |
| 52 | INTESTINAL ACQUISITION | | | | | | | 52 |
| 53 | ISLET CELL ACQUISITION | | | | | | | 53 |
| 54 | SUBTOTALS | 244750 | 67432 | 82878 | 14796 | 492685 | 100 | 38549410 |
| 55 | NONREIMBURSABLE COST CENTERS | | | | | | | 55 |
| 56 | CLINIC | 1127 | 2407 | | 570 | 29357 | | 1429605 |
| 57 | RENTAL SPACE | | | | | | | |
| 58 | CROSS FOOT ADJUSTMENTS | | | | | | | |
| 59 | NEGATIVE COST CENTER | | | | | | | |
| 60 | COST TO BE ALLOC PER B PT I | 207801 | 826147 | 1417679 | 793512 | 287736 | 184534 | 567796 |
| 61 | UNIT COST MULT-WS B PT I | .845142 | | 17.105613 | | .551174 | | .014202 |
| 62 | UNIT COST MULT-WS B PT I | | 11.829307 | | 51.640765 | | 1845.340000 | |
| 63 | COST TO BE ALLOC PER B PT II | | | | | | | |
| 64 | UNIT COST MULT-WS B PT II | | | | | | | |
| 65 | UNIT COST MULT-WS B PT II | | | | | | | |
| 66 | UNIT COST MULT-WS B PT II | | | | | | | |
| 67 | COST TO BE ALLOC PER B PT III | 3733 | 31832 | 144956 | 81136 | 69062 | 24923 | 60031 |
| 68 | UNIT COST MULT-WS B PT III | .015182 | | 1.749029 | | .132292 | | .001502 |
| 69 | UNIT COST MULT-WS B PT III | | .455791 | | 5.280229 | | 249.230000 | |

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

| COST CENTER DESCRIPTION | TOTAL COST (FROM WKST B, PART I, COL 27) 1 | THERAPY LIMIT ADJUSTMENT 2 | TOTAL COSTS 3 | RCE DISALLOWANCE 4 | TOTAL COSTS 5 | |
|-------------------------------------|---|-------------------------------------|---------------------|--------------------------|---------------------|-------|
| INPATIENT ROUTINE SERV COST CENTERS | | | | | | |
| 25 ADULTS & PEDIATRICS | 2801520 | | 2801520 | | 2801520 | 25 |
| 34 SKILLED NURSING FACILITY | 3191775 | | 3191775 | | 3191775 | 34 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 37 OPERATING ROOM | 1323296 | | 1323296 | | 1323296 | 37 |
| 40 ANESTHESIOLOGY | 59078 | | 59078 | | 59078 | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 2256951 | | 2256951 | | 2256951 | 41 |
| 44 LABORATORY | 1946833 | | 1946833 | | 1946833 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMI | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | 81281 | | 81281 | | 81281 | 49 |
| 50 PHYSICAL THERAPY | 781914 | 11007 | 792921 | | 792921 | 50 |
| 51 OCCUPATIONAL THERAPY | 146036 | | 146036 | | 146036 | 51 |
| 52 SPEECH PATHOLOGY | 23342 | | 23342 | | 23342 | 52 |
| 53 ELECTROCARDIOLOGY | 301690 | | 301690 | | 301690 | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO | 556107 | | 556107 | | 556107 | 55 |
| 56 DRUGS CHARGED TO PATIENTS | 1345531 | | 1345531 | | 1345531 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 61 EMERGENCY | 1504458 | | 1504458 | | 1504458 | 61 |
| 62 OBSERVATION BEDS (NON-DISTI | 175470 | | 175470 | | 175470 | 62 |
| 63.50 RHC | 4141221 | | 4141221 | | 4141221 | 63.50 |
| 63.60 FQHC | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 101 SUBTOTAL | 20636503 | 11007 | 20647510 | | 20647510 | 101 |
| 102 LESS OBSERVATION BEDS | 175470 | | 175470 | | 175470 | 102 |
| 103 TOTAL | 20461033 | 11007 | 20472040 | | 20472040 | 103 |

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

| COST CENTER DESCRIPTION | ----- CHARGES ----- | | | COST OR OTHER RATIO 9 | TEFRA INPATIENT RATIO 10 | PPS INPATIENT RATIO 11 |
|-------------------------------------|---------------------|-----------------|------------|--------------------------------|-----------------------------------|---------------------------------|
| | INPATIENT 6 | OUTPATIENT 7 | TOTAL 8 | | | |
| INPATIENT ROUTINE SERV COST CENTERS | | | | | | |
| 25 ADULTS & PEDIATRICS | 2499603 | | 2499603 | | | 25 |
| 34 SKILLED NURSING FACILITY | 1400027 | | 1400027 | | | 34 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 37 OPERATING ROOM | 646383 | 2254666 | 2901049 | .456144 | .456144 | .456144 37 |
| 40 ANESTHESIOLOGY | 7863 | 87927 | 95790 | .616745 | .616745 | .616745 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 1525503 | 8234232 | 9759735 | .231251 | .231251 | .231251 41 |
| 44 LABORATORY | 1508497 | 5919777 | 7428274 | .262084 | .262084 | .262084 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMI | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | 221798 | 157555 | 379353 | .214262 | .214262 | .214262 49 |
| 50 PHYSICAL THERAPY | 349224 | 1659313 | 2008537 | .389295 | .394775 | .394775 50 |
| 51 OCCUPATIONAL THERAPY | 253341 | 150901 | 404242 | .361259 | .361259 | .361259 51 |
| 52 SPEECH PATHOLOGY | 40891 | 11705 | 52596 | .443798 | .443798 | .443798 52 |
| 53 ELECTROCARDIOLOGY | 127130 | 534422 | 661552 | .456034 | .456034 | .456034 53 |
| 55 MEDICAL SUPPLIES CHARGED TO | 859614 | 1502054 | 2361668 | .235472 | .235472 | .235472 55 |
| 56 DRUGS CHARGED TO PATIENTS | 1937591 | 893287 | 2830878 | .475305 | .475305 | .475305 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 61 EMERGENCY | 1252874 | 1375014 | 2627888 | .572497 | .572497 | .572497 61 |
| 62 OBSERVATION BEDS (NON-DISTI | | 267464 | 267464 | .656051 | .656051 | .656051 62 |
| 63.50 RHC | | 3104029 | 3104029 | 1.334144 | 1.334144 | 1.334144 63.50 |
| 63.60 FQHC | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 101 SUBTOTAL | 12630339 | 26152346 | 38782685 | | | 101 |
| 102 LESS OBSERVATION BEDS | | | | | | 102 |
| 103 TOTAL | 12630339 | 26152346 | 38782685 | | | 103 |

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1318) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

| COST CENTER DESCRIPTION | COST TO CHARGE RATIO FROM WORKSHEET C, | | | PROGRAM CHARGES | | |
|---|--|----------------|----------------|--|-------------------------|-----------------------------------|
| | PART II | PART I | PART II | OUTPATIENT AMBULATORY SURGICAL CENTER | OUTPATIENT RADIOLOGY | OTHER OUTPATIENT DIAGNOSTIC |
| | COL. 8 1 | COL. 9 1.01 | COL. 9 1.02 | 2 | 3 | 4 |
| 37 ANCILLARY SERVICE COST CENTERS | | | | | | |
| 40 OPERATING ROOM | .456144 | .456144 | .456144 | | | 37 |
| 41 ANESTHESIOLOGY | .616745 | .616745 | .616745 | | | 40 |
| 44 RADIOLOGY-DIAGNOSTIC | .231251 | .231251 | .231251 | | | 41 |
| 46.30 LABORATORY | .262084 | .262084 | .262084 | | | 44 |
| 49 BLOOD CLOTTING FACTORS ADMIN CO | | | | | | 46.30 |
| 50 RESPIRATORY THERAPY | .214262 | .214262 | .214262 | | | 49 |
| 51 PHYSICAL THERAPY | .389295 | .389295 | .389295 | | | 50 |
| 52 OCCUPATIONAL THERAPY | .361259 | .361259 | .361259 | | | 51 |
| 53 SPEECH PATHOLOGY | .443798 | .443798 | .443798 | | | 52 |
| 55 ELECTROCARDIOLOGY | .456034 | .456034 | .456034 | | | 53 |
| 56 MEDICAL SUPPLIES CHARGED TO PAT | .235472 | .235472 | .235472 | | | 55 |
| 61 DRUGS CHARGED TO PATIENTS | .475305 | .475305 | .475305 | | | 56 |
| 62 OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 63.50 EMERGENCY | .572497 | .572497 | .572497 | | | 61 |
| 63.60 OBSERVATION BEDS (NON-DISTINCT) | .656051 | .656051 | .656051 | | | 62 |
| 65.01 RHC | 1.334144 | 1.334144 | 1.334144 | | | 63.50 |
| 65.02 FQHC | | | | | | 63.60 |
| 65.03 OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 101 65.01 AMBULANCE CHARGES (S-2 LINE 56. | | | | | | 65.01 |
| 102 65.02 AMBULANCE CHARGES (S-2 LINE 56. | | | | | | 65.02 |
| 103 65.03 AMBULANCE CHARGES (S-2 LINE 56. | | | | | | 65.03 |
| 104 SUBTOTAL | | | | | | 101 |
| 102 CRNA CHARGES | | | | | | 102 |
| 103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS | | | | | | 103 |
| 104 NET CHARGES | | | | | | 104 |

PART VI - VACCINE COST APPORTIONMENT

| | | |
|--|---------|------|
| 1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES | 1 | |
| 2 VACCINE CHARGES (OTHER THAN HEPATITIS B) | .475305 | 1 |
| 2.01 VACCINE CHARGES - HEPATITIS B | | 2 |
| 3 VACCINE COSTS (OTHER THAN HEPATITIS B) | | 2.01 |
| 3.01 VACCINE COSTS - HEPATITIS B | | 3 |
| | | 3.01 |

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1318) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

| COST CENTER DESCRIPTION | PROGRAM CHARGES | | | | | PROGRAM COST | | |
|--------------------------------------|-----------------|----------------|---------------|----------------|----------------|---------------------------------------|----------------------|-----------------------------|
| | ALL OTHER (1) | PPS SER- VICES | ALL OTHER | PPS SER- VICES | PPS SER- VICES | OUTPATIENT AMBULATORY SURGICAL CENTER | OUTPATIENT RADIOLOGY | OTHER OUTPATIENT DIAGNOSTIC |
| | (SEE INSTRU.) | (SEE INSTRU.) | (SEE INSTRU.) | (SEE INSTRU.) | (SEE INSTRU.) | 6 | 7 | 8 |
| 37 ANCILLARY SERVICE COST CENTERS | | | | | | | | |
| 37 OPERATING ROOM | 625848 | | | | | | | 37 |
| 40 ANESTHESIOLOGY | 447 | | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 2897093 | | | | | | | 41 |
| 44 LABORATORY | 2723249 | | | | | | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN C | | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | 15111 | | | | | | | 49 |
| 50 PHYSICAL THERAPY | 606898 | | | | | | | 50 |
| 51 OCCUPATIONAL THERAPY | 77316 | | | | | | | 51 |
| 52 SPEECH PATHOLOGY | 4600 | | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | 295344 | | | | | | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PA | 469513 | | | | | | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | 396452 | | | | | | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 61 EMERGENCY | 910007 | | | | | | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | 133054 | | | | | | | 62 |
| 63.50 RHC | | | | | | | | 63.50 |
| 63.60 FQHC | | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | |
| 65.01 AMBULANCE CHARGES (S-2 LINE 56 | | | | | | | | 65.01 |
| 65.02 AMBULANCE CHARGES (S-2 LINE 56 | | | | | | | | 65.02 |
| 65.03 AMBULANCE CHARGES (S-2 LINE 56 | | | | | | | | 65.03 |
| 101 SUBTOTAL | 9154932 | | | | | | | 101 |
| 102 CRNA CHARGES | | | | | | | | 102 |
| 103 PBP CLINIC LAB | | | | | | | | 103 |
| 104 NET CHARGES | 9154932 | | | | | | | 104 |

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

| | | | | | | |
|------------|------|------------------|------|--------------------|-----|---------|
| CHECK | [] | TITLE V - O/P | [XX] | HOSPITAL (14-1318) | [] | SNF |
| APPLICABLE | [XX] | TITLE XVIII-PT B | [] | SUB I | [] | NF |
| BOXES | [] | TITLE XIX - O/P | [] | SUB II | [] | S/B-SNF |
| | | | [] | SUB III | [] | S/B-NF |
| | | | [] | SUB IV | [] | ICF/MR |

| COST CENTER DESCRIPTION | PROGRAM COST | | | | | HOSPITAL | HOSPITAL |
|---|-------------------------|---|-------------------------------------|---|---|---|--|
| | ALL OTHER (COLS 1x5) | PPS SERVICES (COLUMNS 1.01x5.01) | ALL OTHER (COLUMNS 1.01x5.02) | PPS SERVICES (COLUMNS 1.01x5.03) | PPS SERVICES (COLUMNS 1.01x5.04) | I/P PART B CHARGES (SEE INSTRU.) | I/P PART B COST (COLUMNS 1.02x10) |
| | 9 | 9.01 | 9.02 | 9.03 | 9.04 | 10 | 11 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 37 OPERATING ROOM | 285477 | | | | | | 37 |
| 40 ANESTHESIOLOGY | 276 | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 669956 | | | | | | 41 |
| 44 LABORATORY | 713720 | | | | | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | 3238 | | | | | | 49 |
| 50 PHYSICAL THERAPY | 236262 | | | | | | 50 |
| 51 OCCUPATIONAL THERAPY | 27931 | | | | | | 51 |
| 52 SPEECH PATHOLOGY | 2041 | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | 134687 | | | | | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | 110557 | | | | | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | 188436 | | | | | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 61 EMERGENCY | 520976 | | | | | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | 87290 | | | | | | 62 |
| 63.50 RHC | | | | | | | 63.50 |
| 63.60 FQHC | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 65.01 AMBULANCE CHARGES (S-2 LINE 56. | | | | | | | 65.01 |
| 65.02 AMBULANCE CHARGES (S-2 LINE 56. | | | | | | | 65.02 |
| 65.03 AMBULANCE CHARGES (S-2 LINE 56. | | | | | | | 65.03 |
| 101 SUBTOTAL | 2980847 | | | | | | 101 |
| 102 CRNA CHARGES | | | | | | | 102 |
| 103 LESS FBP CLINIC LAB SERV-PGM ONLY CHRGS | | | | | | | 103 |
| 104 NET CHARGES | 2980847 | | | | | | 104 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2007 TO 09/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2007.06
 02/26/2009 12:14

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB IV [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB I [XX] SNF (14-5528) [] TEFRA
 BOXES [] TITLE XIX [] SUB II [] NF
 [] SUB III [] ICF/MR

| COST CENTER DESCRIPTION | OUTPATIENT | | | N/A | N/A | N/A | TOTAL COSTS |
|------------------------------------|-------------------------------|-------------------------------|------------------------|------|------|------|-------------|
| | NONPHYSICIAN ANESTHETIST COST | NONPHYSICIAN ANESTHETIST COST | MEDICAL EDUCATION COST | | | | |
| | 1 | 1.01 | 2 | 2.01 | 2.02 | 2.03 | 3 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 37 OPERATING ROOM | | | | | | | 37 |
| 40 ANESTHESIOLOGY | | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | | | | | | | 41 |
| 44 LABORATORY | | | | | | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | | | | | | | 49 |
| 50 PHYSICAL THERAPY | | | | | | | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | | | | | | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO P | | | | | | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | | | | | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 61 EMERGENCY | | | | | | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINC | | | | | | | 62 |
| 63.50 RHC | | | | | | | 63.50 |
| 63.60 FQHC | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 101 TOTAL | | | | | | | 101 |

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB IV [] PFS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB I [XX] SNF (14-5528) [] TEFRA
 BOXES [] TITLE XIX [] SUB II [] NF
 [] SUB III [] ICF/MR

| COST CENTER DESCRIPTION | OUTPATIENT PASS THROUGH COSTS 3.01 | TOTAL CHARGES 4 | RATIO OF COST TO CHARGES 5 | OUTPATIENT RATIO OF COST TO CHARGES 5.01 | INPATIENT PROGRAM CHARGES 6 | INPATIENT PROGRAM PASS THROUGH COSTS 7 | OUTPATIENT PROGRAM CHARGES 8 |
|------------------------------------|---|-----------------------|-------------------------------------|---|--------------------------------------|--|---------------------------------------|
| ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 37 OPERATING ROOM | | 2901049 | | | | | 37 |
| 40 ANESTHESIOLOGY | | 95790 | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | | 9759735 | | | 2496 | | 41 |
| 44 LABORATORY | | 7428274 | | | 7452 | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | | 379353 | | | 3818 | | 49 |
| 50 PHYSICAL THERAPY | | 2008537 | | | 5903 | | 50 |
| 51 OCCUPATIONAL THERAPY | | 404242 | | | 7064 | | 51 |
| 52 SPEECH PATHOLOGY | | 52596 | | | 5628 | | 52 |
| 53 ELECTROCARDIOLOGY | | 661552 | | | 189 | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO P | | 2361668 | | | 9270 | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | 2830878 | | | 38421 | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 61 EMERGENCY | | 2627888 | | | | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINC | | 267464 | | | | | 62 |
| 63.50 RHC | | 3104029 | | | | | 63.50 |
| 63.60 FQHC | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 101 TOTAL | | 31779026 | | | 80241 | | 101 |

APPORIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB IV [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB I [XX] SNF (14-5528) [] TEFRA
 BOXES [] TITLE XIX [] SUB II [] NF
 [] SUB III [] ICF/MR

| COST CENTER DESCRIPTION | OUTPATIENT PROGRAM CHARGES 8.01 | OUTPATIENT PROGRAM CHARGES 8.02 | OUTPATIENT PROGRAM PASS THROUGH COSTS 9 | OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01 | OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02 |
|------------------------------------|--|--|---|--|--|
| ANCILLARY SERVICE COST CENTERS | | | | | |
| 37 OPERATING ROOM | | | | | 37 |
| 40 ANESTHESIOLOGY | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | | | | | 41 |
| 44 LABORATORY | | | | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | | | | | 49 |
| 50 PHYSICAL THERAPY | | | | | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | 52 |
| 53 ELECTROCARDIOLOGY | | | | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO P | | | | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | | | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | |
| 61 EMERGENCY | | | | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINC | | | | | 62 |
| 63.50 RHC | | | | | 63.50 |
| 63.60 FQHC | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | |
| 101 TOTAL | | | | | 101 |

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

| COST CENTER DESCRIPTION | OLD CAPITAL | | | NEW CAPITAL | | | |
|---------------------------------|----------------------|----------------------|------------------------------|----------------------|----------------------|------------------------------|----|
| | CAPITAL RELATED COST | SWING-BED ADJUSTMENT | REDUCED CAPITAL RELATED COST | CAPITAL RELATED COST | SWING-BED ADJUSTMENT | REDUCED CAPITAL RELATED COST | |
| | 1 | 2 | 3 | 4 | 5 | 6 | |
| 25 INPAT ROUTINE SERV COST CTRS | | | | | | | |
| 25 ADULTS & PEDIATRICS | | | | | | | |
| 26 INTENSIVE CARE UNIT | | | | 281086 | 74956 | 206130 | 25 |
| 27 CORONARY CARE UNIT | | | | | | | 26 |
| 28 BURN INTENSIVE CARE UNIT | | | | | | | 27 |
| 29 SURGICAL INTENSIVE CARE UNIT | | | | | | | 28 |
| 30 OTHER SPECIAL CARE (SPECIFY) | | | | | | | 29 |
| 31 SUBPROVIDER I | | | | | | | 30 |
| 33 NURSERY | | | | | | | 31 |
| 101 TOTAL | | | | 281086 | | 206130 | 33 |

| COST CENTER DESCRIPTION | OLD CAPITAL | | | NEW CAPITAL | | | |
|---------------------------------|--------------------|------------------------|----------|--------------------------------|----------|--------------------------------|-----|
| | TOTAL PATIENT DAYS | INPATIENT PROGRAM DAYS | PER DIEM | INPATIENT PROGRAM CAPITAL COST | PER DIEM | INPATIENT PROGRAM CAPITAL COST | |
| | 7 | 8 | 9 | 10 | 11 | 12 | |
| 25 INPAT ROUTINE SERV COST CTRS | | | | | | | |
| 25 ADULTS & PEDIATRICS | 3091 | 140 | | | 66.69 | 9337 | 25 |
| 26 INTENSIVE CARE UNIT | | | | | | | 26 |
| 27 CORONARY CARE UNIT | | | | | | | 27 |
| 28 BURN INTENSIVE CARE UNIT | | | | | | | 28 |
| 29 SURGICAL INTENSIVE CARE UNIT | | | | | | | 29 |
| 30 OTHER SPECIAL CARE (SPECIFY) | | | | | | | 30 |
| 31 SUBPROVIDER I | | | | | | | 31 |
| 33 NURSERY | | | | | | | 33 |
| 101 TOTAL | 3091 | 140 | | | | 9337 | 101 |

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-1318) [] SUB III [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SUB IV [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [] OTHER

| COST CENTER DESCRIPTION | OLD | NEW | INPATIENT | OLD CAPITAL | | NEW CAPITAL | | |
|------------------------------------|----------------------------|----------------------------|-----------|------------------|--------------------------------|------------------|--------------------------------|------------------|
| | CAPITAL RELATED COST | CAPITAL RELATED COST | | TOTAL CHARGES | RATIO OF COST TO CHARGES | CAPITAL COSTS | RATIO OF COST TO CHARGES | CAPITAL COSTS |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | |
| 37 OPERATING ROOM | | 147761 | 2901049 | | | | .050934 | 37 |
| 40 ANESTHESIOLOGY | | 7691 | 95790 | | | | .080290 | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | | 138285 | 9759735 | | | | .014169 | 41 |
| 44 LABORATORY | | 88726 | 7428274 | | | | .011944 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN | | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | | 5702 | 379353 | | | | .015031 | 49 |
| 50 PHYSICAL THERAPY | | 78278 | 2008537 | | | | .038973 | 50 |
| 51 OCCUPATIONAL THERAPY | | 3682 | 404242 | | | | .009108 | 51 |
| 52 SPEECH PATHOLOGY | | 1119 | 52596 | | | | .021275 | 52 |
| 53 ELECTROCARDIOLOGY | | 33788 | 661552 | | | | .051074 | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO P | | 19567 | 2361668 | | | | .008285 | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | 49308 | 2830878 | | | | .017418 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 61 EMERGENCY | | 126415 | 2627888 | | | | .048105 | 61 |
| 62 OBSERVATION BEDS (NON-DISTINC | | | 267464 | | | | | 62 |
| 63.50 RHC | | | 3104029 | | | | | 63.50 |
| 63.60 FQHC | | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | |
| 101 TOTAL | | 700322 | 31779026 | | | | | 101 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2007 TO 09/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2007.06
 02/26/2009 12:14

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

| COST CENTER | DESCRIPTION | NONPHYSICIAN ANESTHETIST COST 1 | MEDICAL EDUCATION COST 2 | SWING-BED ADJUSTMENT AMOUNT 3 | TOTAL COSTS 4 | TOTAL PATIENT DAYS 5 | PER DIEM 6 | INPATIENT PROGRAM DAYS 7 | INPATIENT PROGRAM PASS THRU COSTS 8 |
|-------------|------------------------------|--|-----------------------------------|--|---------------------|-------------------------------|------------------|-----------------------------------|---|
| | INPAT ROUTINE SERV COST CTRS | | | | | | | | |
| 25 | ADULTS & PEDIATRICS | | | | | 3091 | | 140 | 25 |
| 26 | INTENSIVE CARE UNIT | | | | | | | | 26 |
| 27 | CORONARY CARE UNIT | | | | | | | | 27 |
| 28 | BURN INTENSIVE CARE UNIT | | | | | | | | 28 |
| 29 | SURGICAL INTENSIVE CARE UNIT | | | | | | | | 29 |
| 30 | OTHER SPECIAL CARE (SPECIFY) | | | | | | | | 30 |
| 31 | SUBPROVIDER I | | | | | | | | 31 |
| 33 | NURSERY | | | | | | | | 33 |
| 34 | SKILLED NURSING FACILITY | | | | | 9233 | | | 34 |
| 35 | NURSING FACILITY | | | | | | | | 35 |
| 101 | TOTAL | | | | | 12324 | | 140 | 101 |

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-1318) [] SUB IV [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [] NF [] OTHER
 [] SUB III [] ICF/MR

| COST CENTER DESCRIPTION | OUTPATIENT | | | N/A | N/A | N/A | TOTAL COSTS |
|------------------------------------|-------------------------------|-------------------------------|------------------------|------|------|------|-------------|
| | NONPHYSICIAN ANESTHETIST COST | NONPHYSICIAN ANESTHETIST COST | MEDICAL EDUCATION COST | | | | |
| | 1 | 1.01 | 2 | 2.01 | 2.02 | 2.03 | 3 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 37 OPERATING ROOM | | | | | | | 37 |
| 40 ANESTHESIOLOGY | | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | | | | | | | 41 |
| 44 LABORATORY | | | | | | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | | | | | | | 49 |
| 50 PHYSICAL THERAPY | | | | | | | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | | | | | | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO P | | | | | | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | | | | | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 61 EMERGENCY | | | | | | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINC | | | | | | | 62 |
| 63.50 RHC | | | | | | | 63.50 |
| 63.60 FQHC | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 101 TOTAL | | | | | | | 101 |

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-1318) [] SUB IV [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [] NF [] OTHER
 [] SUB III [] ICF/MR

| COST CENTER DESCRIPTION | OUTPATIENT | TOTAL | RATIO OF | OUTPATIENT | INPATIENT | INPATIENT | OUTPATIENT |
|------------------------------------|--------------|----------|----------|---------------|-----------|--------------|------------|
| | PASS THROUGH | | COST TO | RATIO OF COST | PROGRAM | PROGRAM | |
| | COSTS | CHARGES | CHARGES | TO CHARGES | CHARGES | PASS THROUGH | CHARGES |
| | 3.01 | 4 | 5 | 5.01 | 6 | 7 | 8 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 37 OPERATING ROOM | | 2901049 | | | | | 37 |
| 40 ANESTHESIOLOGY | | 95790 | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | | 9759735 | | | | | 41 |
| 44 LABORATORY | | 7428274 | | | | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | | 379353 | | | | | 49 |
| 50 PHYSICAL THERAPY | | 2008537 | | | | | 50 |
| 51 OCCUPATIONAL THERAPY | | 404242 | | | | | 51 |
| 52 SPEECH PATHOLOGY | | 52596 | | | | | 52 |
| 53 ELECTROCARDIOLOGY | | 661552 | | | | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO P | | 2361668 | | | | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | 2830878 | | | | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 61 EMERGENCY | | 2627888 | | | | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINC | | 267464 | | | | | 62 |
| 63.50 RHC | | 3104029 | | | | | 63.50 |
| 63.60 FQHC | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 101 TOTAL | | 31779026 | | | | | 101 |

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-1318) [] SUB IV [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [] NF [] OTHER
 [] SUB III [] ICF/MR

| COST CENTER DESCRIPTION | OUTPATIENT PROGRAM CHARGES 8.01 | OUTPATIENT PROGRAM CHARGES 8.02 | OUTPATIENT PROGRAM PASS THROUGH COSTS 9 | OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01 | OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02 | |
|------------------------------------|------------------------------------|------------------------------------|--|---|---|-------|
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 37 OPERATING ROOM | | | | | | 37 |
| 40 ANESTHESIOLOGY | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | | | | | | 41 |
| 44 LABORATORY | | | | | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | | | | | | 49 |
| 50 PHYSICAL THERAPY | | | | | | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | | | | | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO P | | | | | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | | | | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 61 EMERGENCY | | | | | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINC | | | | | | 62 |
| 63.50 RHC | | | | | | 63.50 |
| 63.60 FQHC | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 101 TOTAL | | | | | | 101 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

| | HOSPITAL (OTHER) (14-1318) | SUB I | SUB II | SUB III | SUB IV | SNF (PPS) (14-5528) | |
|---|----------------------------------|-------|--------|---------|--------|---------------------------|----|
| INPATIENT DAYS | 1 | 1 | 1 | 1 | 1 | 1 | |
| 1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN) | 4215 | | | | | 9233 | 1 |
| 2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS) | 3091 | | | | | 9233 | 2 |
| 3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS) | | | | | | | 3 |
| 4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS) | 3091 | | | | | 9233 | 4 |
| 5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | 1124 | | | | | | 5 |
| 6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 6 |
| 7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 7 |
| 8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 8 |
| 9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS) | 1164 | | | | | 248 | 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 | 1124 | | | | | | 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 | | | | | | | 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 | | | | | | | 13 |
| 14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS) | | | | | | | 14 |
| 15 TOTAL NURSERY DAYS | | | | | | | 15 |
| 16 TITLE V OR XIX NURSERY DAYS | | | | | | | 16 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I (CONT)

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

| | HOSPITAL (OTHER) (14-1318) | SUB I | SUB II | SUB III | SUB IV | SNF (PPS) (14-5528) | |
|---|----------------------------------|-------|--------|---------|--------|---------------------------|----|
| SWING-BED ADJUSTMENT | | | | | | | |
| | 1 | 1 | 1 | 1 | 1 | 1 | |
| 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 | 100.00 | | | | | | 19 |
| 20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | 100.00 | | | | | | 20 |
| 21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST | 2801520 | | | | | | 21 |
| 22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | 3191775 | 22 |
| 23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 23 |
| 24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 24 |
| 25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 25 |
| 26 TOTAL SWING-BED COST | 747067 | | | | | | 26 |
| 27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST | 2054453 | | | | | 3191775 | 27 |
| PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | | | | | | |
| 28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES) | 1635951 | | | | | 1400027 | 28 |
| 29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES) | | | | | | | 29 |
| 30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES) | 1635951 | | | | | 1400027 | 30 |
| 31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO | 1.255816 | | | | | 2.279795 | 31 |
| 32 AVERAGE PRIVATE ROOM PER DIEM CHARGE | | | | | | | 32 |
| 33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE | 529.26 | | | | | 151.63 | 33 |
| 34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL | | | | | | | 34 |
| 35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL | | | | | | | 35 |
| 36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT | | | | | | | 36 |
| 37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL | 2054453 | | | | | 3191775 | 37 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

| | HOSPITAL (OTHER) (14-1318) | SUB I | SUB II | SUB III | SUB IV | |
|--|----------------------------------|-------------------|---------------------|-----------------|-----------------|----|
| PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS | 1 | 1 | 1 | 1 | 1 | |
| 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM | 664.65 | | | | | 38 |
| 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST | 773653 | | | | | 39 |
| 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM | | | | | | 40 |
| 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST | 773653 | | | | | 41 |
| | TOTAL I/P COST | TOTAL I/P DAYS | AVERAGE PER DIEM | PROGRAM DAYS | PROGRAM COST | |
| | 1 | 2 | 3 | 4 | 5 | |
| 42 NURSERY (TITLES V AND XIX ONLY) | | | | | | 42 |
| 43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS | | | | | | 43 |
| 44 INTENSIVE CARE UNIT | | | | | | 44 |
| 45 CORONARY CARE UNIT | | | | | | 45 |
| 46 BURN INTENSIVE CARE UNIT | | | | | | 46 |
| 47 SURGICAL INTENSIVE CARE UNIT | | | | | | 47 |
| 47 OTHER SPECIAL CARE (SPECIFY) | | | | | | 47 |
| | HOSPITAL (OTHER) (14-1318) | SUB I | SUB II | SUB III | SUB IV | |
| | 1 | 1 | 1 | 1 | 1 | |
| 48 PROGRAM INPATIENT ANCILLARY SERVICE COST | 981357 | | | | | 48 |
| 49 TOTAL PROGRAM INPATIENT COSTS | 1755010 | | | | | 49 |
| | PASS THROUGH COST ADJUSTMENTS | | | | | |
| 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES | | | | | | 50 |
| 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES | | | | | | 51 |
| 52 TOTAL PROGRAM EXCLUDABLE COST | | | | | | 52 |
| 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS | | | | | | 53 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II (CONT)

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

| | HOSPITAL (OTHER) (14-1318) | SUB I | SUB II | SUB III | SUB IV | |
|--|----------------------------------|-------|--------|---------|--------|-------|
| TARGET AMOUNT AND LIMITATION COMPUTATION | | | | | | |
| 54 | 1 | 1 | 1 | 1 | 1 | |
| 54 | | | | | | 54 |
| 55 | | | | | | 55 |
| 56 | | | | | | 56 |
| 57 | | | | | | 57 |
| 58 | | | | | | 58 |
| 58.01 | | | | | | 58.01 |
| 58.02 | | | | | | 58.02 |
| 58.03 | | | | | | 58.03 |
| 58.04 | | | | | | 58.04 |
| 59 | | | | | | 59 |
| 59.01 | | | | | | 59.01 |
| 59.02 | | | | | | 59.02 |
| 59.03 | | | | | | 59.03 |
| 59.04 | | | | | | 59.04 |
| 59.05 | | | | | | 59.05 |
| 59.06 | | | | | | 59.06 |
| 59.07 | | | | | | 59.07 |
| 59.08 | | | | | | 59.08 |
| PROGRAM INPATIENT ROUTINE SWING BED COST | | | | | | |
| 60 | 747067 | | | | | 60 |
| 61 | | | | | | 61 |
| 62 | 747067 | | | | | 62 |
| 63 | | | | | | 63 |
| 64 | | | | | | 64 |
| 65 | | | | | | 65 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PARTS III & IV

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

| | SNF (PPS) (14-5528) 1 | |
|---|--------------------------------|----|
| 66 SNF/NF/ICF/MR ROUTINE SERVICE COST | 3191775 | 66 |
| 67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM | 345.69 | 67 |
| 68 PROGRAM ROUTINE SERVICE COST | 85731 | 68 |
| 69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM | | 69 |
| 70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS | 85731 | 70 |
| 71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS | 189989 | 71 |
| 72 PER DIEM CAPITAL RELATED COSTS | 20.58 | 72 |
| 73 PROGRAM CAPITAL RELATED COSTS | 5104 | 73 |
| 74 INPATIENT ROUTINE SERVICE COST | 80627 | 74 |
| 75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS | | 75 |
| 76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT | 80627 | 76 |
| 77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION | | 77 |
| 78 INPATIENT ROUTINE SERVICE COST LIMITATION | | 78 |
| 79 REASONABLE INPATIENT ROUTINE SERVICE COSTS | 85731 | 79 |
| 80 PROGRAM INPATIENT ANCILLARY SERVICES | 31227 | 80 |
| 81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION | | 81 |
| 82 TOTAL PROGRAM INPATIENT OPERATING COSTS | 116958 | 82 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2007 TO 09/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2007.06
02/26/2009 12:14

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

| HOSPITAL (OTHER) (14-1318) | SUB I | SUB II | SUB III | SUB IV |
|----------------------------------|-------|--------|---------|--------|
| 1 | 1 | 1 | 1 | 1 |

PART IV - COMPUTATION OF OBSERVATION BED COST

| | | |
|---|--------|----|
| 83 TOTAL OBSERVATION BEDS | 264 | 83 |
| 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM | 664.66 | 84 |
| 85 OBSERVATION BED COST | 175470 | 85 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

| | HOSPITAL (PPS) (14-1318) | SUB I | SUB II | SUB III | SUB IV | NF | |
|---|--------------------------------|-------|--------|---------|--------|----|----|
| INPATIENT DAYS | 1 | 1 | 1 | 1 | 1 | 1 | |
| 1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN) | 4215 | | | | | | 1 |
| 2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS) | 3091 | | | | | | 2 |
| 3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS) | | | | | | | 3 |
| 4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS) | 3091 | | | | | | 4 |
| 5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | 1124 | | | | | | 5 |
| 6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 6 |
| 7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 7 |
| 8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 8 |
| 9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS) | 140 | | | | | | 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 | | | | | | | 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 | | | | | | | 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 | | | | | | | 13 |
| 14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS) | | | | | | | 14 |
| 15 TOTAL NURSERY DAYS | | | | | | | 15 |
| 16 TITLE V OR XIX NURSERY DAYS | | | | | | | 16 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I (CONT)

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

| | HOSPITAL (PPS) (14-1318) | SUB I | SUB II | SUB III | SUB IV | NF | |
|---|--------------------------------|-------|--------|---------|--------|----|----|
| SWING-BED ADJUSTMENT | 1 | 1 | 1 | 1 | 1 | 1 | |
| 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 | 100.00 | | | | | | 19 |
| 20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | 100.00 | | | | | | 20 |
| 21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST | 2801520 | | | | | | 21 |
| 22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 22 |
| 23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 23 |
| 24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 24 |
| 25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 25 |
| 26 TOTAL SWING-BED COST | 747067 | | | | | | 26 |
| 27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST | 2054453 | | | | | | 27 |
| PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | | | | | | |
| 28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES) | 1635951 | | | | | | 28 |
| 29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES) | | | | | | | 29 |
| 30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES) | 1635951 | | | | | | 30 |
| 31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO | 1.255816 | | | | | | 31 |
| 32 AVERAGE PRIVATE ROOM PER DIEM CHARGE | | | | | | | 32 |
| 33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE | 529.26 | | | | | | 33 |
| 34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL | | | | | | | 34 |
| 35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL | | | | | | | 35 |
| 36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT | | | | | | | 36 |
| 37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL | 2054453 | | | | | | 37 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

| | HOSPITAL (PPS) (14-1318) | SUB I | SUB II | SUB III | SUB IV | |
|--|--------------------------------|-------------------|---------------------|-----------------|-----------------|-----------------|
| PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS | 1 | 1 | 1 | 1 | 1 | |
| 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM | 664.65 | | | | | 38 |
| 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST | 93051 | | | | | 39 |
| 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM | | | | | | 40 |
| 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST | 93051 | | | | | 41 |
| | TOTAL I/P COST | TOTAL I/P DAYS | AVERAGE PER DIEM | PROGRAM DAYS | PROGRAM DAYS | PROGRAM COST |
| | 1 | 2 | 3 | 4 | 5 | |
| 42 NURSERY (TITLES V AND XIX ONLY) | | | | | | 42 |
| 43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS | | | | | | |
| 44 INTENSIVE CARE UNIT | | | | | | 43 |
| 45 CORONARY CARE UNIT | | | | | | 44 |
| 46 BURN INTENSIVE CARE UNIT | | | | | | 45 |
| 47 SURGICAL INTENSIVE CARE UNIT | | | | | | 46 |
| 47 OTHER SPECIAL CARE (SPECIFY) | | | | | | 47 |
| | HOSPITAL (PPS) (14-1318) | SUB I | SUB II | SUB III | SUB IV | |
| | 1 | 1 | 1 | 1 | 1 | |
| 48 PROGRAM INPATIENT ANCILLARY SERVICE COST | | | | | | 48 |
| 49 TOTAL PROGRAM INPATIENT COSTS | 93051 | | | | | 49 |
| PASS THROUGH COST ADJUSTMENTS | | | | | | |
| 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES | 9337 | | | | | 50 |
| 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES | | | | | | 51 |
| 52 TOTAL PROGRAM EXCLUDABLE COST | 9337 | | | | | 52 |
| 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS | 83714 | | | | | 53 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II (CONT)

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

| | HOSPITAL (PPS) (14-1318) | SUB I | SUB II | SUB III | SUB IV | |
|--|--------------------------------|-------|--------|---------|--------|--|
| TARGET AMOUNT AND LIMITATION COMPUTATION | | | | | | |
| 54 | 1 | 1 | 1 | 1 | 1 | 54 |
| 54 | | | | | | PROGRAM DISCHARGES |
| 55 | | | | | | TARGET AMOUNT PER DISCHARGE |
| 56 | | | | | | TARGET AMOUNT |
| 57 | | | | | | DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT |
| 58 | | | | | | BONUS PAYMENT |
| 58.01 | | | | | | LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET |
| 58.02 | | | | | | LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET |
| 58.03 | | | | | | IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT |
| 58.04 | | | | | | RELIEF PAYMENT |
| 59 | | | | | | ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT |
| 59.01 | | | | | | ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY) |
| 59.02 | | | | | | PROGRAM DISCHARGES PRIOR TO JULY 1 |
| 59.03 | | | | | | PROGRAM DISCHARGES AFTER JULY 1 |
| 59.04 | | | | | | PROGRAM DISCHARGES (SEE INSTRUCTIONS) |
| 59.05 | | | | | | REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1 |
| 59.06 | | | | | | REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 |
| 59.07 | | | | | | REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY) |
| 59.08 | | | | | | REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.) |
| PROGRAM INPATIENT ROUTINE SWING BED COST | | | | | | |
| 60 | | | | | | MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD |
| 61 | | | | | | MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD |
| 62 | | | | | | TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS |
| 63 | | | | | | TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD |
| 64 | | | | | | TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD |
| 65 | | | | | | TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2007 TO 09/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2007.06
02/26/2009 12:14

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY NF

| | | | |
|----|--|---|----|
| 66 | SNF/NF/ICF/MR ROUTINE SERVICE COST | 1 | 66 |
| 67 | ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM | | 67 |
| 68 | PROGRAM ROUTINE SERVICE COST | | 68 |
| 69 | MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM | | 69 |
| 70 | TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS | | 70 |
| 71 | CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS | | 71 |
| 72 | PER DIEM CAPITAL RELATED COSTS | | 72 |
| 73 | PROGRAM CAPITAL RELATED COSTS | | 73 |
| 74 | INPATIENT ROUTINE SERVICE COST | | 74 |
| 75 | AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS | | 75 |
| 76 | TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT | | 76 |
| 77 | INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION | | 77 |
| 78 | INPATIENT ROUTINE SERVICE COST LIMITATION | | 78 |
| 79 | REASONABLE INPATIENT ROUTINE SERVICE COSTS | | 79 |
| 80 | PROGRAM INPATIENT ANCILLARY SERVICES | | 80 |
| 81 | UTILIZATION REVIEW--PHYSICIAN COMPENSATION | | 81 |
| 82 | TOTAL PROGRAM INPATIENT OPERATING COSTS | | 82 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PARTS III & IV

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

HOSPITAL (PPS) (14-1318) SUB I SUB II SUB III SUB IV

1 1 1 1 1

PART IV - COMPUTATION OF OBSERVATION BED COST

| | | | | | | | |
|----|--|--------|--|--|--|--|----|
| 83 | TOTAL OBSERVATION BEDS | 264 | | | | | 83 |
| 84 | ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM | 664.66 | | | | | 84 |
| 85 | OBSERVATION BED COST | 175470 | | | | | 85 |

COMPUTATION OF OBSERVATION BED PASS THROUGH COST - HOSPITAL ROUTINE COST (FROM LINE 27)

| | COST 1 | HOSPITAL ROUTINE COST (FROM LINE 27) 2 | COLUMN 1 DIVIDED BY COLUMN 2 3 | TOTAL OBSERVATION BED COST (FROM LINE 85) 4 | OBSERVATION BED PASS-THROUGH COST COL 3 TIMES COL 4 5 | |
|----|---------------------------|--|---|---|--|----|
| 86 | OLD CAPITAL-RELATED COST | 2054453 | | 175470 | | 86 |
| 87 | NEW CAPITAL-RELATED COST | 2054453 | | 175470 | | 87 |
| 88 | NON PHYSICIAN ANESTHETIST | 2054453 | | 175470 | | 88 |
| 89 | MEDICAL EDUCATION | 2054453 | | 175470 | | 89 |

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

| | | | |
|--|--|----------------------------------|---|
| <input type="checkbox"/> TITLE V | <input checked="" type="checkbox"/> HOSPITAL (14-1318) | <input type="checkbox"/> SNF | <input type="checkbox"/> PPS |
| <input checked="" type="checkbox"/> TITLE XVIII-PT A | <input type="checkbox"/> SUB I | <input type="checkbox"/> NF | <input type="checkbox"/> TEFRA |
| <input type="checkbox"/> TITLE XIX | <input type="checkbox"/> SUB II | <input type="checkbox"/> S/B-SNF | <input checked="" type="checkbox"/> OTHER |
| | <input type="checkbox"/> SUB III | <input type="checkbox"/> S/B-NF | |
| | <input type="checkbox"/> SUB IV | <input type="checkbox"/> ICF/MR | |

| COST CENTER DESCRIPTION | RATIO OF COST | INPATIENT | INPATIENT | |
|---|---------------|-----------------|---------------|-------|
| | TO CHARGES | PROGRAM CHARGES | PROGRAM COSTS | |
| | 1 | 2 | 3 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | |
| 25 ADULTS & PEDIATRICS | | 1291171 | | 25 |
| ANCILLARY SERVICE COST CENTERS | | | | |
| 37 OPERATING ROOM | .456144 | 285012 | 130007 | 37 |
| 40 ANESTHESIOLOGY | .616745 | 3560 | 2196 | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | .231251 | 531860 | 122993 | 41 |
| 44 LABORATORY | .262084 | 629140 | 164888 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | 46.30 |
| 49 RESPIRATORY THERAPY | .214262 | 130401 | 27940 | 49 |
| 50 PHYSICAL THERAPY | .389295 | 64177 | 24984 | 50 |
| 51 OCCUPATIONAL THERAPY | .361259 | 26973 | 9744 | 51 |
| 52 SPEECH PATHOLOGY | .443798 | 13832 | 6139 | 52 |
| 53 ELECTROCARDIOLOGY | .456034 | 1204 | 549 | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | .235472 | 409515 | 96429 | 55 |
| 56 DRUGS CHARGED TO PATIENTS | .475305 | 829805 | 394410 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | |
| 61 EMERGENCY | .572497 | 1883 | 1078 | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | .656051 | | | 62 |
| OTHER REIMBURSABLE COST CENTERS | | | | |
| 63.50 RHC | 1.334144 | | | 63.50 |
| 63.60 FQHC | | | | 63.60 |
| 101 TOTAL | | 2927362 | 981357 | 101 |
| 102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES | | | | 102 |
| 103 NET CHARGES | | 2927362 | | 103 |

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

| | | | |
|--|-----------------------------------|---|---|
| <input type="checkbox"/> TITLE V | <input type="checkbox"/> HOSPITAL | <input checked="" type="checkbox"/> SNF (14-5528) | <input checked="" type="checkbox"/> PPS |
| <input checked="" type="checkbox"/> TITLE XVIII-PT A | <input type="checkbox"/> SUB I | <input type="checkbox"/> NF | <input type="checkbox"/> TEFRA |
| <input type="checkbox"/> TITLE XIX | <input type="checkbox"/> SUB II | <input type="checkbox"/> S/B-SNF | <input type="checkbox"/> OTHER |
| | <input type="checkbox"/> SUB III | <input type="checkbox"/> S/B-NF | |
| | <input type="checkbox"/> SUB IV | <input type="checkbox"/> ICF/MR | |

| COST CENTER DESCRIPTION | RATIO OF COST | INPATIENT | INPATIENT | |
|---|---------------|-----------------|---------------|-------|
| | TO CHARGES | PROGRAM CHARGES | PROGRAM COSTS | |
| | 1 | 2 | 3 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | |
| 25 ADULTS & PEDIATRICS | | | | 25 |
| ANCILLARY SERVICE COST CENTERS | | | | |
| 37 OPERATING ROOM | .456144 | | | 37 |
| 40 ANESTHESIOLOGY | .616745 | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | .231251 | 2496 | 577 | 41 |
| 44 LABORATORY | .262084 | 7452 | 1953 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | 46.30 |
| 49 RESPIRATORY THERAPY | .214262 | 3818 | 818 | 49 |
| 50 PHYSICAL THERAPY | .389295 | 5903 | 2298 | 50 |
| 51 OCCUPATIONAL THERAPY | .361259 | 7064 | 2552 | 51 |
| 52 SPEECH PATHOLOGY | .443798 | 5628 | 2498 | 52 |
| 53 ELECTROCARDIOLOGY | .456034 | 189 | 86 | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | .235472 | 9270 | 2183 | 55 |
| 56 DRUGS CHARGED TO PATIENTS | .475305 | 38421 | 18262 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | |
| 61 EMERGENCY | .572497 | | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS) | .656051 | | | 62 |
| 63.50 RHC | 1.334144 | | | 63.50 |
| 63.60 FQHC | | | | 63.60 |
| 101 TOTAL | | 80241 | 31227 | 101 |
| 102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES | | | | 102 |
| 103 NET CHARGES | | 80241 | | 103 |

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

| | | | |
|--|-----------------------------------|---|---|
| <input type="checkbox"/> TITLE V | <input type="checkbox"/> HOSPITAL | <input type="checkbox"/> SNF | <input type="checkbox"/> PPS |
| <input checked="" type="checkbox"/> TITLE XVIII-PT A | <input type="checkbox"/> SUB I | <input type="checkbox"/> NF | <input type="checkbox"/> TEFRA |
| <input type="checkbox"/> TITLE XIX | <input type="checkbox"/> SUB II | <input checked="" type="checkbox"/> S/B-SNF (14-Z318) | <input checked="" type="checkbox"/> OTHER |
| | <input type="checkbox"/> SUB III | <input type="checkbox"/> S/B-NF | |
| | <input type="checkbox"/> SUB IV | <input type="checkbox"/> ICF/MR | |

| COST CENTER DESCRIPTION | RATIO OF COST | INPATIENT | INPATIENT | |
|---|---------------|-----------------|---------------|-------|
| | TO CHARGES | PROGRAM CHARGES | PROGRAM COSTS | |
| | 1 | 2 | 3 | |
| 25 INPATIENT ROUTINE SERVICE COST CENTERS | | | | 25 |
| ADULTS & PEDIATRICS | | | | |
| 37 ANCILLARY SERVICE COST CENTERS | | | | |
| OPERATING ROOM | .456144 | | | 37 |
| 40 ANESTHESIOLOGY | .616745 | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | .231251 | 65795 | 15215 | 41 |
| 44 LABORATORY | .262084 | 145883 | 38234 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | 46.30 |
| 49 RESPIRATORY THERAPY | .214262 | 47766 | 10234 | 49 |
| 50 PHYSICAL THERAPY | .389295 | 247908 | 96509 | 50 |
| 51 OCCUPATIONAL THERAPY | .361259 | 203608 | 73555 | 51 |
| 52 SPEECH PATHOLOGY | .443798 | 20417 | 9061 | 52 |
| 53 ELECTROCARDIOLOGY | .456034 | 3032 | 1383 | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | .235472 | 120330 | 28334 | 55 |
| 56 DRUGS CHARGED TO PATIENTS | .475305 | 499478 | 237404 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | |
| 61 EMERGENCY | .572497 | | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | .656051 | | | 62 |
| OTHER REIMBURSABLE COST CENTERS | | | | |
| 63.50 RHC | 1.334144 | | | 63.50 |
| 63.60 FQHC | | | | 63.60 |
| 101 TOTAL | | 1354217 | 509929 | 101 |
| 102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES | | | | 102 |
| 103 NET CHARGES | | 1354217 | | 103 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2007 TO 09/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2007.06
 02/26/2009 12:14

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

| | | | |
|---|--|----------------------------------|---|
| <input type="checkbox"/> TITLE V | <input checked="" type="checkbox"/> HOSPITAL (14-1318) | <input type="checkbox"/> SNF | <input checked="" type="checkbox"/> PPS |
| <input type="checkbox"/> TITLE XVIII-PT A | <input type="checkbox"/> SUB I | <input type="checkbox"/> NF | <input type="checkbox"/> TEFRA |
| <input checked="" type="checkbox"/> TITLE XIX | <input type="checkbox"/> SUB II | <input type="checkbox"/> S/B-SNF | <input type="checkbox"/> OTHER |
| | <input type="checkbox"/> SUB III | <input type="checkbox"/> S/B-NF | |
| | <input type="checkbox"/> SUB IV | <input type="checkbox"/> ICF/MR | |

| COST CENTER DESCRIPTION | RATIO OF COST | INPATIENT | INPATIENT |
|---|---------------|-----------------|---------------|
| | TO CHARGES | PROGRAM CHARGES | PROGRAM COSTS |
| | 1 | 2 | 3 |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | |
| 25 ADULTS & PEDIATRICS | | | 25 |
| ANCILLARY SERVICE COST CENTERS | | | |
| 37 OPERATING ROOM | .456144 | | 37 |
| 40 ANESTHESIOLOGY | .616745 | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | .231251 | | 41 |
| 44 LABORATORY | .262084 | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | 46.30 |
| 49 RESPIRATORY THERAPY | .214262 | | 49 |
| 50 PHYSICAL THERAPY | .394775 | | 50 |
| 51 OCCUPATIONAL THERAPY | .361259 | | 51 |
| 52 SPEECH PATHOLOGY | .443798 | | 52 |
| 53 ELECTROCARDIOLOGY | .456034 | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | .235472 | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | .475305 | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | |
| 61 EMERGENCY | .572497 | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | .656051 | | 62 |
| OTHER REIMBURSABLE COST CENTERS | | | |
| 63.50 RHC | 1.334144 | | 63.50 |
| 63.60 FQHC | | | 63.60 |
| 101 TOTAL | | | 101 |
| 102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES | | | 102 |
| 103 NET CHARGES | | | 103 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

| | HOSPITAL | SUB I | SUB II | SUB III | SUB IV | |
|--|----------|-------|--------|---------|--------|------|
| DRG AMOUNT | | | | | | |
| 1 OTHER THAN OUTLIER PAYMENTS OCCURRING BEFORE OCTOBER 1 | | | | | | 1 |
| 1.01 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER OCTOBER 1 AND BEFORE JANUARY 1 | | | | | | 1.01 |
| 1.02 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER JAN 1 MANAGED CARE PATIENTS | | | | | | 1.02 |
| 1.03 PAYMENTS PRIOR TO MARCH 1 OR OCTOBER 1 | | | | | | 1.03 |
| 1.04 PAYMENTS ON OR AFTER OCTOBER 1 AND PRIOR TO JANUARY 1 | | | | | | 1.04 |
| 1.05 PAYMENTS ON OR AFTER JAN 1 BUT BEFORE APR 1/OCT 1 | | | | | | 1.05 |
| 1.06 ADDITIONAL AMOUNT RECEIVED OR TO BE RECEIVED | | | | | | 1.06 |
| 1.07 PAYMENTS FOR DISCHARGES ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001 | | | | | | 1.07 |
| 1.08 SIMULATED PAYMENTS FROM THE PS&R ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001 | | | | | | 1.08 |
| 2 OUTLIER PAYMENTS PRIOR TO OCTOBER 1, 1997 | | | | | | 2 |
| 2.01 OUTLIER PAYMENTS ON OR AFTER OCTOBER 1, 1997 INDIRECT MEDICAL EDUCATION ADJUSTMENT | | | | | | 2.01 |
| 3 BED DAYS AVAILABLE DIVIDED BY NO. OF DAYS IN CR PERIOD | | | | | | 3 |
| 3.01 NO OF INTERNS & RESIDENTS FROM WORKSHEET S-3, PART I | | | | | | 3.01 |
| 3.02 INDIRECT MEDICAL EDUCATION PERCENTAGE | | | | | | 3.02 |
| 3.03 INDIRECT MEDICAL EDUCATION ADJUSTMENT | | | | | | 3.03 |
| 3.04 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR THE MOST RECENT CR PERIOD ENDING ON OR BEFORE DEC 31, 1996 | | | | | | 3.04 |
| 3.05 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii) | | | | | | 3.05 |
| 3.06 ADJUSTED FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii) [FOR CR PERIODS ENDING] [ON OR AFTER 7/1/2005] [E-3,PT.VI,LN.15][PLUS LN.3.06] | | | | | | 3.06 |
| 3.07 SUM OF LINES 3.04-3.06 | | | 0.00 | 0.00 | | 3.07 |
| 3.08 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS | | | | | | 3.08 |
| 3.09 FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING PRIOR TO OCTOBER 1 | | | | | | 3.09 |
| 3.10 FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING ON OR AFTER OCT. 1 | | | | | | 3.10 |
| 3.11 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.09 | | | | | | 3.11 |
| 3.12 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.10 | | | | | | 3.12 |
| 3.13 FTE COUNT FOR RESIDENTS IN DENTAL & PODIATRIC PROGRAMS | | | | | | 3.13 |
| 3.14 CURRENT YEAR ALLOWABLE FTE | | | | | | 3.14 |
| 3.15 TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR, IF NONE BUT PRIOR YEAR TEACHING WAS IN EFFECT ENTER 1 HERE.. | | | | | | 3.15 |
| 3.16 TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO. IF THERE WAS NO FTE COUNT IN THIS PERIOD BUT PRIOR YR TEACHING WAS IN EFFECT ENTER 1 HERE.. | | | | | | 3.16 |
| 3.17 SUM OF LINES 3.14 THROUGH 3.16 DIVIDED BY THE NUMBER OF THOSE LINES IN EXCESS OF ZERO | | | | 0.00 | | 3.17 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A
 (CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

HOSPITAL SUB I SUB II SUB III SUB IV

| | | | | | | |
|-------|--|---|---|--|--|-------|
| 3.18 | CURRENT YEAR RESIDENT TO BED RATIO | | | | | 3.18 |
| 3.19 | PRIOR YEAR RESIDENT TO BED RATIO | | | | | 3.19 |
| 3.20 | FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1997, ENTER THE LESSER OF LINES 3.18 OR 3.19 | | | | | 3.20 |
| 3.21 | IME PAYMENTS FOR DSCHGS OCCURRING PRIOR TO OCTOBER 1 | | | | | 3.21 |
| 3.22 | IME PAYMENTS FOR DSCHGS AFTER SEP 30 BUT BEFORE JAN 1 | | | | | 3.22 |
| 3.23 | IME PAYMENTS FOR DSCHGS OCCURRING ON OR AFTER JANUARY 1 [SUM OF LINES][PLUS E-3,PT.VI] [3.21-3.23] [LINE 23] | | | | | 3.23 |
| 3.24 | SUM OF LINES 3.21-3.23 DISPROPORTIONATE SHARE ADJUSTMENT | 0 | 0 | | | 3.24 |
| 4 | PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS | | | | | 4 |
| 4.01 | PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS | | | | | 4.01 |
| 4.02 | SUM OF 4 AND 4.01 | | | | | 4.02 |
| 4.03 | ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE | | | | | 4.03 |
| 4.04 | DISPROPORTIONATE SHARE ADJUSTMENT ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES | | | | | 4.04 |
| 5 | TOTAL MEDICARE DISCHARGES ON WKST S-3, PART I EXCLUDING DISCHARGES FOR DRGs 302, 316 AND 317 | | | | | 5 |
| 5.01 | TOTAL ESRD MEDICARE DISCHARGES EXCLUDING DRGs 302, | | | | | 5.01 |
| 5.02 | DIVIDE LINE 5.01 BY LINE 5 | | | | | 5.02 |
| 5.03 | TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING DRGs | | | | | 5.03 |
| 5.04 | RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK | | | | | 5.04 |
| 5.05 | AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS | | | | | 5.05 |
| 5.06 | TOTAL ADDITIONAL PAYMENT | | | | | 5.06 |
| 6 | SUBTOTAL | | | | | 6 |
| 7 | HOSPITAL SPECIFIC PAYMENTS | | | | | 7 |
| 7.01 | HOSPITAL SPECIFIC PAYMENTS (1996 HSR) | | | | | 7.01 |
| 8 | TOTAL PAYMENT FOR INPATIENT OPERATING COSTS | | | | | 8 |
| 9 | PAYMENT FOR INPATIENT PROGRAM CAPITAL | | | | | 9 |
| 10 | EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL | | | | | 10 |
| 11 | DIRECT GRADUATE MEDICAL EDUCATION PAYMENT | | | | | 11 |
| 11.01 | NURSING AND ALLIED HEALTH MANAGED CARE | | | | | 11.01 |
| 11.02 | ADD-ON PAYMENT FOR NEW TECHNOLOGIES | | | | | 11.02 |
| 12 | NET ORGAN ACQUISITION COST | | | | | 12 |
| 13 | COST OF TEACHING PHYSICIANS | | | | | 13 |
| 14 | ROUTINE SERVICE OTHER PASS THROUGH COSTS | | | | | 14 |
| 15 | ANCILLARY SERVICE OTHER PASS THROUGH COSTS | | | | | 15 |
| 16 | TOTAL | | | | | 16 |
| 17 | PRIMARY PAYER PAYMENTS | | | | | 17 |
| 18 | TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES | | | | | 18 |
| 19 | DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES | | | | | 19 |
| 20 | COINSURANCE BILLED TO PROGRAM BENEFICIARIES | | | | | 20 |
| 21 | REIMBURSABLE BAD DEBTS | | | | | 21 |
| 21.01 | REDUCED PROGRAM REIMBURSABLE BAD DEBTS | | | | | 21.01 |
| 21.02 | REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES | | | | | 21.02 |
| 22 | SUBTOTAL | | | | | 22 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A
(CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

HOSPITAL SUB I SUB II SUB III SUB IV

| | | | | | | |
|-------|--|--|--|--|--|-------|
| 23 | RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION | | | | | 23 |
| 24 | OTHER ADJUSTMENTS | | | | | 24 |
| 25 | AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS | | | | | 25 |
| 26 | AMOUNT DUE PROVIDER | | | | | 26 |
| 27 | SEQUESTRATION ADJUSTMENT | | | | | 27 |
| 28 | INTERIM PAYMENTS | | | | | 28 |
| 28.01 | TENTATIVE SETTLEMENT (FOR FI USE ONLY) | | | | | 28.01 |
| 29 | BALANCE DUE PROVIDER (PROGRAM) | | | | | 29 |
| 30 | PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2 | | | | | 30 |
| | TO BE COMPLETED BY INTERMEDIARY | | | | | |
| 50 | OPERATING OUTLIER AMOUNT FROM WKST E, PART A, LINE 2.01 | | | | | 50 |
| 51 | CAPITAL OUTLIER AMOUNT FROM WKST L, PART I, LINE 3.01 | | | | | 51 |
| 52 | OPERATING OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIO | | | | | 52 |
| 53 | CAPITAL OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS) | | | | | 53 |
| 54 | THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY | | | | | 54 |
| 55 | TIME VALUE OF MONEY (SEE INSTRUCTIONS) | | | | | 55 |
| 56 | CAPITAL TIME VALUE OF MONEY (SEE INSTRUCTIONS) | | | | | 56 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

| | HOSPITAL (14-1318) | HOSPITAL (14-1318) | HOSPITAL (14-1318) |
|--|-----------------------|-----------------------|-----------------------|
| | 1 | 1.01 | 1.02 |
| 1 MEDICAL AND OTHER SERVICES | 2980847 | | 1 |
| 1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000 | | | 1.01 |
| 1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS | | | 1.02 |
| 1.03 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO | | | 1.03 |
| 1.04 LINE 1.01 TIMES LINE 1.03 | | | 1.04 |
| 1.05 LINE 1.02 DIVIDED BY LINE 1.04 | | | 1.05 |
| 1.06 TRANSITIONAL CORRIDOR PAYMENT | | | 1.06 |
| 1.07 AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101 | | | 1.07 |
| 2 INTERNS AND RESIDENTS | | | 2 |
| 3 ORGAN ACQUISITIONS | | | 3 |
| 4 COST OF TEACHING PHYSICIANS | | | 4 |
| 5 TOTAL COST | 2980847 | | 5 |
| COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES | | | |
| 6 ANCILLARY SERVICE CHARGES | | | 6 |
| 7 INTERNS AND RESIDENTS SERVICE CHARGES | | | 7 |
| 8 ORGAN ACQUISITION CHARGES | | | 8 |
| 9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS | | | 9 |
| 10 TOTAL REASONABLE CHARGES | | | 10 |
| CUSTOMARY CHARGES | | | |
| 11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS | | | 11 |
| 12 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) | | | 12 |
| 13 RATIO OF LINE 11 TO LINE 12 | | | 13 |
| 14 TOTAL CUSTOMARY CHARGES | | | 14 |
| 15 EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST | | | 15 |
| 16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES | | | 16 |
| 17 LESSER OF COST OR CHARGES | 3010655 | | 17 |
| 17.01 TOTAL PPS PAYMENTS | | | 17.01 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

| | HOSPITAL (14-1318) | HOSPITAL (14-1318) | HOSPITAL (14-1318) |
|---|-----------------------|-----------------------|-----------------------|
| | 1 | 1.01 | 1.02 |
| COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | |
| 18 DEDUCTIBLES | 23870 | | 18 |
| 18.01 COINSURANCE | 1296300 | | 18.01 |
| 19 SUBTOTAL | 1690485 | | 19 |
| 20 SUM OF AMOUNTS FROM WKST E, PARTS C,D & E | | | 20 |
| 21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS | | | 21 |
| 22 ESRD DIRECT MEDICAL EDUCATION COSTS | | | 22 |
| 23 SUBTOTAL | 1690485 | | 23 |
| 24 PRIMARY PAYER PAYMENTS | 211 | | 24 |
| 25 SUBTOTAL | 1690274 | | 25 |
| REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | | | |
| 26 COMPOSITE RATE ESRD | | | 26 |
| 27 BAD DEBTS | 174876 | | 27 |
| 27.01 REDUCED REIMBURSABLE BAD DEBTS | 174876 | | 27.01 |
| 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS) | 174876 | | 27.02 |
| 28 SUBTOTAL | 1865150 | | 28 |
| 29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION | | | 29 |
| 30 OTHER ADJUSTMENTS | | | 30 |
| 30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT) | | | 30.99 |
| 31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS | | | 31 |
| 32 SUBTOTAL | 1865150 | | 32 |
| 33 SEQUESTRATION ADJUSTMENT | | | 33 |
| 34 INTERIM PAYMENTS | 1784218 | | 34 |
| 34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY) | | | 34.01 |
| 35 BALANCE DUE PROVIDER/PROGRAM | 80932 | | 35 |
| 36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2 | 54734 | | 36 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

| | SNF (14-5528) | SNF (14-5528) | SNF (14-5528) | |
|--|------------------|------------------|------------------|-------|
| | 1 | 1.01 | 1.02 | |
| 1 MEDICAL AND OTHER SERVICES | | | | 1 |
| 1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000 | | | | 1.01 |
| 1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS | | | | 1.02 |
| 1.03 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO | | | | 1.03 |
| 1.04 LINE 1.01 TIMES LINE 1.03 | | | | 1.04 |
| 1.05 LINE 1.02 DIVIDED BY LINE 1.04 | | | | 1.05 |
| 1.06 TRANSITIONAL CORRIDOR PAYMENT | | | | 1.06 |
| 1.07 AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101 | | | | 1.07 |
| 2 INTERNS AND RESIDENTS | | | | 2 |
| 3 ORGAN ACQUISITIONS | | | | 3 |
| 4 COST OF TEACHING PHYSICIANS | | | | 4 |
| 5 TOTAL COST | | | | 5 |
| COMPUTATION OF LESSER OF COST OR CHARGES | | | | |
| REASONABLE CHARGES | | | | |
| 6 ANCILLARY SERVICE CHARGES | | | | 6 |
| 7 INTERNS AND RESIDENTS SERVICE CHARGES | | | | 7 |
| 8 ORGAN ACQUISITION CHARGES | | | | 8 |
| 9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS | | | | 9 |
| 10 TOTAL REASONABLE CHARGES | | | | 10 |
| CUSTOMARY CHARGES | | | | |
| 11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS | | | | 11 |
| 12 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) | | | | 12 |
| 13 RATIO OF LINE 11 TO LINE 12 | | | | 13 |
| 14 TOTAL CUSTOMARY CHARGES | | | | 14 |
| 15 EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST | | | | 15 |
| 16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES | | | | 16 |
| 17 LESSER OF COST OR CHARGES | | | | 17 |
| 17.01 TOTAL PPS PAYMENTS | | | | 17.01 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

| | SNF (14-5528) 1 | SNF (14-5528) 1.01 | SNF (14-5528) 1.02 | |
|---|-----------------------|--------------------------|--------------------------|---|
| COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | | |
| 18 | | | | 18 |
| | | | | DEDUCTIBLES |
| 18.01 | | | | 18.01 |
| | | | | COINSURANCE |
| 19 | | | | 19 |
| | | | | SUBTOTAL |
| 20 | | | | 20 |
| | | | | SUM OF AMOUNTS FROM WKST E, PARTS C,D & E |
| 21 | | | | 21 |
| | | | | DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS |
| 22 | | | | 22 |
| | | | | ESRD DIRECT MEDICAL EDUCATION COSTS |
| 23 | | | | 23 |
| | | | | SUBTOTAL |
| 24 | | | | 24 |
| | | | | PRIMARY PAYER PAYMENTS |
| 25 | | | | 25 |
| | | | | SUBTOTAL |
| | | | | REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR |
| | | | | PROFESSIONAL SERVICES) |
| 26 | | | | 26 |
| | | | | COMPOSITE RATE ESRD |
| 27 | | | | 27 |
| | | | | BAD DEBTS |
| 27.01 | | | | 27.01 |
| | | | | REDUCED REIMBURSABLE BAD DEBTS |
| 27.02 | | | | 27.02 |
| | | | | REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE |
| | | | | BENEFICIARIES (SEE INSTRUCTIONS) |
| 28 | | | | 28 |
| | | | | SUBTOTAL |
| 29 | | | | 29 |
| | | | | RECOVERY OF EXCESS DEPRECIATION RESULTING |
| | | | | FROM PROVIDER TERMINATION OR A DECREASE IN |
| | | | | PROGRAM UTILIZATION |
| 30 | | | | 30 |
| | | | | OTHER ADJUSTMENTS |
| 30.99 | | | | 30.99 |
| | | | | OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION |
| | | | | AMOUNT) |
| 31 | | | | 31 |
| | | | | AMOUNTS APPLICABLE TO PRIOR COST REPORTING |
| | | | | PERIODS RESULTING FROM DISPOSITION OF |
| | | | | DEPRECIABLE ASSETS |
| 32 | | | | 32 |
| | | | | SUBTOTAL |
| 33 | | | | 33 |
| | | | | SEQUESTRATION ADJUSTMENT |
| 34 | | | | 34 |
| | | | | INTERIM PAYMENTS |
| 34.01 | | | | 34.01 |
| | | | | TENTATIVE SETTLEMENT (FOR FI USE ONLY) |
| 35 | | | | 35 |
| | | | | BALANCE DUE PROVIDER/PROGRAM |
| 36 | | | | 36 |
| | | | | PROTESTED AMOUNTS (NONALLOWABLE COST |
| | | | | REPORT ITEMS) IN ACCORDANCE WITH CMS PUB |
| | | | | 15-II, SECTION 115.2 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART C

PART C - OUTPATIENT AMBULATORY SURGICAL CENTER

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

HOSPITAL
(14-1318)
OCTOBER 1, 1997
PRIOR TO ON OR AFTER
1 1.01

| | | |
|----|--|----|
| 1 | STANDARD OVERHEAD AMOUNTS (ASC FEES) | 1 |
| 2 | DEDUCTIBLES | 2 |
| 3 | SUBTOTAL | 3 |
| 4 | 80 PERCENT OF LINE 3 | 4 |
| 5 | ASC PORTION OF BLEND | 5 |
| 6 | OUTPATIENT ASC COST | 6 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | |
| 7 | TOTAL CHARGES | 7 |
| | CUSTOMARY CHARGES | |
| 8 | AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS | 8 |
| 9 | 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) | 9 |
| 10 | RATIO OF LINE 8 TO LINE 9 | 10 |
| 11 | TOTAL CUSTOMARY CHARGES | 11 |
| 12 | EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST | 12 |
| 13 | EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES | 13 |
| 14 | LESSER OF COST OR CHARGES | 14 |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | |
| 15 | DEDUCTIBLES AND COINSURANCE | 15 |
| 16 | TOTAL | 16 |
| 17 | HOSPITAL SPECIFIC PORTION OF BLEND | 17 |
| 18 | ASC BLENDED AMOUNT | 18 |
| 19 | LESSER OF LINES 16 OR 18 | 19 |
| 20 | PART B DEDUCTIBLES AND COINSURANCE | 20 |
| 21 | ASC PAYMENT AMOUNT | 21 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART D

PART D - OUTPATIENT RADIOLOGY SERVICES

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

HOSPITAL
(14-1318)
OCTOBER 1, 1997
PRIOR TO ON OR AFTER
1 1.01

| | | |
|--|---|----|
| 1 | PREVAILING CHARGES | 1 |
| 2 | 62 PERCENT OF LINE 1 | 2 |
| 3 | DEDUCTIBLES | 3 |
| 4 | SUBTOTAL | 4 |
| 5 | BLENDED CHARGE PROPORTION | 5 |
| 6 | COST OF OUTPATIENT RADIOLOGY | 6 |
| COMPUTATION OF LESSER OF COST OR CHARGES | | |
| 7 | TOTAL CHARGES | 7 |
| CUSTOMARY CHARGES | | |
| 8 | AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS | 8 |
| 9 | AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E) | 9 |
| 10 | RATIO OF LINE 8 TO LINE 9 | 10 |
| 11 | TOTAL CUSTOMARY CHARGES | 11 |
| 12 | EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST | 12 |
| 13 | EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES | 13 |
| 14 | LESSER OF COST OR CHARGES | 14 |
| COMPUTATION OF REIMBURSEMENT SETTLEMENT | | |
| 15 | DEDUCTIBLES AND COINSURANCE | 15 |
| 16 | TOTAL | 16 |
| 17 | COST PROPORTION | 17 |
| 18 | OUTPATIENT RADIOLOGY BLENDED AMOUNT | 18 |
| 19 | LESSER OF LINE 16 OR LINE 18 | 19 |
| 20 | PART B DEDUCTIBLES AND COINSURANCE | 20 |
| 21 | RADIOLOGY PAYMENT AMOUNT | 21 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2007 TO 09/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2007.06
02/26/2009 12:14

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART E

PART E - OTHER OUTPATIENT DIAGNOSTIC PROCEDURES

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

HOSPITAL
(14-1318)
OCTOBER 1, 1997
PRIOR TO ON OR AFTER
1 1.01

| | | |
|--|---|----|
| 1 | PREVAILING CHARGES | 1 |
| 2 | 42 PERCENT OF LINE 1 | 2 |
| 3 | DEDUCTIBLES | 3 |
| 4 | SUBTOTAL | 4 |
| 5 | BLENDED CHARGE PROPORTION | 5 |
| 6 | COST OF OTHER OUTPATIENT DIAGNOSTIC PROCEDURES | 6 |
| | | |
| COMPUTATION OF LESSER OF COST OR CHARGES | | |
| 7 | TOTAL CHARGES | 7 |
| | | |
| CUSTOMARY CHARGES | | |
| 8 | AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS | 8 |
| 9 | AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E) | 9 |
| 10 | RATIO OF LINE 8 TO LINE 9 | 10 |
| 11 | TOTAL CUSTOMARY CHARGES | 11 |
| 12 | EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST | 12 |
| 13 | EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES | 13 |
| 14 | LESSER OF COST OR CHARGES | 14 |
| | | |
| COMPUTATION OF REIMBURSEMENT SETTLEMENT | | |
| 15 | DEDUCTIBLES AND COINSURANCE | 15 |
| 16 | TOTAL | 16 |
| 17 | COST PROPORTION | 17 |
| 18 | OTHER OUTPATIENT DIAGNOSTIC BLENDED AMOUNT | 18 |
| 19 | LESSER OF LINE 16 OR LINE 18 | 19 |
| 20 | PART B DEDUCTIBLES AND COINSURANCE | 20 |
| 21 | DIAGNOSTIC PAYMENT AMOUNT | 21 |

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 HOSPITAL (14-1318)

WORKSHEET E-1

| DESCRIPTION | INPATIENT PART A | | PART B | | |
|--|--|-------------|-----------------|-------------|--|
| | MM/DD/YYYY 1 | AMOUNT 2 | MM/DD/YYYY 3 | AMOUNT 4 | |
| 1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER | | 1421665 | | 1784218 | 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. | | NONE | | NONE | 2 |
| 3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | PROGRAM .01 TO .02 PROVIDER .04 PROGRAM .05 PROVIDER .51 TO .52 PROGRAM .53 .54 | NONE | | NONE | 3.01 3.02 3.03 3.04 3.05 3.50 3.51 3.52 3.53 3.54 |
| SUBTOTAL | .99 | | | | 3.99 |
| 4 TOTAL INTERIM PAYMENTS | | 1421665 | | 1784218 | 4 |
| TO BE COMPLETED BY INTERMEDIARY | | | | | |
| 5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .50 TO .51 PROGRAM .52 | | | | 5.01 5.02 5.03 5.50 5.51 5.52 |
| SUBTOTAL | .99 | | | | 5.99 |
| 6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT. | PROGRAM TO .01 PROVIDER TO .02 PROGRAM | | | | 6.01 6.02 |
| 7 TOTAL MEDICARE PROGRAM LIABILITY | | | | | 7 |

NAME OF INTERMEDIARY:

INTERMEDIARY NUMBER:

SIGNATURE OF AUTHORIZED PERSON:

DATE (MO/DAY/YR):

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 SKILLED NURSING FACILITY I (14-5528)

WORKSHEET E-1

| DESCRIPTION | INPATIENT PART A | | PART B | |
|--|------------------|--------|------------|--------|
| | MM/DD/YYYY | AMOUNT | MM/DD/YYYY | AMOUNT |
| | 1 | 2 | 3 | 4 |
| 1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER | | 39517 | | 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. | | NONE | NONE | 2 |
| 3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | PROGRAM .01 | | | 3.01 |
| | TO .02 | | | 3.02 |
| | PROVIDER .03 | NONE | NONE | 3.03 |
| | PROVIDER .04 | | | 3.04 |
| | .05 | | | 3.05 |
| | .50 | | | 3.50 |
| | PROVIDER .51 | | | 3.51 |
| | TO .52 | NONE | NONE | 3.52 |
| | PROGRAM .53 | | | 3.53 |
| | .54 | | | 3.54 |
| SUBTOTAL | .99 | | | 3.99 |
| 4 TOTAL INTERIM PAYMENTS | | 39517 | | 4 |
| TO BE COMPLETED BY INTERMEDIARY | | | | |
| 5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | PROGRAM .01 | | | 5.01 |
| | TO .02 | | | 5.02 |
| | PROVIDER .03 | | | 5.03 |
| | PROVIDER .50 | | | 5.50 |
| | TO .51 | | | 5.51 |
| | PROGRAM .52 | | | 5.52 |
| SUBTOTAL | .99 | | | 5.99 |
| 6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT. | PROGRAM TO .01 | | | 6.01 |
| | PROVIDER TO .02 | | | 6.02 |
| PROGRAM | | | | |
| 7 TOTAL MEDICARE PROGRAM LIABILITY | | | | 7 |

NAME OF INTERMEDIARY:

INTERMEDIARY NUMBER:

SIGNATURE OF AUTHORIZED PERSON:

DATE (MO/DAY/YR):

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 SWING BED SKILLED NURSING FACILITY (14-2318)

WORKSHEET E-1

| DESCRIPTION | INPATIENT PART A | | PART B | |
|--|---|-------------|-----------------|--|
| | MM/DD/YYYY 1 | AMOUNT 2 | MM/DD/YYYY 3 | AMOUNT 4 |
| 1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER | | 1052897 | | 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. | | NONE | NONE | 2 |
| 3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | PROGRAM .01 TO .02 PROVIDER .03 TO .04 PROVIDER .05 TO .50 PROVIDER .51 TO .52 PROGRAM .53 .54 | NONE | NONE | 3.01 3.02 3.03 3.04 3.05 3.50 3.51 3.52 3.53 3.54 |
| SUBTOTAL | .99 | | | 3.99 |
| 4 TOTAL INTERIM PAYMENTS | | 1052897 | | 4 |
| TO BE COMPLETED BY INTERMEDIARY | | | | |
| 5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .50 TO .51 PROGRAM .52 | | | 5.01 5.02 5.03 5.50 5.51 5.52 |
| SUBTOTAL | .99 | | | 5.99 |
| 6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT. | PROGRAM TO .01 PROVIDER TO .02 PROGRAM | | | 6.01 6.02 |
| 7 TOTAL MEDICARE PROGRAM LIABILITY | | | | 7 |

NAME OF INTERMEDIARY: _____
 SIGNATURE OF AUTHORIZED PERSON: _____

INTERMEDIARY NUMBER: _____
 DATE (MO/DAY/YR): _____

CALCULATION OF REIMBURSEMENT SETTLEMENT
 SWING BEDS

SUPPLEMENTAL
 WORKSHEET E-2

COMPUTATION OF NET COST OF COVERED SERVICES

| | TITLE V | --- TITLE XVIII --- | | --- TITLE XIX --- | | |
|-------|--|---------------------|---------------------|-------------------|--------|-------|
| | S/B NF | S/B SNF | S/B SNF | S/B SNF | S/B NF | |
| | 1 | PART A (14-Z318) | PART B (14-Z318) | 1 | 1 | |
| 1 | INPATIENT ROUTINE SERVICES - SWING BED - SNF | 754538 | | | | 1 |
| 2 | INPATIENT ROUTINE SERVICES - SWING BED - NF | | | | | 2 |
| 3 | ANCILLARY SERVICES | 515028 | | | | 3 |
| 4 | PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM | | | | | 4 |
| 5 | PROGRAM DAYS | 1124 | | | | 5 |
| 6 | INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM | | | | | 6 |
| 7 | UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY | | | | | 7 |
| 8 | SUBTOTAL | 1269566 | | | | 8 |
| 9 | PRIMARY PAYER PAYMENTS | | | | | 9 |
| 10 | SUBTOTAL | 1269566 | | | | 10 |
| 11 | DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES) | | | | | 11 |
| 12 | SUBTOTAL | 1269566 | | | | 12 |
| 13 | COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES) | 26372 | | | | 13 |
| 14 | 80% OF PART B COSTS | | | | | 14 |
| 15 | SUBTOTAL | 1243194 | | | | 15 |
| 16 | OTHER ADJUSTMENTS | | | | | 16 |
| 17 | REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PHYSICIAN PROFESSIONAL SERVICES) | | | | | 17 |
| 17.01 | REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES | | | | | 17.01 |
| 18 | TOTAL | 1243194 | | | | 18 |
| 19 | SEQUESTRATION ADJUSTMENT | | | | | 19 |
| 20 | INTERIM PAYMENTS | 1052897 | | | | 20 |
| 20.01 | TENTATIVE SETTLEMENT (FOR FI USE ONLY) | | | | | 20.01 |
| 21 | BALANCE DUE PROVIDER/PROGRAM | 190297 | | | | 21 |
| 22 | PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2 | 22668 | | | | 22 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

| | HOSPITAL (14-1318) | SUB I | SUB II | SUB III | SUB IV | SNF I |
|--|--|---------|--------|---------|--------|-------|
| 1 | INPATIENT SERVICES | 1755010 | | | | 1 |
| 1.01 | NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS) | | | | | 1.01 |
| 2 | ORGAN ACQUISITION | | | | | 2 |
| 3 | COST OF TEACHING PHYSICIANS | | | | | 3 |
| 4 | SUBTOTAL | 1755010 | | | | 4 |
| 5 | PRIMARY PAYER PAYMENTS | | | | | 5 |
| 6 | TOTAL COST | 1772560 | | | | 6 |
| COMPUTATION OF LESSER OF COST OR CHARGES | | | | | | |
| REASONABLE CHARGES | | | | | | |
| 7 | ROUTINE SERVICE CHARGES | | | | | 7 |
| 8 | ANCILLARY SERVICE CHARGES | | | | | 8 |
| 9 | ORGAN ACQUISITION CHARGES, NET OF REVENUE | | | | | 9 |
| 10 | TEACHING PHYSICIANS | | | | | 10 |
| 11 | TOTAL REASONABLE CHARGES | | | | | 11 |
| 12 | AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENT LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS | | | | | 12 |
| 13 | AMOUNT 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) | | | | | 13 |
| 14 | RATIO OF LINE 12 TO LINE 13 | | | | | 14 |
| 15 | TOTAL CUSTOMARY CHARGES | | | | | 15 |
| 16 | EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST | | | | | 16 |
| 17 | EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES | | | | | 17 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

| | HOSPITAL (14-1318) | SUB I | SUB II | SUB III | SUB IV | SNF I |
|---|-----------------------|-------|--------|---------|--------|-------|
| COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | | | | |
| 18 | | | | | | 18 |
| 19 | | | | | | 19 |
| 20 | | | | | | 20 |
| 21 | | | | | | 21 |
| 22 | | | | | | 22 |
| 23 | | | | | | 23 |
| 24 | | | | | | 24 |
| 25 | | | | | | 25 |
| 25.01 | | | | | | 25.01 |
| 25.02 | | | | | | 25.02 |
| 26 | | | | | | 26 |
| 27 | | | | | | 27 |
| 28 | | | | | | 28 |
| 29 | | | | | | 29 |
| 30 | | | | | | 30 |
| 31 | | | | | | 31 |
| 32 | | | | | | 32 |
| 32.01 | | | | | | 32.01 |
| 33 | | | | | | 33 |
| 34 | | | | | | 34 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART III

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

SNF I
 (14-5528)
 (PPS)
 2

| | | | |
|---|--|-------|----|
| COMPUTATION OF NET COST OF COVERED SERVICES | | | |
| 1 | INPATIENT HOSPITAL/SNF/NF SERVICES | | 1 |
| 2 | MEDICAL AND OTHER SERVICES | | 2 |
| 3 | INTERNS AND RESIDENTS | | 3 |
| 4 | ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS ONLY | | 4 |
| 5 | COST OF TEACHING PHYSICIANS | | 5 |
| 6 | SUBTOTAL | | 6 |
| 7 | INPATIENT PRIMARY PAYER PAYMENTS | | 7 |
| 8 | OUTPATIENT PRIMARY PAYER PAYMENTS | | 8 |
| 9 | SUBTOTAL | | 9 |
| COMPUTATION OF LESSER OF COST OR CHARGES | | | |
| 10 | ROUTINE SERVICE CHARGES | | 10 |
| 11 | ANCILLARY SERVICE CHARGES | | 11 |
| 12 | INTERNS AND RESIDENTS SERVICE CHARGES | | 12 |
| 13 | ORGAN ACQUISITION CHARGES, NET OF REVENUE | | 13 |
| 14 | TEACHING PHYSICIANS | | 14 |
| 15 | INCENTIVE FROM TARGET AMOUNT COMPUTATION | | 15 |
| 16 | TOTAL REASONABLE CHARGES | | 16 |
| CUSTOMARY CHARGES | | | |
| 17 | AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS | | 17 |
| 18 | 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) | | 18 |
| 19 | RATIO OF LINE 17 TO LINE 18 | | 19 |
| 20 | TOTAL CUSTOMARY CHARGES | | 20 |
| 21 | EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST | | 21 |
| 22 | EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES | | 22 |
| 23 | COST OF COVERED SERVICES | | 23 |
| PROSPECTIVE PAYMENT AMOUNT | | | |
| 24 | OTHER THAN OUTLIER PAYMENTS | 61073 | 24 |
| 25 | OUTLIER PAYMENTS | | 25 |
| 26 | PROGRAM CAPITAL PAYMENTS | | 26 |
| 27 | CAPITAL EXCEPTION PAYMENTS | | 27 |
| 28 | ROUTINE SERVICE OTHER PASS THROUGH COSTS | | 28 |
| 29 | ANCILLARY SERVICE OTHER PASS THROUGH COSTS | | 29 |
| 30 | SUBTOTAL | 61073 | 30 |
| 31 | CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY) | | 31 |
| 32 | AMOUNT FROM LINE 30 | 61073 | 32 |
| 33 | DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT) | | 33 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART III

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

| | [] TITLE V | [XX] TITLE XVIII | [] TITLE XIX |
|---|---|----------------------------------|---------------|
| | | SNF I (14-5520) (PPS) 2 | |
| COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | |
| 34 | EXCESS OF REASONABLE COST | | 34 |
| 35 | SUBTOTAL | 61073 | 35 |
| 36 | COINSURANCE | 21556 | 36 |
| 37 | SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E, LINE 19 | | 37 |
| 38 | REIMBURSABLE BAD DEBTS | | 38 |
| 38.01 | REDUCED REIMBURSABLE BAD DEBTS | | 38.01 |
| 38.02 | REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS) | | 38.02 |
| 38.03 | ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING ON OR AFTER 10/01/05 (SEE INSTR.) | | 38.03 |
| 39 | UTILIZATION REVIEW | | 39 |
| 40 | SUBTOTAL | 39517 | 40 |
| 41 | INPATIENT ROUTINE SERVICE COST | | 41 |
| 42 | MEDICARE INPATIENT ROUTINE CHARGES | | 42 |
| 43 | AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS | | 43 |
| 44 | 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) | | 44 |
| 45 | RATIO OF LINE 43 TO LINE 44 | | 45 |
| 46 | TOTAL CUSTOMARY CHARGES | | 46 |
| 47 | EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST | | 47 |
| 48 | EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES | | 48 |
| 49 | RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION | | 49 |
| 50 | AMOUNT TO ZERO OUT SNF | | 50 |
| 51 | AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS | | 51 |
| 52 | SUBTOTAL | 39517 | 52 |
| 53 | INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY) | | 53 |
| 54 | DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS | | 54 |
| 55 | TOTAL AMOUNT PAYABLE TO THE PROVIDER | 39517 | 55 |
| 56 | SEQUESTRATION ADJUSTMENT | | 56 |
| 57 | INTERIM PAYMENTS | 39517 | 57 |
| 57.01 | TENTATIVE SETTLEMENT (FOR FI USE ONLY) | | 57.01 |
| 58 | BALANCE DUE PROVIDER/PROGRAM | | 58 |
| 59 | PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2 | | 59 |

CALCULATION OF REIMBURSEMENT SETTLEMENT
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3
 PART III

| | [] TITLE V | [] TITLE XVIII | [XX] TITLE XIX | | NF I | | |
|----|--|--------------------------------|----------------|--------|---------|--------|-------|
| | | HOSPITAL (14-1318) (PPS) | SUB I | SUB II | SUB III | SUB IV | (PPS) |
| | COMPUTATION OF NET COST OF COVERED SERVICES | 1 | 1 | 1 | 1 | 1 | |
| 1 | INPATIENT HOSPITAL/SNF/NF SERVICES | | | | | | 1 |
| 2 | MEDICAL AND OTHER SERVICES | | | | | | 2 |
| 3 | INTERNS AND RESIDENTS | | | | | | 3 |
| 4 | ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O | | | | | | 4 |
| 5 | COST OF TEACHING PHYSICIANS | | | | | | 5 |
| 6 | SUBTOTAL | | | | | | 6 |
| 7 | INPATIENT PRIMARY PAYER PAYMENTS | | | | | | 7 |
| 8 | OUTPATIENT PRIMARY PAYER PAYMENTS | | | | | | 8 |
| 9 | SUBTOTAL | | | | | | 9 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | | | |
| 10 | ROUTINE SERVICE CHARGES | | | | | | 10 |
| 11 | ANCILLARY SERVICE CHARGES | | | | | | 11 |
| 12 | INTERNS AND RESIDENTS SERVICE CHARGES | | | | | | 12 |
| 13 | ORGAN ACQUISITION CHARGES, NET OF REVENUE | | | | | | 13 |
| 14 | TEACHING PHYSICIANS | | | | | | 14 |
| 15 | INCENTIVE FROM TARGET AMOUNT COMPUTATION | | | | | | 15 |
| 16 | TOTAL REASONABLE CHARGES | | | | | | 16 |
| | CUSTOMARY CHARGES | | | | | | |
| 17 | AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE | | | | | | 17 |
| 18 | AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E) | | | | | | 18 |
| 19 | RATIO OF LINE 17 TO LINE 18 | | | | | | 19 |
| 20 | TOTAL CUSTOMARY CHARGES | | | | | | 20 |
| 21 | EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST | | | | | | 21 |
| 22 | EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES | | | | | | 22 |
| 23 | COST OF COVERED SERVICES | | | | | | 23 |
| | PROSPECTIVE PAYMENT AMOUNT | | | | | | |
| 24 | OTHER THAN OUTLIER PAYMENTS | | | | | | 24 |
| 25 | OUTLIER PAYMENTS | | | | | | 25 |
| 26 | PROGRAM CAPITAL PAYMENTS | | | | | | 26 |
| 27 | CAPITAL EXCEPTION PAYMENTS | | | | | | 27 |
| 28 | ROUTINE SERVICE OTHER PASS THROUGH COSTS | | | | | | 28 |
| 29 | ANCILLARY SERVICE OTHER PASS THROUGH COSTS | | | | | | 29 |
| 30 | SUBTOTAL | | | | | | 30 |
| 31 | CUSTOMARY CHARGES (TITLE XIX PPS COVERED | | | | | | 31 |
| 32 | LESSER OF LINES 30 OR 31 | | | | | | 32 |
| 33 | DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT) | | | | | | 33 |

CALCULATION OF REIMBURSEMENT SETTLEMENT
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3
 PART III

| | [] TITLE V | [] TITLE XVIII | [XX] TITLE XIX | | NF I | |
|-------|--|--------------------------------|----------------|--------|---------|--------|
| | | HOSPITAL (14-1318) (PPS) | SUB I | SUB II | SUB III | SUB IV |
| | | 1 | 1 | 1 | 1 | 1 |
| 34 | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | | | |
| 34 | EXCESS OF REASONABLE COST | | | | | 34 |
| 35 | SUBTOTAL | | | | | 35 |
| 36 | COINSURANCE | | | | | 36 |
| 37 | SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E, | | | | | 37 |
| 38 | REIMBURSABLE BAD DEBTS | | | | | 38 |
| 38.01 | REDUCED REIMBURSABLE BAD DEBTS | | | | | 38.01 |
| 38.02 | REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS) | | | | | 38.02 |
| 39 | UTILIZATION REVIEW | | | | | 39 |
| 40 | SUBTOTAL | | | | | 40 |
| 41 | INPATIENT ROUTINE SERVICE COST | | | | | 41 |
| 42 | MEDICARE INPATIENT ROUTINE CHARGES | | | | | 42 |
| 43 | AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE | | | | | 43 |
| 44 | AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E) | | | | | 44 |
| 45 | RATIO OF LINE 43 TO LINE 44 | | | | | 45 |
| 46 | TOTAL CUSTOMARY CHARGES | | | | | 46 |
| 47 | EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST | | | | | 47 |
| 48 | EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES | | | | | 48 |
| 49 | RECOVERY OF EXCESS DEPRECIATION RESULTING FROM UTILIZATION | | | | | 49 |
| 50 | AMOUNT TO ZERO OUT SNF | | | | | 50 |
| 51 | AMOUNTS APPLICABLE TO PRIOR COST REPORTING DEPRECIABLE ASSETS | | | | | 51 |
| 52 | SUBTOTAL | | | | | 52 |
| 53 | INDIRECT MEDICAL EDUCATION ADJUSTMENT | | | | | 53 |
| 54 | DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS | | | | | 54 |
| 55 | TOTAL AMOUNT PAYABLE TO THE PROVIDER | | | | | 55 |
| 56 | SEQUESTRATION ADJUSTMENT | | | | | 56 |
| 57 | INTERIM PAYMENTS | | | | | 57 |
| 57.01 | TENTATIVE SETTLEMENT (FOR FI USE ONLY) | | | | | 57.01 |
| 58 | BALANCE DUE PROVIDER/PROGRAM | | | | | 58 |
| 59 | PROTESTED AMOUNTS (NONALLOWABLE COST REPORT SECTION 115.2 | | | | | 59 |

BALANCE SHEET

WORKSHEET G

| ASSETS | | GENERAL FUND | SPECIFIC PURPOSE FUND | ENDOWMENT FUND | PLANT FUND |
|-------------------------------|---|--------------|-----------------------|----------------|------------|
| | | 1 | 2 | 3 | 4 |
| CURRENT ASSETS | | | | | |
| 1 | CASH ON HAND AND IN BANKS | 1454573 | | | 1 |
| 2 | TEMPORARY INVESTMENTS | | | | 2 |
| 3 | NOTES RECEIVABLE | | | | 3 |
| 4 | ACCOUNTS RECEIVABLE | 3107205 | | | 4 |
| 5 | OTHER RECEIVABLES | -93863 | | | 5 |
| 6 | ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE | | | | 6 |
| 7 | INVENTORY | 593909 | | | 7 |
| 8 | PREPAID EXPENSES | | | | 8 |
| 9 | OTHER CURRENT ASSETS | 136473 | | | 9 |
| 10 | DUE FROM OTHER FUNDS | | | | 10 |
| 11 | TOTAL CURRENT ASSETS | 5198297 | | | 11 |
| FIXED ASSETS | | | | | |
| 12 | LAND | 325000 | | | 12 |
| 12.01 | ACCUMULATED DEPRECIATION | | | | 12.01 |
| 13 | LAND IMPROVEMENTS | 146120 | | | 13 |
| 13.01 | ACCUMULATED DEPRECIATION | -40697 | | | 13.01 |
| 14 | BUILDINGS | 2373840 | | | 14 |
| 14.01 | ACCUMULATED DEPRECIATION | -596504 | | | 14.01 |
| 15 | LEASEHOLD IMPROVEMENTS | | | | 15 |
| 15.01 | ACCUMULATED AMORTIZATION | | | | 15.01 |
| 16 | FIXED EQUIPMENT | | | | 16 |
| 16.01 | ACCUMULATED DEPRECIATION | | | | 16.01 |
| 17 | AUTOMOBILES AND TRUCKS | | | | 17 |
| 17.01 | ACCUMULATED DEPRECIATION | | | | 17.01 |
| 18 | MAJOR MOVABLE EQUIPMENT | 2745325 | | | 18 |
| 18.01 | ACCUMULATED DEPRECIATION | -1145001 | | | 18.01 |
| 19 | MINOR EQUIPMENT DEPRECIABLE | | | | 19 |
| 19.01 | ACCUMULATED DEPRECIATION | | | | 19.01 |
| 20 | MINOR EQUIPMENT-NONDEPRECIABLE | | | | 20 |
| 21 | TOTAL FIXED ASSETS | 3808083 | | | 21 |
| OTHER ASSETS | | | | | |
| 22 | INVESTMENTS | | | | 22 |
| 23 | DEPOSITS ON LEASES | | | | 23 |
| 24 | DUE FROM OWNERS/OFFICERS | | | | 24 |
| 25 | OTHER ASSETS | 7961534 | | | 25 |
| 26 | TOTAL OTHER ASSETS | 7961534 | | | 26 |
| 27 | TOTAL ASSETS | 16967914 | | | 27 |
| LIABILITIES AND FUND BALANCES | | | | | |
| | | GENERAL FUND | SPECIFIC PURPOSE FUND | ENDOWMENT FUND | PLANT FUND |
| | | 1 | 2 | 3 | 4 |
| CURRENT LIABILITIES | | | | | |
| 28 | ACCOUNTS PAYABLE | 808091 | | | 28 |
| 29 | SALARIES, WAGES & FEES PAYABLE | 942404 | | | 29 |
| 30 | PAYROLL TAXES PAYABLE | | | | 30 |
| 31 | NOTES & LOANS PAYABLE (SHORT TERM) | | | | 31 |
| 32 | DEFERRED INCOME | | | | 32 |
| 33 | ACCELERATED PAYMENTS | | | | 33 |
| 34 | DUE TO OTHER FUNDS | 218843 | | | 34 |
| 35 | OTHER CURRENT LIABILITIES | 1657299 | | | 35 |
| 36 | TOTAL CURRENT LIABILITIES | 3626637 | | | 36 |
| LONG-TERM LIABILITIES | | | | | |
| 37 | MORTGAGE PAYABLE | | | | 37 |
| 38 | NOTES PAYABLE | | | | 38 |
| 39 | UNSECURED LOANS | | | | 39 |
| 40 | LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66 | | | | 40 |
| 41 | OTHER LONG TERM LIABILITIES | 151850 | | | 41 |
| 42 | TOTAL LONG TERM LIABILITIES | 151850 | | | 42 |
| 43 | TOTAL LIABILITIES | 3778487 | | | 43 |
| CAPITAL ACCOUNTS | | | | | |
| 44 | GENERAL FUND BALANCE | 13189427 | | | 44 |
| 45 | SPECIFIC PURPOSE FUND BALANCE | | | | 45 |
| 46 | DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED | | | | 46 |
| 47 | DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED | | | | 47 |
| 48 | GOVERNING BODY CREATED - ENDOWMENT FUND BAL | | | | 48 |
| 49 | PLANT FUND BALANCE - INVESTED IN PLANT | | | | 49 |
| 50 | PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION | | | | 50 |
| 51 | TOTAL FUND BALANCES | 13189427 | | | 51 |
| 52 | TOTAL LIABILITIES AND FUND BALANCES | 16967914 | | | 52 |

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

| | GENERAL FUND 1 | SPECIFIC PURPOSE FUND 2 | ENDOWMENT FUND 3 | PLANT FUND 4 |
|---|-------------------|----------------------------|---------------------|-----------------|
| 1 FUND BALANCES AT BEGINNING OF PERIOD | 13361745 | | | 1 |
| 2 NET INCOME (LOSS) | -197195 | | | 2 |
| 3 TOTAL | 13164550 | | | 3 |
| 4 ADDITIONS (CREDIT ADJUSTMENTS) | 24877 | | | 4 |
| 5 | | | | 5 |
| 6 | | | | 6 |
| 7 | | | | 7 |
| 8 | | | | 8 |
| 9 | | | | 9 |
| 10 TOTAL ADDITIONS | 24877 | | | 10 |
| 11 SUBTOTAL | 13189427 | | | 11 |
| 12 DEDUCTIONS (DEBIT ADJUSTMENTS) | | | | 12 |
| 13 | | | | 13 |
| 14 | | | | 14 |
| 15 | | | | 15 |
| 16 | | | | 16 |
| 17 | | | | 17 |
| 18 TOTAL DEDUCTIONS | | | | 18 |
| 19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET | 13189427 | | | 19 |

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

| REVENUE CENTER | INPATIENT 1 | OUTPATIENT 2 | TOTAL 3 | |
|---|----------------|-----------------|------------|-------|
| 1 GENERAL INPATIENT ROUTINE CARE SERVICES | | | | |
| 2 HOSPITAL | 1635951 | | 1635951 | 1 |
| 3 SUBPROVIDER I | | | | 2 |
| 4 SWING BED - SNF | 837000 | | 837000 | 4 |
| 5 SWING BED - NF | | | | 5 |
| 6 SKILLED NURSING FACILITY | 1400027 | | 1400027 | 6 |
| 7 NURSING FACILITY | | | | 7 |
| 8 OTHER LONG TERM CARE | | | | 8 |
| 9 TOTAL GENERAL INPATIENT CARE SERVICES | 3872978 | | 3872978 | 9 |
| 10 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES | | | | 10 |
| 11 INTENSIVE CARE UNIT | | | | 11 |
| 12 CORONARY CARE UNIT | | | | 11 |
| 13 BURN INTENSIVE CARE UNIT | | | | 12 |
| 14 SURGICAL INTENSIVE CARE UNIT | | | | 13 |
| 15 OTHER SPECIAL CARE (SPECIFY) | | | | 14 |
| 16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE | 3872978 | | 3872978 | 15 |
| 17 TOTAL INPATIENT ROUTINE CARE SERVICES | 6793743 | | 6793743 | 16 |
| 18 ANCILLARY SERVICES | | | | 17 |
| 19 OUTPATIENT SERVICES | | 28516298 | 28516298 | 18 |
| 18.50 RHC | | 3104029 | 3104029 | 18.50 |
| 18.60 FQHC | | | | 18.60 |
| 19 HOME HEALTH AGENCY | | 11830 | 11830 | 19 |
| 20 AMBULANCE | | | | 20 |
| 21 CORF | | | | 21 |
| 22 ASC | | | | 22 |
| 23 HOSPICE | | | | 23 |
| 24 | | | | 24 |
| 25 TOTAL PATIENT REVENUES | 10666721 | 31632157 | 42298878 | 25 |

PART II - OPERATING EXPENSES

| | 1 | 2 | |
|-----------------------------|---------|----------|----|
| 26 OPERATING EXPENSES | | 21524024 | 26 |
| 27 ADD (SPECIFY) | | | 27 |
| 28 BAD DEBT | 1350697 | | 28 |
| 29 | | | 29 |
| 30 | | | 30 |
| 31 | | | 31 |
| 32 | | | 32 |
| 33 TOTAL ADDITIONS | | 1350697 | 33 |
| 34 DEDUCT (SPECIFY) | | | 34 |
| 35 | | | 35 |
| 36 | | | 36 |
| 37 | | | 37 |
| 38 | | | 38 |
| 39 TOTAL DEDUCTIONS | | | 39 |
| 40 TOTAL OPERATING EXPENSES | | 22874721 | 40 |

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

| DESCRIPTION | | | |
|-------------|---|----------|-------|
| 1 | TOTAL PATIENT REVENUES | 42298878 | 1 |
| 2 | LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS | 19916051 | 2 |
| 3 | NET PATIENT REVENUES | 22382827 | 3 |
| 4 | LESS - TOTAL OPERATING EXPENSES | 22874721 | 4 |
| 5 | NET INCOME FROM SERVICE TO PATIENTS | -491894 | 5 |
| 6 | CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC. | 82138 | 6 |
| 7 | INCOME FROM INVESTMENTS | 16179 | 7 |
| 8 | REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE | | 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 | 34084 | 14 |
| 15 | REVENUE FROM RENTAL OF LIVING QUARTERS | | 15 |
| 16 | REV FROM SALE OF MED & SURG SUPP 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 | 6325 | 18 |
| 19 | TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.) | | 19 |
| 20 | REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN | | 20 |
| 21 | RENTAL OF VENDING MACHINES | | 21 |
| 22 | RENTAL OF HOSPITAL SPACE | 11503 | 22 |
| 23 | GOVERNMENTAL APPROPRIATIONS | | 23 |
| 24 | OTHER INCOME | 85272 | 24 |
| 24.01 | GRANT INCOME | 59198 | 24.01 |
| 24.02 | WORKERS COMP | | 24.02 |
| 25 | TOTAL OTHER INCOME | 294699 | 25 |
| 26 | TOTAL | -197195 | 26 |
| 27 | | | 27 |
| 28 | | | 28 |
| 29 | | | 29 |
| 30 | TOTAL OTHER EXPENSES | | 30 |
| 31 | NET INCOME (OR LOSS) FOR THE PERIOD | -197195 | 31 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2007 TO 09/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (05/2007)

VERSION: 2007.06
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7627

WORKSHEET H

| | SALARIES | EMPLOYEE BENEFITS | TRANS-PORTATION | CONTRACTED/PURCH SVCS | OTHER COSTS | TOTAL HHA COST |
|--|----------|-------------------|-----------------|-----------------------|-------------|----------------|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| GENERAL SERVICE COST CENTER | | | | | | |
| 1 CAPITAL RELATED-BLDG & FIXTURES | | | | | | 1 |
| 2 CAPITAL RELATED-MOVABLE EQUIPMENT | | | | | | 2 |
| 3 PLANT OPERATION & MAINTENANCE | | | | | | 3 |
| 4 TRANSPORTATION | | | | | | 4 |
| 5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES | | | | | 7578 | 7578 5 |
| 6 SKILLED NURSING CARE | 8555 | | 364 | | | 8919 6 |
| 7 PHYSICAL THERAPY | | | | | | 7 |
| 8 OCCUPATIONAL THERAPY | 157 | | 47 | | | 204 8 |
| 9 SPEECH PATHOLOGY | | | | | | 9 |
| 10 MEDICAL SOCIAL SERVICES | | | | | | 10 |
| 11 HOME HEALTH AIDE | 275 | | 39 | | | 314 11 |
| 12 SUPPLIES | | | | | | 12 |
| 13 DRUGS | | | | | | 13 |
| 13.20 COST OF ADMINISTERING VACCINES | | | | | | 13.20 |
| 14 DME | | | | | | 14 |
| HHA NONREIMBURSABLE SERVICES | | | | | | |
| 15 HOME DIALYSIS AIDE SERVICES | | | | | | 15 |
| 16 RESPIRATORY THERAPY | | | | | | 16 |
| 17 PRIVATE DUTY NURSING | 1260 | | 184 | | 37 | 1481 17 |
| 18 CLINIC | | | | | | 18 |
| 19 HEALTH PROMOTION ACTIVITIES | | | | | | 19 |
| 20 DAY CARE PROGRAM | | | | | | 20 |
| 21 HOME DELIVERED MEALS PROGRAM | | | | | | 21 |
| 22 HOMEMAKER SERVICE | | | | | | 22 |
| 23 ALL OTHERS | | | | | | 23 |
| 23.50 TELEMEDICINE | | | | | | 23.50 |
| 24 TOTAL | 10247 | | 634 | | 7615 | 18496 24 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7627

WORKSHEET H
 (CONTINUED)

| | RECLASSIFI- CATIONS 7 | RECLASSIFIED TRIAL BALANCE 8 | ADJUSTMENTS 9 | NET EXPENSES FOR ALLOCATION 10 | |
|-------|-----------------------------|------------------------------------|------------------|--------------------------------------|-------|
| 1 | | | | | 1 |
| 2 | | | | | 2 |
| 3 | | | | | 3 |
| 4 | | | | | 4 |
| 5 | | 7578 | | 7578 | 5 |
| 6 | | 8919 | | 8919 | 6 |
| 7 | 32 | 32 | | 32 | 7 |
| 8 | -204 | | | | 8 |
| 9 | | | | | 9 |
| 10 | | | | | 10 |
| 11 | | 314 | | 314 | 11 |
| 12 | | | | | 12 |
| 13 | | | | | 13 |
| 13.20 | | | | | 13.20 |
| 14 | | | | | 14 |
| 15 | | | | | 15 |
| 16 | | | | | 16 |
| 17 | | 1481 | | 1481 | 17 |
| 18 | | | | | 18 |
| 19 | | | | | 19 |
| 20 | | | | | 20 |
| 21 | | | | | 21 |
| 22 | | | | | 22 |
| 23 | | | | | 23 |
| 23.50 | | | | | 23.50 |
| 24 | | 18324 | | 18324 | 24 |
| | -172 | | | | |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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KPMG LLP COMPU-MAX MICRO SYSTEM
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COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 14-7627

WORKSHEET H-4
 PART I

| | NET EXPENSES FOR COST ALLOCATION | CAP REL BLDGS & FIXTURES | CAP REL MOVABLE EQUIPMENT | PLANT OPERATN & MAINT | TRANSPORT- ATION | SUBTOTAL 4A | ADMIN & GENERAL 5 | TOTAL 6 |
|---|--|--------------------------------|---------------------------------|-----------------------------|---------------------|----------------|-------------------------|------------|
| | 0 | 1 | 2 | 3 | 4 | | | |
| GENERAL SERVICE COST CENTER | | | | | | | | |
| 1 CAPITAL RELATED-BLDG & FIXT | | | | | | | | 1 |
| 2 CAPITAL RELATED-MOVABLE EQUIP | | | | | | | | 2 |
| 3 PLANT OPERATION & MAINTENANCE | | | | | | | | 3 |
| 4 TRANSPORTATION | | | | | | | | 4 |
| 5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES | 7578 | | | | | 7578 | 7578 | 5 |
| 6 SKILLED NURSING CARE | 8919 | | | | | 8919 | 4238 | 13157 6 |
| 7 PHYSICAL THERAPY | 32 | | | | | 32 | 2197 | 2229 7 |
| 8 OCCUPATIONAL THERAPY | | | | | | | | 8 |
| 9 SPEECH PATHOLOGY | | | | | | | | 9 |
| 10 MEDICAL SOCIAL SERVICES | | | | | | | | 10 |
| 11 HOME HEALTH AIDE | 314 | | | | | 314 | 149 | 463 11 |
| 12 SUPPLIES | | | | | | | 138 | 138 12 |
| 13 DRUGS | | | | | | | 152 | 152 13 |
| 13.20 COST OF ADMINISTERING VACCINES | | | | | | | | 13.20 |
| 14 DME | | | | | | | | 14 |
| HHA NONREIMBURSABLE SERVICES | | | | | | | | |
| 15 HOME DIALYSIS AIDE SERVICES | | | | | | | | 15 |
| 16 RESPIRATORY THERAPY | | | | | | | | 16 |
| 17 PRIVATE DUTY NURSING | 1481 | | | | | 1481 | 704 | 2185 17 |
| 18 CLINIC | | | | | | | | 18 |
| 19 HEALTH PROMOTION ACTIVITIES | | | | | | | | 19 |
| 20 DAY CARE PROGRAM | | | | | | | | 20 |
| 21 HOME DELIVERED MEALS PROGRAM | | | | | | | | 21 |
| 22 HOMEMAKER SERVICE | | | | | | | | 22 |
| 23 ALL OTHERS | | | | | | | | 23 |
| 23.50 TELEMEDICINE | | | | | | | | 23.50 |
| 24 TOTAL | 18324 | | | | | 18324 | | 18324 24 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7627

WORKSHEET H-4
 PART II

| | CAP REL BLDGS & FIXTURES (SQUARE FEET) 1 | CAP REL MOVABLE EQUIPMENT (DOLLAR VALUE) 2 | PLANT OPERATN & MAINT (SQUARE FEET) 3 | TRANSPORT- ATION (MILEAGE) 4 | RECONCIL- IATION 5A | ADMIN & GENERAL (ACCUM COST) 5 | |
|-------|---|---|--|---------------------------------------|---------------------------|--|-------|
| 1 | | | | | | | 1 |
| 2 | 18324 | | | | | | 2 |
| 3 | | | | | | | 3 |
| 4 | | | | | | | 4 |
| 5 | 7579 | | | | -7578 | 15951 | 5 |
| 6 | 8919 | | | | | 8919 | 6 |
| 7 | 32 | | | | 4593 | 4625 | 7 |
| 8 | | | | | 1 | 1 | 8 |
| 9 | | | | | | | 9 |
| 10 | | | | | | | 10 |
| 11 | | | | | | 314 | 11 |
| 12 | 313 | | | | 291 | 291 | 12 |
| 13 | | | | | 320 | 320 | 13 |
| 13.20 | | | | | | | 13.20 |
| 14 | | | | | | | 14 |
| 15 | | | | | | | 15 |
| 16 | | | | | | | 16 |
| 17 | 1481 | | | | | 1481 | 17 |
| 18 | | | | | | | 18 |
| 19 | | | | | | | 19 |
| 20 | | | | | | | 20 |
| 21 | | | | | | | 21 |
| 22 | | | | | | | 22 |
| 23 | | | | | | | 23 |
| 23.50 | | | | | | | 23.50 |
| 24 | 18324 | | | | -2373 | 15951 | 24 |
| 25 | | | | | | 7578 | 25 |
| 26 | | | | | | .475080 | 26 |

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7627

WORKSHEET H-5
 PART I

| HHA COST CENTER | I&R | PARAMED | SUBTOTAL | I&R COST & | SUBTOTAL | ALLOCATED | TOTAL | |
|---------------------------------|---------|-----------|----------|------------|----------|-----------|-----------|-------|
| | PROGRAM | EDUCATION | | POST STEP- | | HHA | | |
| | COSTS | | | DOWN ADJS | | A & G | HHA COSTS | |
| | 23 | 24 | 25 | 26 | 27 | 28 | 29 | |
| 1 ADMINISTRATIVE AND GENERAL | | | 5258 | | 5258 | | | 1 |
| 2 SKILLED NURSING CARE | | | 22587 | | 22587 | 3734 | 26321 | 2 |
| 3 PHYSICAL THERAPY | | | 3275 | | 3275 | 542 | 3817 | 3 |
| 4 OCCUPATIONAL THERAPY | | | | | | | | 4 |
| 5 SPEECH PATHOLOGY | | | | | | | | 5 |
| 6 MEDICAL SOCIAL SERVICES | | | | | | | | 6 |
| 7 HOME HEALTH AIDE | | | 785 | | 785 | 130 | 915 | 7 |
| 8 SUPPLIES | | | 203 | | 203 | 34 | 237 | 8 |
| 9 DRUGS | | | 223 | | 223 | 37 | 260 | 9 |
| 9.20 COST OF ADMINISTERING VACC | | | | | | | | 9.20 |
| 10 DME | | | | | | | | 10 |
| 11 HOME DIALYSIS AIDE SERVICE | | | | | | | | 11 |
| 12 RESPIRATORY THERAPY | | | | | | | | 12 |
| 13 PRIVATE DUTY NURSING | | | 3688 | | 3688 | 610 | 4298 | 13 |
| 14 CLINIC | | | | | | | | 14 |
| 15 HEALTH PROMOTION ACTIVITIE | | | | | | | | 15 |
| 16 DAY CARE PROGRAM | | | | | | | | 16 |
| 17 HOME DELIVERED MEALS PROGR | | | | | | | | 17 |
| 18 HOMEMAKER SERVICE | | | | | | | | 18 |
| 19 ALL OTHERS | | | 1032 | | 1032 | 171 | 1203 | 19 |
| 19.50 TELEMEDICINE | | | | | | | | 19.50 |
| 20 TOTALS | | | 37051 | | 37051 | 5258 | 37051 | 20 |
| 21 UNIT COST MULTIPLIER | | | | | | .165382 | | 21 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7627

WORKSHEET H-5
 PART II

| HHA COST CENTER | OLD CAP BLDGS & FIXTURES SQUARE FEET | OLD CAP MOVABLE EQUIPMENT SQUARE FEET | NEW CAP BLDGS & FIXTURES SQUARE FEET | NEW CAP MOVABLE EQUIPMENT SQUARE FEET | NEW CAP MVBLE EQUIP NH SQUARE FEET | EMPLOYEE BENEFITS GROSS SALARIES | RECON- CILIATION | ADMINIS- TRATIVE + GENERAL ACCUM COST | |
|---------------------------------|--|---|--|---|--|---|---------------------|---|-------|
| | 1 | 2 | 3 | 4 | 4.01 | 5 | 6A | 6 | |
| 1 ADMINISTRATIVE AND GENERAL | | | 76 | 76 | | | | 1178 | 1 |
| 2 SKILLED NURSING CARE | | | | | | 8587 | | 15375 | 2 |
| 3 PHYSICAL THERAPY | | | | | | | | 2229 | 3 |
| 4 OCCUPATIONAL THERAPY | | | | | | | | | 4 |
| 5 SPEECH PATHOLOGY | | | | | | | | | 5 |
| 6 MEDICAL SOCIAL SERVICES | | | | | | | | | 6 |
| 7 HOME HEALTH AIDE | | | | | | 275 | | 534 | 7 |
| 8 SUPPLIES | | | | | | | | 138 | 8 |
| 9 DRUGS | | | | | | | | 152 | 9 |
| 9.20 COST OF ADMINISTERING VACC | | | | | | | | | 9.20 |
| 10 DME | | | | | | | | | 10 |
| 11 HOME DIALYSIS AIDE SERVICE | | | | | | | | | 11 |
| 12 RESPIRATORY THERAPY | | | | | | | | | 12 |
| 13 PRIVATE DUTY NURSING | | | | | | 1260 | | 2510 | 13 |
| 14 CLINIC | | | | | | | | | 14 |
| 15 HEALTH PROMOTION ACTIVITIE | | | | | | | | | 15 |
| 16 DAY CARE PROGRAM | | | | | | | | | 16 |
| 17 HOME DELIVERED MEALS PROGR | | | | | | | | | 17 |
| 18 HOMEMAKER SERVICE | | | | | | | | | 18 |
| 19 ALL OTHERS | | | | | | | | | 19 |
| 19.50 TELEMEDICINE | | | | | | | | | 19.50 |
| 20 TOTALS | | | 76 | 76 | | 10122 | | 22116 | 20 |
| 21 TOTAL COST TO BE ALLOCATED | | | 126 | 1052 | | 2614 | | 10376 | 21 |
| 22 UNIT COST MULTIPLIER | | | 1.657895 | | | | | | 22 |
| 22 UNIT COST MULTIPLIER | | | | 13.842105 | | .258249 | | .469163 | 22 |

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7627

WORKSHEET H-5
 PART II

| HHA COST CENTER | MAIN- TENANCE & REPAIRS SQUARE FEET | OPERATION OF PLANT SQUARE FEET | LAUNDRY + LINEN SERVICE POUNDS OF LAUNDRY | HOUSE- KEEPING SQUARE FEET | DIETARY MEALS SERVED | CAFETERIA FTE'S | MAIN- TENANCE OF PERSONNEL HOUSED | NURSING ADMINIS- TRATION DIRECT NRSING HRS | |
|---------------------------------|---|---|---|-------------------------------------|----------------------------|--------------------|--|--|-------|
| | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | |
| 1 ADMINISTRATIVE AND GENERAL | | 76 | | 76 | | 4 | | | 1 |
| 2 SKILLED NURSING CARE | | | | | | | | | 2 |
| 3 PHYSICAL THERAPY | | | | | | | | | 3 |
| 4 OCCUPATIONAL THERAPY | | | | | | | | | 4 |
| 5 SPEECH PATHOLOGY | | | | | | | | | 5 |
| 6 MEDICAL SOCIAL SERVICES | | | | | | | | | 6 |
| 7 HOME HEALTH AIDE | | | | | | | | | 7 |
| 8 SUPPLIES | | | | | | | | | 8 |
| 9 DRUGS | | | | | | | | | 9 |
| 9.20 COST OF ADMINISTERING VACC | | | | | | | | | 9.20 |
| 10 DME | | | | | | | | | 10 |
| 11 HOME DIALYSIS AIDE SERVICE | | | | | | | | | 11 |
| 12 RESPIRATORY THERAPY | | | | | | | | | 12 |
| 13 PRIVATE DUTY NURSING | | | | | | | | | 13 |
| 14 CLINIC | | | | | | | | | 14 |
| 15 HEALTH PROMOTION ACTIVITIE | | | | | | | | | 15 |
| 16 DAY CARE PROGRAM | | | | | | | | | 16 |
| 17 HOME DELIVERED MEALS PROGR | | | | | | | | | 17 |
| 18 HOMEMAKER SERVICE | | | | | | | | | 18 |
| 19 ALL OTHERS | | | | | | 20 | | | 19 |
| 19.50 TELEMEDICINE | | | | | | | | | 19.50 |
| 20 TOTALS | | 76 | | 76 | | 24 | | | 20 |
| 21 TOTAL COST TO BE ALLOCATED | | 2285 | | 899 | | 1239 | | | 21 |
| 22 UNIT COST MULTIPLIER | | | | | | | | | 22 |
| 22 UNIT COST MULTIPLIER | | 30.065789 | | 11.828947 | | 51.625000 | | | 22 |

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PERIOD FROM 10/01/2007 TO 09/30/2008

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
STATISTICAL BASIS

HHA NO.: 14-7627

WORKSHEET H-5
PART II

| HHA COST CENTER | PARAMED EDUCATION | ASSIGNED TIME |
|---------------------------------|----------------------|------------------|
| | | 24 |
| 1 ADMINISTRATIVE AND GENERAL | | 1 |
| 2 SKILLED NURSING CARE | | 2 |
| 3 PHYSICAL THERAPY | | 3 |
| 4 OCCUPATIONAL THERAPY | | 4 |
| 5 SPEECH PATHOLOGY | | 5 |
| 6 MEDICAL SOCIAL SERVICES | | 6 |
| 7 HOME HEALTH AIDE | | 7 |
| 8 SUPPLIES | | 8 |
| 9 DRUGS | | 9 |
| 9.20 COST OF ADMINISTERING VACC | | 9.20 |
| 10 DME | | 10 |
| 11 HOME DIALYSIS AIDE SERVICE | | 11 |
| 12 RESPIRATORY THERAPY | | 12 |
| 13 PRIVATE DUTY NURSING | | 13 |
| 14 CLINIC | | 14 |
| 15 HEALTH PROMOTION ACTIVITIE | | 15 |
| 16 DAY CARE PROGRAM | | 16 |
| 17 HOME DELIVERED MEALS PROGR | | 17 |
| 18 HOMEMAKER SERVICE | | 18 |
| 19 ALL OTHERS | | 19 |
| 19.50 TELEMEDICINE | | 19.50 |
| 20 TOTALS | | 20 |
| 21 TOTAL COST TO BE ALLOCATED | | 21 |
| 22 UNIT COST MULTIPLIER | | 22 |
| 22 UNIT COST MULTIPLIER | | 22 |

APPORIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7627

WORKSHEET H-6
 PARTS I & II

CHECK APPLICABLE BOX: [] TITLE V [] TITLE XVIII [] TITLE XIX

PART I - APPORIONMENT OF HHA COST CENTERS: COMPUTATION OF THE LESSER OF AGGREGATE PROGRAM COST OR THE AGGREGATE OF THE PROGRAM LIMITATION

| COST PER VISIT COMPUTATION | | FROM | FACILITY | SHARED | TOTAL HHA | TOTAL | AVERAGE | |
|---|--|---|------------|--------------------|-----------|------------|---------------------------|-------|
| PATIENT SERVICES | | WKST H-5, PART I, COL 29, LINE | COSTS | ANCILLARY COSTS | COSTS | VISITS | COST PER VISIT | |
| | | 1 | 2 | 3 | 4 | 5 | | |
| 1 | SKILLED NURSING CARE | 2 | 26321 | | 26321 | 163 | 161.48 | 1 |
| 2 | PHYSICAL THERAPY | 3 | 3817 | 7348 | 11165 | 98 | 113.93 | 2 |
| 3 | OCCUPATIONAL THERAPY | 4 | | 4905 | 4905 | 28 | 175.18 | 3 |
| 4 | SPEECH PATHOLOGY | 5 | | | | | | 4 |
| 5 | MEDICAL SOCIAL SERV | 6 | | | | | | 5 |
| 6 | HOME HEALTH AIDE SERV | 7 | 915 | | 915 | 28 | 32.68 | 6 |
| 7 | TOTAL | | 31053 | 12253 | 43306 | 317 | | 7 |
| LIMITATION COST COMPUTATION | | | MSA NO. | | | | PROGRAM COST LIMITS | |
| PATIENT SERVICES | | | 1 | 2 | 3 | 4 | 5 | |
| 8 | SKILLED NURSING CARE | | 9914 | | | | | 8 |
| 9 | PHYSICAL THERAPY | | 9914 | | | | | 9 |
| 10 | OCCUPATIONAL THERAPY | | 9914 | | | | | 10 |
| 11 | SPEECH PATHOLOGY | | 9914 | | | | | 11 |
| 12 | MEDICAL SOCIAL SERV | | 9914 | | | | | 12 |
| 13 | HOME HEALTH AIDE SERV | | 9914 | | | | | 13 |
| 14 | TOTAL | | | | | | | 14 |
| SUPPLIES AND DRUGS COST COMPUTATIONS | | FROM | FACILITY | SHARED | TOTAL HHA | TOTAL | RATIO | |
| OTHER PATIENT SERVICES | | WKST H-5, PART I, COL 29, LINE | COSTS | ANCILLARY COSTS | COSTS | CHARGES | | |
| | | 1 | 2 | 3 | 4 | 5 | | |
| 15 | COST OF MEDICAL SUPPLIES | 8 | 237 | 58 | 295 | 248 | 1.189516 | 15 |
| 16 | COST OF DRUGS | 9 | 260 | | 260 | | | 16 |
| 16.20 | COST OF ADMINISTERING VACCINES | 9.20 | | | | | | 16.20 |
| PER BENEFICIARY COST LIMITATION: | | | | | | MSA NO. | AMOUNT | |
| | | | | | | 1 | 2 | |
| 17 | PROGRAM UNDUPLICATED CENSUS FROM WORKSHEET S-4 | | | | | 9914 | | 17 |
| 18 | PER BENEFICIARY COST LIMITATION | | | | | 9914 | | 18 |
| 19 | PER BENEFICIARY COST LIMITATION | | | | | | | 19 |

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7627

WORKSHEET H-6
 PARTS II & III

CHECK APPLICABLE BOX: [] TITLE V [XX] TITLE XVIII [] TITLE XIX

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

| | FROM WKST C, PART I, COL 9, LINE | COST TO CHARGE RATIO | TOTAL HHA CHARGES | HHA SHARED ANCILLARY COSTS | TRANSFER TO PART I | |
|---|--|----------------------------|-------------------------|-------------------------------------|--------------------------|---|
| | 1 | 2 | 3 | 4 | 5 | |
| 1 | PHYSICAL THERAPY 50 | .389295 | 18875 | 7348 | COL 2, LINE 2 | 1 |
| 2 | OCCUPATIONAL THERAPY 51 | .361259 | 13578 | 4905 | COL 2, LINE 3 | 2 |
| 3 | SPEECH PATHOLOGY 52 | .443798 | | | COL 2, LINE 4 | 3 |
| 4 | MEDICAL SUPPLIES CHARGED TO PA 55 | .235472 | 248 | 58 | COL 2, LINE 15 | 4 |
| 5 | DRUGS CHARGED TO PATIENTS 56 | .475305 | | | COL 2, LINE 16 | 5 |

PART III - OUTPATIENT THERAPY REDUCTION COMPUTATION

| | FROM PART I COL. 5 | COST PER VISIT | PART B SERVICES SUBJECT TO DEDUCTIBLES AND COINSURANCE | | | | |
|---|------------------------|-------------------|--|--|------------------------------------|--|---|
| | | | PROGRAM VISITS PRIOR TO 1/1/98 | PROGRAM VISITS FROM 1/1/98 THRU 12/31/98 | PROGRAM COST PRIOR TO 1/1/98 | PROGRAM COST FROM 1/1/98 THRU 12/31/98 | PROGRAM VISITS ON OR AFTER 1/1/99 |
| | 1 | 2 | 3 | 4 | 5 | | |
| 1 | PHYSICAL THERAPY 2 | 113.93 | 2.01 | 3 | 3.01 | 4 | 1 |
| 2 | OCCUPATIONAL THERAPY 3 | 175.18 | | | | | 2 |
| 3 | SPEECH PATHOLOGY 4 | | | | | | 3 |
| 4 | TOTAL | | | | | | 4 |

CALCULATION OF HHA REMBURSEMENT SETTLEMENT

HHA NO.: 14-7627

WORKSHEET H-7
 PARTS I & II

CHECK APPLICABLE BOX: [] TITLE V [XX] TITLE XVIII [] TITLE XIX

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

| DESCRIPTION | ----- PART B ----- | | |
|---|--------------------|---|---|
| | PART A 1 | NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2 | SUBJECT TO DEDUCTIBLES & COINSURANCE 3 |
| 1 REASONABLE COST OF PROGRAM SERVICES | | | 1 |
| 2 REASONABLE COST OF SERVICES | | | 2 |
| 2 TOTAL CHARGES | | | 2 |
| CUSTOMARY CHARGES | | | |
| 3 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS | | | 3 |
| 4 AMOUNT 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(B) | | | 4 |
| 5 RATIO OF LINE 3 TO LINE 4 (NOT TO EXCEED 1.000000) | | | 5 |
| 6 TOTAL CUSTOMARY CHARGES | | | 6 |
| 7 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST | | | 7 |
| 8 EXCESS OF TOTAL REASONABLE COST OVER TOTAL CUSTOMARY CHARGES | | | 8 |
| 9 PRIMARY PAYOR PAYMENTS | | | 9 |

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

| DESCRIPTION | PART A SERVICES 1 | PART B SERVICES 2 | |
|--|-------------------------|-------------------------|-------|
| 10 TOTAL REASONABLE COST | | | 10 |
| 10.01 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS | | | 10.01 |
| 10.02 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS | 18280 | 9898 | 10.02 |
| 10.03 TOTAL PPS REIMBURSEMENT - LUPA EPISODES | 356 | | 10.03 |
| 10.04 TOTAL PPS REIMBURSEMENT - PEP EPISODES | 1826 | 5655 | 10.04 |
| 10.05 TOTAL PPS REIMBURSEMENT - SCIC WITHIN A PEP EPISODES | | | 10.05 |
| 10.06 TOTAL PPS REIMBURSEMENT - SCIC EPISODES | | | 10.06 |
| 10.07 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS | | | 10.07 |
| 10.08 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES | | | 10.08 |
| 10.09 TOTAL PPS OUTLIER REIMBURSEMENT - SCIC WITHIN A PEP EPISODES | | | 10.09 |
| 10.10 TOTAL PPS OUTLIER REIMBURSEMENT - SCIC EPISODES | | | 10.10 |
| 10.11 TOTAL OTHER PAYMENTS | | | 10.11 |
| 10.12 DME PAYMENTS | | | 10.12 |
| 10.13 OXYGEN PAYMENTS | | | 10.13 |
| 10.14 PROSTHETIC AND ORTHOTIC PAYMENTS | | | 10.14 |
| 11 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCL COINSURANCE) | | | 11 |
| 12 SUBTOTAL | 20462 | 15553 | 12 |
| 13 EXCESS REASONABLE COST | | | 13 |
| 14 SUBTOTAL | 20462 | 15553 | 14 |
| 15 COINSURANCE BILLED TO PROGRAM PATIENTS | | | 15 |
| 16 NET COST | 20462 | 15553 | 16 |
| 17 REIMBURSABLE BAD DEBTS | | | 17 |
| 17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES | | | 17.01 |
| 18 TOTAL COSTS - CURRENT COST REPORTING PERIOD | 20462 | 15553 | 18 |
| 19 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS | | | 19 |
| 20 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM AGENCIES' TERMINATION OR OR DECREASE IN PROGRAM UTILIZATION | | | 20 |
| 21 OTHER ADJUSTMENTS (SPECIFY): | | | 21 |
| 22 SUBTOTAL | 20462 | 15553 | 22 |
| 23 SEQUESTRATION ADJUSTMENT | | | 23 |
| 24 SUBTOTAL | 20462 | 15553 | 24 |
| 25 TOTAL INTERIM PAYMENTS | 20462 | 15553 | 25 |
| 25.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY) | | | 25.01 |
| 26 BALANCE DUE PROVIDER/PROGRAM | | | 26 |
| 27 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2 | | | 27 |

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHA'S
 FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

HHA NO.: 14-7627

WORKSHEET H-8

| DESCRIPTION | PART A | | PART B | | |
|---|----------------|-------------|----------------|-------------|------|
| | MO/DAY/YR 1 | AMOUNT 2 | MO/DAY/YR 3 | AMOUNT 4 | |
| 1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER | | 20462 | | 15553 | 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. | | NONE | | NONE | 2 |
| 3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM | | | | | |
| ADJUSTMENT AMOUNT BASED ON SUBSEQUENT | PROGRAM | .01 | | | 3.01 |
| REVISION OF THE INTERIM RATE FOR THE COST | TO | .02 | | | 3.02 |
| REPORTING PERIOD. ALSO SHOW DATE OF EACH | PROVIDER | .03 | NONE | NONE | 3.03 |
| PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | PROVIDER | .04 | | | 3.04 |
| | | .05 | | | 3.05 |
| | | .50 | | | 3.50 |
| | PROVIDER | .51 | | | 3.51 |
| | TO | .52 | NONE | NONE | 3.52 |
| | PROGRAM | .53 | | | 3.53 |
| | | .54 | | | 3.54 |
| SUBTOTAL | | .99 | | | 3.99 |
| 4 TOTAL INTERIM PAYMENTS | | 20462 | | 15553 | 4 |
| TO BE COMPLETED BY INTERMEDIARY | | | | | |
| 5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | PROGRAM | .01 | | | 5.01 |
| | TO | .02 | | | 5.02 |
| | PROVIDER | .03 | | | 5.03 |
| | PROVIDER | .50 | | | 5.50 |
| | TO | .51 | | | 5.51 |
| | PROGRAM | .52 | | | 5.52 |
| SUBTOTAL | | .99 | | | 5.99 |
| 6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT. | PROGRAM TO | .01 | | | 6.01 |
| | PROVIDER TO | .02 | | | 6.02 |
| 7 TOTAL MEDICARE PROGRAM LIABILITY | PROGRAM | | | | 7 |

NAME OF INTERMEDIARY:

INTERMEDIARY NUMBER:

SIGNATURE OF AUTHORIZED PERSON:

DATE (MO/DAY/YR):

CALCULATION OF CAPITAL PAYMENT - TITLE XIX - COST METHOD

WORKSHEET L

| | HOSPITAL (14-1318) | SUB I | SUB II | SUB III | SUB IV |
|--|---|-------|--------|---------|--------|
| PART I - FULLY PROSPECTIVE METHOD | | | | | |
| 1 | CAPITAL HOSPITAL SPECIFIC RATE PAYMENTS | | | | 1 |
| | CAPITAL FEDERAL AMOUNT | | | | |
| 2 | CAPITAL DRG OTHER THAN OUTLIER | | | | 2 |
| 3 | CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED PRIOR TO OCTOBER 1, 1997 | | | | 3 |
| 3.01 | CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1997 | | | | 3.01 |
| | INDIRECT MEDICAL EDUCATION ADJUSTMENT | | | | |
| 4 | TOTAL INPAT DAYS DIVIDED BY NO OF DAYS IN CR PERIOD | | | | 4 |
| 4.01 | NUMBER OF INTERNS AND RESIDENTS FROM WORKSHEET S-3, PART I | | | | 4.01 |
| 4.02 | INDIRECT MEDICAL EDUCATION PERCENTAGE | | | | 4.02 |
| 4.03 | INDIRECT MEDICAL EDUCATION ADJUSTMENT DISPROPORTIONATE SHARE ADJUSTMENT | | | | 4.03 |
| 5 | % OF SSI RECIPIENT PAT DAYS TO MEDICARE PART A PAT DAYS | | | | 5 |
| 5.01 | % OF MEDICAID PAT DAYS TO TOTAL DAYS ON WKST S-3, PART I | | | | 5.01 |
| 5.02 | SUM OF LINES 5 AND 5.01 | | | | 5.02 |
| 5.03 | ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE | | | | 5.03 |
| 5.04 | DISPROPORTIONATE SHARE ADJUSTMENT | | | | 5.04 |
| 6 | TOTAL PROSPECTIVE CAPITAL PAYMENTS | | | | 6 |
| PART II - HOLD HARMLESS METHOD | | | | | |
| 1 | NEW CAPITAL | | | | 1 |
| 2 | OLD CAPITAL | | | | 2 |
| 3 | TOTAL CAPITAL | | | | 3 |
| 4 | RATIO OF NEW CAPITAL TO TOTAL CAPITAL | | | | 4 |
| 5 | TOTAL CAPITAL PAYMENTS UNDER 100% FEDERAL RATE | | | | 5 |
| 6 | REDUCTION FACTOR FOR HOLD HARMLESS PAYMENT | | | | 6 |
| 7 | REDUCED OLD CAPITAL AMOUNT | | | | 7 |
| 8 | HOLD HARMLESS PAYMENT FOR NEW CAPITAL | | | | 8 |
| 9 | SUBTOTAL | | | | 9 |
| 10 | PAYMENT UNDER HOLD HARMLESS (GREATER OF LINE 5 OR LINE 9) | | | | 10 |
| PART III - PAYMENT UNDER REASONABLE COST | | | | | |
| 1 | PROGRAM INPATIENT ROUTINE CAPITAL COST | | | | 1 |
| 2 | PROGRAM INPATIENT ANCILLARY CAPITAL COST | | | | 2 |
| 3 | TOTAL INPATIENT PROGRAM CAPITAL | | | | 3 |
| 4 | CAPITAL COST PAYMENT FACTOR | | | | 4 |
| 5 | TOTAL INPATIENT PROGRAM CAPITAL COST | | | | 5 |
| PART IV - COMPUTATION OF EXCEPTION PAYMENTS | | | | | |
| 1 | PROGRAM INPATIENT CAPITAL COSTS | | | | 1 |
| 2 | PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES | | | | 2 |
| 3 | NET PROGRAM INPATIENT CAPITAL COSTS | | | | 3 |
| 4 | APPLICABLE EXCEPTION PERCENTAGE | | | | 4 |
| 5 | CAPITAL COST FOR COMPARISON TO PAYMENTS | | | | 5 |
| 6 | PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES | | | | 6 |
| 7 | ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES | | | | 7 |
| 8 | CAPITAL MINIMUM PAYMENT LEVEL | | | | 8 |
| 9 | CURRENT YEAR CAPITAL PAYMENTS | | | | 9 |
| 10 | CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS | | | | 10 |
| 11 | CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT | | | | 11 |
| 12 | NET COMPARISON OF CAPITAL MINIMUM PYMNT LEVEL TO CAPITAL PYMNTS | | | | 12 |
| 13 | CURRENT YEAR EXCEPTION PAYMENT | | | | 13 |
| 14 | CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR FOLLOWING PERIOD | | | | 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 | | | | 17 |

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

| COST CENTER DESCRIPTION | EXTRAORDI- NARY CAP- REL COSTS | SUBTOTAL | SUBTOTAL | I&R COST & POST STEP- DOWN ADJS | TOTAL | |
|---------------------------------------|--------------------------------------|----------|----------|---------------------------------------|-------|-------|
| | 0 | 4A | 25 | 26 | 27 | |
| GENERAL SERVICE COST CENTERS | | | | | | |
| 1 OLD CAP REL COSTS-BLDG & FIXT | | | | | | 1 |
| 2 OLD CAP REL COSTS-MVBLE EQUIP | | | | | | 2 |
| 3 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 3 |
| 4 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 4 |
| 4.01 NEW CAP REL COSTS-MVBLE EQUIP N | | | | | | 4.01 |
| 5 EMPLOYEE BENEFITS | | | | | | 5 |
| 6 ADMINISTRATIVE & GENERAL | | | | | | 6 |
| 7 MAINTENANCE & REPAIRS | | | | | | 7 |
| 8 OPERATION OF PLANT | | | | | | 8 |
| 9 LAUNDRY & LINEN SERVICE | | | | | | 9 |
| 10 HOUSEKEEPING | | | | | | 10 |
| 11 DIETARY | | | | | | 11 |
| 12 CAFETERIA | | | | | | 12 |
| 13 MAINTENANCE OF PERSONNEL | | | | | | 13 |
| 14 NURSING ADMINISTRATION | | | | | | 14 |
| 15 CENTRAL SERVICES & SUPPLY | | | | | | 15 |
| 16 PHARMACY | | | | | | 16 |
| 17 MEDICAL RECORDS & LIBRARY | | | | | | 17 |
| 18 SOCIAL SERVICE | | | | | | 18 |
| 20 NONPHYSICIAN ANESTHETISTS | | | | | | 20 |
| 21 NURSING SCHOOL | | | | | | 21 |
| 22 I&R SERVICES-SALARY & FRINGES A | | | | | | 22 |
| 23 I&R SERVICES-OTHER PRGM COSTS A | | | | | | 23 |
| 24 PARAMED ED PRGM-(SPECIFY) | | | | | | 24 |
| INPATIENT ROUTINE SERV COST CENTERS | | | | | | |
| 25 ADULTS & PEDIATRICS | | | | | | 25 |
| 34 SKILLED NURSING FACILITY | | | | | | 34 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 37 OPERATING ROOM | | | | | | 37 |
| 40 ANESTHESIOLOGY | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | | | | | | 41 |
| 44 LABORATORY | | | | | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | | | | | | 49 |
| 50 PHYSICAL THERAPY | | | | | | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | | | | | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | | | | | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | | | | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 61 EMERGENCY | | | | | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | | | | | | 62 |
| 63.50 RHC | | | | | | 63.50 |
| 63.60 FQHC | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 69.10 CMHC | | | | | | 69.10 |
| 69.20 OUTPATIENT PHYSICAL THERAPY | | | | | | 69.20 |
| 69.30 OUTPATIENT OCCUPATIONAL THERAPY | | | | | | 69.30 |
| 69.40 OUTPATIENT SPEECH PATHOLOGY | | | | | | 69.40 |
| 71 HOME HEALTH AGENCY | | | | | | 71 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 85.01 PANCREAS ACQUISITION | | | | | | 85.01 |
| 85.02 INTESTINAL ACQUISITION | | | | | | 85.02 |
| 85.03 ISLET CELL ACQUISITION | | | | | | 85.03 |
| 95 SUBTOTALS | | | | | | 95 |
| NONREIMBURSABLE COST CENTERS | | | | | | |
| 00 CLINIC | | | | | | 00 |
| 00.01 RENTAL SPACE | | | | | | 00.01 |
| 101 CROSS FOOT ADJUSTMENTS | | | | | | 101 |
| 102 NEGATIVE COST CENTER | | | | | | 102 |
| 103 TOTAL | | | | | | 103 |
| 104 TOTAL STATISTICAL BASIS | | | | | | 104 |
| 105 UNIT COST MULTIPLIER | | | | | | 105 |
| 105 UNIT COST MULTIPLIER | | | | | | 105 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2007 TO 09/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2007.06
 02/26/2009 12:14

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
 FEDERALLY QUALIFIED HEALTH CENTER COSTS

RHC I
 COMPONENT NO: 14-3461

WORKSHEET M-1

CHECK [XX] RHC
 APPLICABLE BOX: [] FQHC

| | COMPEN- SATION 1 | OTHER COSTS 2 | TOTAL 3 | RECLASSIFI- CATIONS 4 | RECLASSIFIED TRIAL BALANCE 5 | ADJUST- MENTS 6 | NET EXPENSES FOR ALLOCATION 7 | |
|--|------------------------|---------------------|------------|-----------------------------|---------------------------------------|-----------------------|--|----|
| FACILITY HEALTH CARE STAFF COSTS | | | | | | | | |
| 1 PHYSICIAN | 1087024 | 20360 | 1107384 | | 1107384 | | 1107384 | 1 |
| 2 PHYSICIAN ASSISTANT | 245425 | | 245425 | | 245425 | | 245425 | 2 |
| 3 NURSE PRACTITIONER | | | | | | | | 3 |
| 4 VISITING NURSE | | | | | | | | 4 |
| 5 OTHER NURSE | 297956 | | 297956 | | 297956 | | 297956 | 5 |
| 6 CLINICAL PSYCHOLOGIST | | | | | | | | 6 |
| 7 CLINICAL SOCIAL WORKER | | | | | | | | 7 |
| 8 LABORATORY TECHNICIAN | | | | | | | | 8 |
| 9 OTHER FACILITY HEALTH CARE STAFF COSTS | | | | | | | | 9 |
| 10 SUBTOTAL (SUM OF LINES 1-9) COSTS UNDER AGREEMENT | 1630405 | 20360 | 1650765 | | 1650765 | | 1650765 | 10 |
| 11 PHYSICIAN SERVICES UNDER AGREEMENT | | | | | | | | 11 |
| 12 PHYSICIAN SUPERVISION UNDER AGREEMENT | | | | | | | | 12 |
| 13 OTHER COSTS UNDER AGREEMENT | | | | | | | | 13 |
| 14 SUBTOTAL (SUM OF LINES 11-13) OTHER HEALTH CARE COSTS | | | | | | | | 14 |
| 15 MEDICAL SUPPLIES | | 42311 | 42311 | | 42311 | | 42311 | 15 |
| 16 TRANSPORTATION (HEALTH CARE STAFF) | | 2727 | 2727 | | 2727 | | 2727 | 16 |
| 17 DEPRECIATION-MEDICAL EQUIPMENT | | | | | | | | 17 |
| 18 PROFESSIONAL LIABILITY INSURANCE | | 66000 | 66000 | | 66000 | | 66000 | 18 |
| 19 OTHER HEALTH CARE COSTS | | 57390 | 57390 | | 57390 | | 57390 | 19 |
| 20 ALLOWABLE GME COSTS | | | | | | | | 20 |
| 21 SUBTOTAL (SUM OF LINES 15-20) | | 168428 | 168428 | | 168428 | | 168428 | 21 |
| 22 TOTAL COSTS OF HEALTH CARE SERVICES COSTS OTHER THAN RHC/FQHC SERVICES | 1630405 | 188788 | 1819193 | | 1819193 | | 1819193 | 22 |
| 23 PHARMACY | | | | | | | | 23 |
| 24 DENTAL | | | | | | | | 24 |
| 25 OPTOMETRY | | | | | | | | 25 |
| 26 ALL OTHER NONREIMBURSABLE COSTS | | 1974 | 1974 | | 1974 | | 1974 | 26 |
| 27 NONALLOWABLE GME COSTS | | | | | | | | 27 |
| 28 TOTAL NONREIMBURSABLE COSTS FACILITY OVERHEAD | | 1974 | 1974 | | 1974 | | 1974 | 28 |
| 29 FACILITY COSTS | | | | | | | | 29 |
| 30 ADMINISTRATIVE COSTS | 294441 | 112486 | 406927 | -361631 | 45296 | -12425 | 32871 | 30 |
| 31 TOTAL FACILITY OVERHEAD | 294441 | 112486 | 406927 | -361631 | 45296 | -12425 | 32871 | 31 |
| 32 TOTAL FACILITY COSTS | 1924846 | 303248 | 2228094 | -361631 | 1866463 | -12425 | 1854038 | 32 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2007 TO 09/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2007.06
 02/26/2009 12:14

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3461

WORKSHEET M-2

CHECK [XX] RHC
 APPLICABLE BOX: [] FQHC

VISITS AND PRODUCTIVITY

| | NUMBER OF FTE PERSONNEL 1 | TOTAL VISITS 2 | PRODUCTIVITY STANDARD 3 | MINIMUM VISITS 4 | GREATER OF COL. 2 OR COL. 4 5 | |
|---------------------------------------|------------------------------------|----------------------|-------------------------------|------------------------|--|---|
| 1 PHYSICIANS | 4.10 | 19626 | 4200 | 17220 | | 1 |
| 2 PHYSICIAN ASSISTANTS | 3.19 | 13562 | 2100 | 6699 | | 2 |
| 3 NURSE PRACTITIONERS | | | 2100 | | | 3 |
| 4 SUBTOTAL | 7.29 | 33188 | | 23919 | 33188 | 4 |
| 5 VISITING NURSE | | | | | | 5 |
| 6 CLINICAL PSYCHOLOGIST | | | | | | 6 |
| 7 CLINICAL SOCIAL WORKER | | | | | | 7 |
| 8 TOTAL FTEs AND VISITS | 7.29 | 33188 | | | 33188 | 8 |
| 9 PHYSICIAN SERVICES UNDER AGREEMENTS | | | | | | 9 |

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

| | | | | | | |
|---|--|--|--|--|----------|----|
| 10 TOTAL COSTS OF HEALTH CARE SERVICES | | | | | 1819193 | 10 |
| 11 TOTAL NONREIMBURSABLE COSTS | | | | | 1974 | 11 |
| 12 COST OF ALL SERVICES (EXCLUDING OVERHEAD) | | | | | 1821167 | 12 |
| 13 RATIO OF RHC/FQHC SERVICES | | | | | 0.998916 | 13 |
| 14 TOTAL FACILITY OVERHEAD | | | | | 32871 | 14 |
| 15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY | | | | | 2287183 | 15 |
| 16 TOTAL OVERHEAD | | | | | 2320054 | 16 |
| 17 ALLOWABLE GME OVERHEAD | | | | | | 17 |
| 18 SUBTRACT LINE 17 FROM LINE 16 | | | | | 2320054 | 18 |
| 19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES | | | | | 2317539 | 19 |
| 20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES | | | | | 4136732 | 20 |

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3461

WORKSHEET M-3

CHECK [XX] RHC [] TITLE V
 APPLICABLE BOX: [] FQHC [XX] TITLE XVIII
 [] TITLE XIX

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

| | | | | |
|---|---|--|---------|---|
| 1 | TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES | | 4136732 | 1 |
| 2 | COST OF VACCINES AND THEIR ADMINISTRATION | | 133 | 2 |
| 3 | TOTAL ALLOWABLE COST EXCLUDING VACCINE | | 4136599 | 3 |
| 4 | TOTAL VISITS | | 33188 | 4 |
| 5 | PHYSICIANS VISITS UNDER AGREEMENT | | | 5 |
| 6 | TOTAL ADJUSTED VISITS | | 33188 | 6 |
| 7 | ADJUSTED COST PER VISIT | | 124.64 | 7 |

CALCULATION OF LIMIT(1)
 PRIOR TO ON OR AFTER
 JANUARY 1 JANUARY 1 (SEE INSTR.)
 1 2 3

| | | | | |
|---|---------------------------------|--------|--------|---|
| 8 | PER VISIT PAYMENT LIMIT | 74.29 | 75.63 | 8 |
| 9 | RATE FOR PROGRAM COVERED VISITS | 124.64 | 124.64 | 9 |

CALCULATION OF SETTLEMENT

| | | | | |
|-------|--|--|--------|-------|
| 10 | PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES | | 6290 | 10 |
| 11 | PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES | | 783986 | 11 |
| 12 | PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES | | | 12 |
| 13 | PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES | | | 13 |
| 14 | LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES | | | 14 |
| 15 | GRADUATE MEDICAL EDUCATION PASS THROUGH COST | | | 15 |
| 16 | TOTAL PROGRAM COST | | 783986 | 16 |
| 16.01 | PRIMARY PAYOR PAYMENTS | | | 16.01 |
| 17 | LESS: BENEFICIARY DEDUCTIBLE | | 88447 | 17 |
| 18 | NET PROGRAM COST EXCLUDING VACCINES | | 695539 | 18 |
| 19 | REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE | | 556431 | 19 |
| 20 | PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION | | 92 | 20 |
| 21 | TOTAL REIMBURSABLE PROGRAM COST | | 556523 | 21 |
| 22 | REIMBURSABLE BAD DEBTS | | | 22 |
| 22.01 | REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES | | | 22.01 |
| 23 | OTHER ADJUSTMENTS | | | 23 |
| 24 | NET REIMBURSABLE AMOUNT | | 556523 | 24 |
| 25 | INTERIM PAYMENTS | | 488270 | 25 |
| 25.01 | TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY) | | | 25.01 |
| 26 | BALANCE DUE COMPONENT/PROGRAM | | 68253 | 26 |
| 27 | PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2 | | -24860 | 27 |

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2007 TO 09/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
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VERSION: 2007.06
 02/26/2009 12:14

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC I
 COMPONENT NO: 14-3461

WORKSHEET M-4

CHECK [XX] RHC [] TITLE V
 APPLICABLE BOX: [] FQHC [XX] TITLE XVIII
 [] TITLE XIX

| | PNEUMOCOCCAL 1 | INFLUENZA 2 | |
|--|-------------------|----------------|----|
| 1 HEALTH CARE STAFF COSTS | 1650765 | 1650765 | 1 |
| 2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME | 0.000001 | 0.000001 | 2 |
| 3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST | 2 | 2 | 3 |
| 4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE | 38 | 17 | 4 |
| 5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE | 40 | 19 | 5 |
| 6 TOTAL DIRECT COST OF THE FACILITY | 1819193 | 1819193 | 6 |
| 7 TOTAL OVERHEAD | 2320054 | 2320054 | 7 |
| 8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST | 0.000022 | 0.000010 | 8 |
| 9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE | 51 | 23 | 9 |
| 10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION | 91 | 42 | 10 |
| 11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS | 105 | 759 | 11 |
| 12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION | 0.87 | 0.06 | 12 |
| 13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES | 76 | 435 | 13 |
| 14 MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION | 66 | 26 | 14 |
| 15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION | | 133 | 15 |
| 16 TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION | | 92 | 16 |

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2007 TO 09/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2007.06
02/26/2009 12:14

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER
FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

RHC I
COMPONENT NO: 14-3461

WORKSHEET M-5

CHECK [XX] RHC
APPLICABLE BOX: [] FQHC

| DESCRIPTION | PART B | | |
|--|---|-------------|--|
| | 1 MM/DD/YYYY | 2 AMOUNT | |
| 1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER | | 488270 | 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. | | NONE | 2 |
| 3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .04 .05 .50 PROVIDER .51 TO .52 PROGRAM .53 .54 | NONE | 3.01 3.02 3.03 3.04 3.05 3.50 3.51 3.52 3.53 3.54 |
| SUBTOTAL | .99 | | 3.99 |
| 4 TOTAL INTERIM PAYMENTS | | 488270 | 4 |
| TO BE COMPLETED BY INTERMEDIARY | | | |
| 5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .50 TO .51 PROGRAM .52 | | 5.01 5.02 5.03 5.50 5.51 5.52 |
| SUBTOTAL | .99 | | 5.99 |
| 6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT. | PROGRAM TO .01 PROVIDER TO .02 PROGRAM | | 6.01 6.02 |
| 7 TOTAL MEDICARE PROGRAM LIABILITY | | | 7 |

NAME OF INTERMEDIARY:

INTERMEDIARY NUMBER:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE (MO/DAY/YR): _____

***** REPORT 97 ***** UTILIZATION STATISTICS *****

HOSPITAL

| COST CENTERS | ---- TITLE XVIII ---- | | ----- TITLE XIX ----- | | ----- TITLE V ----- | | TOTAL THIRD PARTY UTIL |
|--|-----------------------|-------------|-----------------------|-----------------|---------------------|-----------------|------------------------|
| | PART A 1 | PART B 2 | INPATIENT 3 | OUTPATIENT 4 | INPATIENT 5 | OUTPATIENT 6 | |
| UTILIZATION PERCENTAGES BASED ON DAYS | | | | | | | |
| 25 ADULTS & PEDIATRICS | 37.66 | | 4.53 | | | | 42.19 25 |
| UTILIZATION PERCENTAGES BASED ON CHARGES | | | | | | | |
| 37 OPERATING ROOM | 9.82 | 21.57 | | | | | 31.39 37 |
| 40 ANESTHESIOLOGY | 3.72 | 0.47 | | | | | 4.19 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 5.45 | 29.68 | | | | | 35.13 41 |
| 44 LABORATORY | 8.47 | 36.66 | | | | | 45.13 44 |
| 49 RESPIRATORY THERAPY | 34.37 | 3.98 | | | | | 38.35 49 |
| 50 PHYSICAL THERAPY | 3.20 | 30.22 | | | | | 33.42 50 |
| 51 OCCUPATIONAL THERAPY | 6.67 | 19.13 | | | | | 25.80 51 |
| 52 SPEECH PATHOLOGY | 26.30 | 8.75 | | | | | 35.05 52 |
| 53 ELECTROCARDIOLOGY | 0.18 | 44.64 | | | | | 44.82 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | 17.34 | 19.88 | | | | | 37.22 55 |
| 56 DRUGS CHARGED TO PATIENTS | 29.31 | 14.00 | | | | | 43.31 56 |
| 61 EMERGENCY | 0.07 | 34.63 | | | | | 34.70 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | | 49.75 | | | | | 49.75 62 |
| 101 TOTAL CHARGES | 7.55 | 23.61 | | | | | 31.16 101 |

***** REPORT 97 ***** UTILIZATION STATISTICS *****

SNF / NF

| COST CENTERS | SNF | | NF | | NF | | TOTAL THIRD PARTY UTIL |
|--|-----------------------|-------------|---------------------|-----------------|-------------------|-----------------|---------------------------|
| | ---- TITLE XVIII ---- | | ---- TITLE XIX ---- | | ---- TITLE V ---- | | |
| | PART A 1 | PART B 2 | INPATIENT 3 | OUTPATIENT 4 | INPATIENT 5 | OUTPATIENT 6 | |
| UTILIZATION PERCENTAGES BASED ON DAYS | | | | | | | |
| 34 SKILLED NURSING FACILITY | | 2.69 | | | | | 2.69 34 |
| UTILIZATION PERCENTAGES BASED ON CHARGES | | | | | | | |
| 41 RADIOLOGY-DIAGNOSTIC | 0.03 | | | | | | 0.03 41 |
| 44 LABORATORY | 0.10 | | | | | | 0.10 44 |
| 49 RESPIRATORY THERAPY | 1.01 | | | | | | 1.01 49 |
| 50 PHYSICAL THERAPY | 0.29 | | | | | | 0.29 50 |
| 51 OCCUPATIONAL THERAPY | 1.75 | | | | | | 1.75 51 |
| 52 SPEECH PATHOLOGY | 10.70 | | | | | | 10.70 52 |
| 53 ELECTROCARDIOLOGY | 0.03 | | | | | | 0.03 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | 0.39 | | | | | | 0.39 55 |
| 56 DRUGS CHARGED TO PATIENTS | 1.36 | | | | | | 1.36 56 |
| 101 TOTAL CHARGES | 0.21 | | | | | | 0.21 101 |

| COST CENTER | --- DIRECT COSTS --- | | -- ALLOCATED OVERHEAD -- | | --- TOTAL COSTS --- | | |
|---------------------------------------|----------------------|--------|--------------------------|------|---------------------|--------|--------|
| | AMOUNT | % | AMOUNT | % | AMOUNT | % | |
| 69.20 OUTPATIENT PHYSICAL THERAPY | | | | | | | 69.20 |
| 69.30 OUTPATIENT OCCUPATIONAL THERAPY | | | | | | | 69.30 |
| 69.40 OUTPATIENT SPEECH PATHOLOGY | | | | | | | 69.40 |
| 71 HOME HEALTH AGENCY | 18324 | .08 | 18727 | .15 | 37051 | .17 | 71 |
| SPECIAL PURPOSE COST CENTERS | | | | | | | |
| 85.01 PANCREAS ACQUISITION | | | | | | | 85.01 |
| 85.02 INTESTINAL ACQUISITION | | | | | | | 85.02 |
| 85.03 ISLET CELL ACQUISITION | | | | | | | 85.03 |
| NONREIMBURSABLE COST CENTERS | | | | | | | |
| 100 CLINIC | 718531 | 3.27 | 785761 | 6.20 | 1504292 | 6.84 | 100 |
| 100.01 RENTAL SPACE | | | | | | | 100.01 |
| 101 CROSS FOOT ADJUSTMENTS | | | | | | | 101 |
| 102 NEGATIVE COST CENTER | | | | | | | 102 |
| 103 TOTAL | 22002376 | 100.00 | 0 | .00 | 22002376 | 100.00 | 103 |

**** THIS PROVIDER IS NOT A PPS HOSPITAL

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

| | |
|---|---------|
| 1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPFS. (WKST D, PART V, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 x COLUMN 1.01 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66) | 2714613 |
| 2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPFS. (WKST D, PART V, LINE 104, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66) | 8466118 |
| 3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2) | .321 |

Exhibit 1 CMS-339 Rev 6.0
OMB NO. 0938-0301

KPMG LLP Q339 Ver 1.1 Submitted in Lieu of CMS-339 Rev 6.0

This questionnaire is required under the authority of sections 1815(a) and 1833(e) of the Social Security Act. Failure to submit this questionnaire will result in suspension of Medicare payments.

To the degree that the information in CMS-339: 1) constitutes commercial or financial information which is confidential, and/or 2) is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0301. The time required to complete this information collection is estimated to average 17 hours and 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE (You MUST USE Instructions For Completing This Form Located In PRM-II, \$\$1100ff.)

Provider Name: OSF Holy Family Medical Center
Filed with Form CMS-2552
(Other Specify) _____

Provider Number: 14-1318
Period From 10/01/2007
Period To 09/30/2008

Other Providers: OSF Holy Family SB SNF 14z318, OSF Holy Family SNF 143461

145528, OSF Holy Family HHA 147627, OSF Holy Family Clinics

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS QUESTIONNAIRE MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

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 information prepared by OSF Holy Family Medical Center 14-1318 (Provider name(s) and Number(s)) for the cost report period beginning 10/01/2007 and ending 09/30/2008, and that 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(s) in accordance with applicable instructions, except as noted.

(Signed) 
Officer or Administrator of Provider(s)

Date 2/26/09 Title CFO

Name and Telephone Number of Person to Contact for More Information: Michelle Carrothers (309)655-8273

NOTE: 42 CFR 413.20 and instructions contained in the PRM-1 require that the provider maintain adequate financial and statistical data necessary for the intermediary to use for a proper determination of costs payable under the program. Providers are, therefore, required to maintain and have available for audit all records necessary to verify the amounts and allowability of costs and equity capital included in the filed cost report. Failure to have such records available for review by fiscal intermediaries acting under the authority of the Secretary of the Department of Health and Human Services will render the amount claimed in the cost report unallowable.

| A. Provider Organization and Operation (NOTE: Section A to be completed by all providers.) | YES | NO | N/A |
|--|-----|----|-----|
| 1. The provider has: | | | |
| a. Changed ownership. If 'yes', submit name and address of new owner, date of change, copy of sales agreement, or any similar agreement affecting change of ownership. | | X | |
| OSF Healthcare System 800 N.E. GLEN OAK AVENUE PEORIA, ILLINOIS 61603 04/12/07 | | | |
| B. Terminated participation. If 'yes', list date of termination, and reason (Voluntary/Involuntary). | | X | |
| 2. The provider, members of the board of directors, officers, medical staff or management personnel are associated with or involved in business transactions with the following: | | | |
| a. Related organizations, management contracts and services under arrangements as owners (stockholders), management, by family relationship, or any other similar type relationship. | | X | |
| b. Management personnel of major suppliers of the provider (drug, medical supply companies, etc.). If 'yes' to question 2a and/or 2b, attach a list of the individuals, the organizations involved, and description of the transactions. | | X | |
| B. Financial Data and Reports (NOTE: Section B to be completed by all providers.) | | | |
| 1. During this cost reporting period, the financial statements are prepared by Certified Public Accountants or Public Accountants (submit complete copy or indicate available date) and are: | X | | |
| a. Audited; | | X | |
| b. Compiled; and | | | |
| c. Reviewed. | | | |
| NOTE: Where there is no affirmative response to the above described financial statements, attach a copy | | | |

B. Financial Data and Reports (Continued)

YES NO N/A

of the financial statements prepared and a description of the changes in accounting policies and practices if not mentioned in those statements.

2. Cost report total expenses and total revenues differ from those on the filed financial statement. If 'yes', submit reconciliation.

C. Capital-Related Cost (NOTE: Section C to be completed only by hospitals excluded from PPS (except Children 's) and PPS hospitals that have a unit excluded from PPS.)

1. Assets have been relifed for Medicare purposes. If 'yes', attach detailed listing of these specific assets, by classes, as shown in the Fixed Asset Register.

NOTE: For cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001, under the capital - PPS consistency rule (42 CFR 412.302 (d)), PPS hospitals are precluded from relifing old capital.

2. Due to appraisals made during this cost reporting period, changes have occurred to Medicare depreciation expense. If 'yes', attach copy of Appraisal Report and Appraisal Summary by class of asset.

3. New leases and/or amendments to existing leases for land, equipment, or facilities with annual rental payment in excess of the amounts listed in the instructions, have been entered into during this cost reporting period. If 'yes', submit a listing of these new leases and/or amendments to existing leases that have the following information:

- o A new lease or lease renewal;
- o Parties to the lease;
- o Period covered by the lease;
- o Description of the asset being leased; and
- o Annual charge by the lessor.

NOTE: Providers are required to submit copies of the lease, or significant extracts, upon request from the intermediary.

4. There have been new capitalized leases entered into during the current cost reporting period. If 'yes', attach a list of the individual assets by class, the department assigned to, and respective dollar amounts for all capitalized leases in accordance with the thresholds discussed in the instructions.

Available upon request

| | YES | NO | N/A |
|--|-----|----|-----|
| of the financial statements prepared and a description of the changes in accounting policies and practices if not mentioned in those statements. | | | |
| 2. Cost report total expenses and total revenues differ from those on the filed financial statement. If 'yes', submit reconciliation. | | X | |
| 1. Assets have been relifed for Medicare purposes. If 'yes', attach detailed listing of these specific assets, by classes, as shown in the Fixed Asset Register. | | X | |
| 2. Due to appraisals made during this cost reporting period, changes have occurred to Medicare depreciation expense. If 'yes', attach copy of Appraisal Report and Appraisal Summary by class of asset. | | X | |
| 3. New leases and/or amendments to existing leases for land, equipment, or facilities with annual rental payment in excess of the amounts listed in the instructions, have been entered into during this cost reporting period. If 'yes', submit a listing of these new leases and/or amendments to existing leases that have the following information: | | X | |
| 4. There have been new capitalized leases entered into during the current cost reporting period. If 'yes', attach a list of the individual assets by class, the department assigned to, and respective dollar amounts for all capitalized leases in accordance with the thresholds discussed in the instructions. | | X | |

| C. Capital Related Cost (Continued) | YES | NO | N/A |
|---|-----|----|-----|
| 5. Assets which were subject to §2314 of DEFRA were acquired during the period. If 'yes', supply a computation of the basis. | | X | |
| 6. Provider's capitalization policy changed during cost reporting period. If 'yes', submit copy. | | X | |
| 7. Obligated capital has been placed into use during the cost reporting period. If 'yes', attach schedule listing each project, the cost of these projects and the date placed into service for patient care. | | X | |
| D. Interest Expense (NOTE: Section D to be completed only by hospitals excluded from PPS (except Children 's) and PPS hospitals that have a unit excluded from PPS.) | | | |
| 1. New loan, mortgage agreements or letters of credit were entered into during the cost reporting period. If 'yes', state the purpose and submit copies of debt documents and amortization schedules. | | X | |
| 2. The provider has a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account. If 'yes', submit a detailed analysis of the funded depreciation account for the cost reporting period. (See PRM-1, §226.4.) | | X | |
| 3. Provider replaced existing debt prior to its scheduled maturity with new debt. If 'yes', submit support for new debt and calculation of allowable cost. (See §233.3 for description of allowable cost.) | | X | |
| 4. Provider recalled debt before scheduled maturity without issuance of new debt. If 'yes', submit detail of debt cancellation costs. (See §215 for description and treatment of debt cancellation costs.) | | X | |
| E. Approved Educational Activities (NOTE: Section E to be completed by all providers.) | | | |
| 1. Costs were claimed for Nursing School and Allied Health Programs. If 'yes', attach list of the programs and annotate for each whether the provider is the legal operator of the program. | | X | |
| 2. Approvals and/or renewals were obtained during this cost reporting period for Nursing School and/or Allied Health Programs. If 'yes', submit copies. | | X | |
| 3. Provider has claimed Intern-Resident costs on the current cost report. If 'yes', submit the current year Intern-Resident Information System (IRIS) on diskette. | | X | |

E. Approved Educational Activities (Continued)

YES NO N/A

4. Provider has initiated an Intern-Resident program in the current year or obtained a renewal of an existing program. If 'yes', submit certification/program approval.

| | | |
|--|---|---|
| | X | |
| | | X |

5. Graduate Medical Education costs have been directly assigned to cost centers other than the Intern-Resident Services in an Approved Teaching Program, on Worksheet A, Form CMS-2552. If 'yes', submit appropriate workpapers indicating to which cost centers assigned and the amounts.

F. Purchased Services (NOTE: Questions 1 and 2 to be completed only by hospitals excluded from PPS (except Children 's) and PPS hospitals that have a unit excluded from PPS. Question 3 to be completed only by Inpatient PPS (IPPS) hospitals, hospitals with an IPPS subprovider, hospitals that would be subject to IPPS if not granted a waiver, and SNF's.)

1. Changes or new agreements have occurred in patient care services furnished through contractual arrangements with suppliers of services. If 'yes', submit copies of changes or contracts, or where there are no written agreements, attach description.

| | | |
|--|---|--|
| | X | |
|--|---|--|

NOTE: Hospitals are only required to submit such information where the cost of the individual's services exceed \$25,000 per year.

Available upon request

2. The requirements of §2135.2 were applied pertaining to competitive bidding. If 'no', attach explanation.

| | | |
|---|--|--|
| X | | |
|---|--|--|

3. Contract services are reported on Worksheet S-3, Part II, line 9 (hospitals) or line 17 (SNF's). If 'yes', submit a schedule showing the total direct patient care related contract labor, hours and calculated rate for each invoice paid during the year for the direct patient care related contract labor reported on Worksheet S-3, Part II, line 9 (hospitals) or line 17 (SNF's). Contracted labor will include any wage related costs. The contracted amounts for the top four management personnel (CEO, CFO, COO and Nursing Administrator) are not required to be reported by individuals. The total aggregate wage and hours will be reported for these management contracts. Other contracts or contracts for other management personnel should NOT be reported as they are not allowed in the computation of the wage index.

| | | |
|--|--|---|
| | | X |
|--|--|---|

G. Provider-Based Physicians (NOTE: Section G to be completed only by hospitals excluded from PPS (except Children 's) and PPS hospitals that have a unit excluded from PPS.)

| | | |
|--|--|--|
| | | |
|--|--|--|

G. Provider-Based Physicians (Continued)

| | YES | NO | N/A |
|--|-----|----|-----|
| 1. Services are furnished at the provider facility under an arrangement with provider-based physicians. If 'yes', submit completed provider-based physician questionnaire (Exhibits 2 through 4A). | X | | |
| 2. The provider has entered into new agreements or amended existing agreements with provider-based physicians during this cost reporting period. If 'yes', submit copies of new agreements or amendments to existing agreements and assignment authorizations. | X | | |

H. Home Office Costs (NOTE: Questions 1 through 6 to be completed only by hospitals excluded from PPS (except Children 's) and PPS hospitals that have a unit excluded from PPS. Question 7 to be completed only by IPPS hospitals, hospitals with an IPPS subprovider, hospitals that would be subject to IPPS if not granted a waiver, and SNF's.)

| | | | |
|--|---|---|--|
| 1. The provider is part of a chain organization. If 'yes', give full name and address of the home office: | X | | |
| Name OSF Healthcare Systems | | | |
| Address 800 NE Glen Oak | | | |
| City Peoria | | | |
| State IL | | | |
| Zip 61603 | | | |
| Designated Intermediary: Wisconsin Physician Services | | | |
| 2. A home office cost statement has been prepared by the home office. If 'yes', submit a schedule displaying the entire chain's direct, functional and pooled cost as provided to the designated home office intermediary as part of the home office cost statement. | X | | |
| 3. The fiscal year end of the home office is different from that of the provider. If 'yes', indicate the fiscal year end of the home office. | | X | |
| FYE _____ | | | |
| NOTE: Where the year ends of the provider and home office are not the same (nonconcurrent year ends), the summary listing, as described in number 2 above, will be necessary to support the provider's cost report. | | | |
| 4. Describe the operation of the intercompany accounts. Include in this description the types of costs included from these intercompany accounts and their location on the cost report. (Provide informative attachments if not shown on Worksheet A-8-1). | | | |

H. Home Office Costs (Continued)

| | YES | NO | N/A |
|--|-----|----|-----|
| 5. Actual expense amounts are transferred by the home office to the provider components on an interim basis. (Provide informative attachments if not shown on Worksheet A-8-1). | | | |
| 6. The provider renders services to: | | | |
| Other chain components: | | X | |
| The home office: | | X | |
| If 'yes', to either of the above, provide informative attachments. | | | |
| 7. Home Office or Related Organization personnel cost are reported on Worksheet S-3, Part II, Line 11 (hospitals) or line 18 (SNFs). | | | X |
| If 'yes', submit a schedule displaying the wages, wage related costs, and hours allocated to the individual chain components as provided to the designated home office intermediary to support the amount reported on Worksheet S-3, Part II, line 11 (hospitals) or line 18 (SNFs). | | | |

I. Bad Debts (NOTE: Section I to be completed by all providers.)

| | | | |
|--|---|---|--|
| 1. The provider seeks Medicare reimbursement for bad debts. If 'yes', complete Exhibit 5 or submit internal schedules duplicating documentation required on Exhibit 5 to support bad debts claimed. (see instructions) | X | | |
| 2. The provider's bad debt collection policy changed during the cost reporting period. If 'yes', submit copy. | | X | |
| 3. The provider waives patient deductibles and/or copayments. If yes, insure that they are not included on Exhibit 5. | | X | |

J. Bed Complement (NOTE: Section J to be completed by all providers.)

| | | | |
|--|--|---|--|
| The provider's total available beds have changed from prior cost reporting period. If 'yes', provide an analysis of available beds and explain any changes during the cost reporting period. | | X | |
|--|--|---|--|

K. PS&R Data (NOTE 1: Section K to be completed by all providers.)
 (NOTE 2: Refer to the instructions regarding required documentation and attachments.)

K. PS&R Data (Continued)

| | YES | NO | N/A |
|--|-----|----|-----|
| 1. The cost report was prepared using the PS&R only? | | | |
| a) Part A (including subproviders, SNF, etc.)? | X | | |
| b) Part B (inpatient and outpatient) | X | | |
| If 'yes', attach a crosswalk between revenue codes and charges found on the PS&R to the cost center groupings on the cost report. This crosswalk will reflect a cost center to revenue code match only. | | | |
| 2. The cost report was prepared using the PS&R for totals and the provider records for allocation. | | | |
| a) Part A (including subproviders, SNF, etc.) | | X | |
| b) Part B (inpatient and outpatient) | | X | |
| If yes, include a detailed crosswalk between revenue codes, departments and charges on the PS&R to the cost center groupings on the cost report. This crosswalk must include which revenue codes were allocated to each cost center. Supporting workpapers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records. | | | |
| If the PS&R is used for the allocation of ASC, Radiology, Other Diagnostic, and All Other Part B, explain how the total charges are detailed to the various PS&R Medicare outpatient types. Include workpapers supporting the allocation of charges into the various cost centers. If internal records are used for either the type of service breakdown or the charge allocation, the source of this information must be included in the documentation. | | | |
| 3. Provider records only were used to complete the cost report? | | | |
| a) Part A (including subproviders, SNF, etc.) | | X | |
| b) Part B (inpatient and outpatient) | | X | |
| If yes, attach detailed documentation of the system used to support the data reported on the cost report. If the detail documentation was previously supplied, submit only necessary updated documentation. | | | |
| The minimum requirements are: | | | |
| - Copies of input tables, calculations, or charts supporting data elements for PPS operating rate components, capital PPS rate components, ASC payment group rates, Radiology and Other Diagnostic prevailing rates and other claims PRICING information. | | | |
| - Log summaries and log detail supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a consistent manner with the PS&R. | | | |

YES NO N/A

hospitals that would be subject to IPPS if not granted a waiver, and SNF's.)

| | | | |
|---|--|--|---|
| 1. Complete EXHIBIT 6, Part I. (Per instructions) Part III must be completed to reconcile any differences between any fringe benefit cost reported on Worksheet A, Column 2, using Medicare principles and the corresponding wage related costs reported under GAAP for purposes of the wage index computation. | | | |
| 2. The individual wage related cost exceeds one percent of total adjusted salaries after removing excluded salaries. (Salaries reported on Worksheet S-3, Part III, Column 3, line 3 (CMS-2552-96), or Worksheet S-3, Part II, Column 3, line 26 (CMS-2540-96).) | | | X |
| 3. Additional wage related costs were provided that meet ALL of the following tests: | | | |
| a. The cost is not listed on Part I of EXHIBIT 6. | | | X |
| b. If any of the additional wage related cost applies to the excluded areas of the hospital, the cost associated with the excluded areas has been removed prior to making the 1 percent threshold test in question 2 above. | | | X |
| c. The wage related cost has been reported to the IRS, as a fringe benefit if so required by the IRS. | | | X |
| d. The individual wage related cost is not included in salaries reported on the S-3, Part III, Column 3, line 3 (CMS-2552-96), or Worksheet S-3, Part II, Column 3, line 16 (CMS-2540-96).) | | | X |
| e. The wage related cost is not being furnished for the convenience of the employer. | | | X |

Allocation of Physician Compensation Hours

Physician Name: Various

Department: Emergency

Basis of Allocation: contract

| Services | Total Hours |
|--|-------------|
| 1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions. | 0 |
| 1A. Provider Services - Teaching and Supervision of Allied Health Students | 0 |
| 1B. Provider Services - Non Teaching Reimbursable Activities such as Departmental Administration, Supervision of Nursing and Technical Staff, Utilization Review, etc. | 1588 |
| 1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.) | 0 |
| 1D. Sub-Total - Provider Administrative Services (Line 1, 1A, 1B, 1C). | 1588 |
| 2. Physician Services: Medical and Surgical Services to Individual Patients | 2698 |
| 3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc. | 0 |
| 4. Total Hours: (Lines 1D, 2, and 3) | 4286 |
| 5. Professional Component Percentage (Line 2 / Line 4) | 0.63 |
| 6. Provider Component Percentage - (Line 1D / Line 4) | 0.37 |

 2/26/09
Signature: Physician or Physician Department Head Date

Allocation of Physician Compensation Hours

Physician Name: Various

Department: Lab

Basis of Allocation: contract

| Services | Total Hours |
|--|-------------|
| 1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions. | 0 |
| 1A. Provider Services - Teaching and Supervision of Allied Health Students | 0 |
| 1B. Provider Services - Non Teaching Reimbursable Activities such as Departmental Administration, Supervision of Nursing and Technical Staff, Utilization Review, etc. | 1 |
| 1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.) | 0 |
| 1D. Sub-Total - Provider Administrative Services (Line 1, 1A, 1B, 1C). | 1 |
| 2. Physician Services: Medical and Surgical Services to Individual Patients | 0 |
| 3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc. | 0 |
| 4. Total Hours: (Lines 1D, 2, and 3) | 1 |
| 5. Professional Component Percentage (Line 2 / Line 4) | 0.00 |
| 6. Provider Component Percentage - (Line 1D / Line 4) | 1.00 |


Signature: Physician or Physician Department Head

2/26/09
Date

Allocation of Physician Compensation Hours

Physician Name: Various

Department: A & G

Basis of Allocation: contract

| Services | Total Hours |
|--|-------------|
| 1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions. | 0 |
| 1A. Provider Services - Teaching and Supervision of Allied Health Students | 0 |
| 1B. Provider Services - Non Teaching Reimbursable Activities such as Departmental Administration, Supervision of Nursing and Technical Staff, Utilization Review, etc. | 1 |
| 1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.) | 0 |
| 1D. Sub-Total - Provider Administrative Services (Line 1, 1A, 1B, 1C). | 1 |
| 2. Physician Services: Medical and Surgical Services to Individual Patients | 0 |
| 3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc. | 0 |
| 4. Total Hours: (Lines 1D, 2, and 3) | 1 |
| 5. Professional Component Percentage (Line 2 / Line 4) | 0.00 |
| 6. Provider Component Percentage - (Line 1D / Line 4) | 1.00 |


Signature: Physician or Physician Department Head Date: 2/26/09

Hospital Emergency Department Provider-Based Physician Allowable Availability Service Costs
 Under Hourly Rate or Salary Arrangements: Data Elements

Geographic Location of Provider:

Physician Name: Various

Specialty:

| Allocation Agreement: | Time - Percentage | Total Hours Worked |
|---------------------------------------|-------------------|--------------------|
| Availability Services | 0.00 | 0 |
| Supervision & Administrative Services | 0.00 | 0 |

Reasonable Compensation Equivalent (RCE) from Table I, Estimate of FTE 0

RCE Area: Non-Metropolitan ___ Metropolitan, Less Than One Million ___ Metropolitan, Greater Than One Million ___

Actual Provider Payments:

| | |
|-----------------------------------|---|
| Supervision and Administration | 0 |
| Availability Services | 0 |
| Membership in Professional Assoc. | 0 |
| Continuing Medical Education | 0 |
| Malpractice Insurance Premiums | 0 |

Total Charges:

| | |
|----------------------------|---|
| Billed Inpatient Charges | 0 |
| Billed Outpatient Charges | 0 |
| Imputed Inpatient Charges | 0 |
| Imputed Outpatient Charges | 0 |
| Imputed Employee Charges | 0 |
| Other - Inpatient | 0 |
| Other - Outpatient | 0 |

Compensation Based on:

| | | | |
|-------------|------|-----------------|---|
| Hourly Rate | 0.00 | or Salary Basis | 0 |
|-------------|------|-----------------|---|

Note: Attach copy of Approved Allocation Agreements

Hospital Emergency Department Provider-Based Physician Allowable Availability Service Costs
 Under Hourly Rate or Salary Arrangements: Computation

Geographic Location of Provider:

Physician Name: Various

Specialty:

The reasonable cost of the supervisory, administrative and availability services time is computed as follows:

1. Determine the applicable RCE base:

| | | | | |
|--|---|------|---|----------|
| Total Hours (Supervisory, Administrative And Availability) / Work Year Hours (2080) | X | RCE | = | RCE Base |
| 0 / 2080 | X | 0.00 | = | 0.00 |

2. Determine the limit on the allowance for membership in professional associations and continuing education:

| | | | | |
|----------|---|-----|---|-------|
| RCE Base | X | 5% | = | Limit |
| 0.00 | X | .05 | = | 0.00 |

3. Provider payments for membership in professional associations and continuing medical education:

| | |
|---|------|
| Membership in Professional Associations | 0.00 |
| Continuing Medical Education | 0.00 |
| Total | 0.00 |

4. Malpractice Insurance Expense:
 (Provider Services Portion)

0.00

5. Adjusted RCE Base:

| | | | |
|-----------|------|------------------------|------|
| Sum of #1 | 0.00 | + the less of #2 or #3 | 0.00 |
| + #4 | 0.00 | = #5 | 0.00 |

Hospital Emergency Department Provider-Based Physician Allowable Availability Service Costs
 Under Hourly Rate or Salary Arrangements: Computation (Continued)

Physician Name: Various

Specialty:

6. Actual Provider Payments:

| | |
|---|------|
| Supervision and Administration | 0.00 |
| Availability Services | 0.00 |
| Membership in Professional Associations | 0.00 |
| Continuing Medical Education | 0.00 |
| Malpractice (Provider Services Related) | 0.00 |
| Total | 0.00 |

7. Amount includable in allowable costs:

(lesser of #5 or #6) 0.00

8. Allocation of Allowable Costs:

| | |
|--|------|
| Billed Outpatient Charges (Emergency Department) | 0.00 |
| Imputed Outpatient and Employee Charges | 0.00 |
| Total Outpatient Charges | 0.00 |
| Imputed Inpatient Charges | 0.00 |
| Billed Inpatient Charges | 0.00 |
| Total Inpatient Charges | 0.00 |
| Total Charges | 0.00 |

| | | | | |
|---|---|--------------------------|---|------------------------|
| Total Outpatient Charges / Total Charges | X | Allowable Provider Costs | = | Allowable Part B Costs |
| 0.00 / 0.00 | X | 0.00 | | 0.00 |
| Total Inpatient Charges / Total Charges | X | Allowable Provider Costs | = | Allowable Part A Costs |
| 0.00 / 0.00 | X | 0.00 | | 0.00 |

Hospital Emergency Department Provider-Based Physician Allowable Unmet Guarantee Amounts
 Under Minimum Guarantee Arrangements: Data Elements

Geographic Location of Provider:

Physician Name: Various

Specialty:

| Allocation Agreement: | Time - Percentage | Total Hours Worked |
|--|-------------------|--------------------|
| Professional Services to Individual Patients (incl. inpatients and employees) and Availability Services | 0.00 | 0 |
| Supervision & Administrative Services | 0.00 | 0 |
| Total | 100.00 | 0 |

Reasonable Compensation Equivalent (RCE) from Table I, Estimate of FTE 0

RCE Area: Non-Metropolitan ___ Metropolitan, Less Than One Million ___ Metropolitan, Greater Than One Million ___

Actual Provider Payments:

| | |
|-----------------------------------|---|
| Supervision and Administration | 0 |
| Unmet Guarantee Amount | 0 |
| Membership in Professional Assoc. | 0 |
| Continuing Medical Education | 0 |
| Malpractice Insurance Premiums | 0 |
| Other | 0 |

Total Charges:

| | |
|----------------------------|---|
| Billed Outpatient Charges | 0 |
| Billed Inpatient Charges | 0 |
| Imputed Inpatient Charges | 0 |
| Imputed Outpatient Charges | 0 |
| Imputed Employee Charges | 0 |
| Other - Inpatient | 0 |
| Other - Outpatient | 0 |

Actual Minimum Guarantee Amount 0

Total Outpatient Charges 0
 Total Inpatient Charges 0

Note: Attach copy of Approved Allocation Agreements

Hospital Emergency Department Provider-Based Physician Allowable Unmet Guarantee Amounts
 Under Minimum Guarantee Arrangements: Computation

Geographic Location of Provider:

Physician Name: Various

Specialty:

 Computation of Reasonable Allowable Cost for Supervisory and Administrative Duties

The reasonable cost of the supervisory, administrative and availability services time is computed as follows:

1. Determine the applicable RCE base:

| | | | | |
|---|---|------|---|----------|
| Total Hours (Supervisory and Administrative Services) / Work Year Hours (2080) | X | RCE | = | RCE Base |
| 0 / 2080 | X | 0.00 | = | 0.00 |

2. Determine the limit on the allowance for membership in professional associations and continuing education:

| | | | | |
|----------|---|-----|---|-------|
| RCE Base | X | 5% | = | Limit |
| 0.00 | X | .05 | = | 0.00 |

3. Determine actual provider payment for membership in professional associations and continuing medical education applicable to supervisory and administrative services:

| | | | | |
|--|---|---|---|-------------------------|
| Total Hours (Supervisory and Administrative) / Total Hours Worked | X | Total Payments for Membership in Professional Associations and Continuing Medical Education | = | Actual Provider Payment |
| 0 / 0 | X | 0.00 | = | 0.00 |

4. Determine the allowance for Malpractice Insurance (Supervision and Administration (S&A)):

| | | | | |
|---|---|--|---|-----------|
| Supervisory & Admin Hrs / Total Hours Worked | X | Total Payment for Malpractice Insurance | = | Allowance |
| 0 / 0 | X | 0.00 | = | 0.00 |

Hospital Emergency Department Provider-Based Physician Allowable Unmet Guarantee Amounts
 Under Minimum Guarantee Arrangements: Computation (Continued)

Physician Name: Various Specialty:

5. Adjusted RCE Base for Supervision and Administrative Services:

| | | | |
|-----------|------|------------------------|------|
| Sum of #1 | 0.00 | + the less of #2 or #3 | 0.00 |
| + #4 | 0.00 | = #5 | 0.00 |

6. Determine Provider Payments Attributable to Supervision and Administrative Services:

Supervision and Administration (S&A):

| | | | | |
|-----------|---|------|---|------|
| S&A Hours | X | Rate | | |
| 0.00 | X | 0.00 | = | 0.00 |

Membership in Professional Associations:

| | | | | | |
|-----------|---|-------------|---|------|--------|
| S&A Hours | / | Total Hours | X | Cost | |
| 0.00 | / | 0.00 | X | 0.00 | = 0.00 |

Continuing Medical Education:

| | | | | | |
|-----------|---|-------------|---|------|--------|
| S&A Hours | / | Total Hours | X | Cost | |
| 0.00 | / | 0.00 | X | 0.00 | = 0.00 |

Malpractice Insurance Premiums:

| | | | | | |
|-----------|---|-------------|---|------|--------|
| S&A Hours | / | Total Hours | X | Cost | |
| 0.00 | / | 0.00 | X | 0.00 | = 0.00 |

Total = 0.00

7. Amount Includable in Allowable Costs

(Lower of #5 or #6) 0.00

Hospital Emergency Department Provider-Based Physician Allowable Unmet Guarantee Amounts
 Under Minimum Guarantee Arrangements: Computation (Continued)

Physician Name: Various Specialty:

Computation of Reasonable Allowable Cost for an Unmet Guarantee Amount

8. Determine the Applicable RCE Base:

| | | | | |
|---|---|------|---|----------|
| Total Hours (Professional and Availability) / Work Year Hours (2080) | X | RCE | = | RCE Base |
| 0 / 2080 | X | 0.00 | = | 0.00 |

9. Determine the Limit on the Allowance for Membership in Professional Associations and Continuing Medical Education:

| | | | | |
|----------|---|-----|---|-------|
| RCE Base | X | 5% | = | Limit |
| 0.00 | X | .05 | = | 0.00 |

10. Determine Actual Provider Payment for Membership in Professional Associations and Continuing Medical Education applicable to Professional and Availability Services:

| | | | | |
|---|---|---|---|-------------------------|
| Total Hours (P&A) / Total Hours Worked | X | Total Payments for Membership in Professional Associations and Continuing Medical Education | = | Actual Provider Payment |
| 0 / 0 | X | 0.00 | = | 0.00 |

11. Determine the Allowance for Malpractice Insurance (Professional and Availability (P&A) Services):

| | | | | |
|---|---|--|---|-----------|
| Total Hours (Professional and Availability) / Total Hours Worked | X | Total Payment for Malpractice Insurance | = | Allowance |
| 0 / 0 | X | 0.00 | = | 0.00 |

12. Adjusted RCE Base:

| | | | |
|-----------|------|-------------------------|------|
| Sum of #8 | 0.00 | + the less of #9 or #10 | 0.00 |
| + #11 | 0.00 | = #12 | 0.00 |

Hospital Emergency Department Provider-Based Physician Allowable Unmet Guarantee Amounts
Under Minimum Guarantee Arrangements: Computation (Continued)

| Physician Name: Various | Specialty: |
|---|------------|
| 13. Actual Minimum Guarantee Amount: | 0.00 |
| 14. Reasonable Minimum Guarantee Amount (Lesser of #12 or #13) | 0.00 |
| 15. Total Charges: | |
| Billed Inpatient Charges | 0.00 |
| Billed Outpatient Charges | 0.00 |
| Imputed Inpatient Charges | 0.00 |
| Imputed Outpatient Charges | 0.00 |
| Imputed Employee Charges | 0.00 |
| Total | 0.00 |
| 16. Reasonable Unmet Guarantee Amount (#14 less #15) | 0.00 |
| 17. Summary of Allowable Provider Costs: | |
| Supervisory and Administrative Services (#7) | 0.00 |
| Reasonable Unmet Guarantee Amount (#16) | 0.00 |
| Total | 0.00 |

PART I - WAGE RELATED COST (Core Cost)

RETIREMENT COSTS:

| | |
|--|--------|
| 1. 401K Employer Contributions | 0 |
| 2. Tax Sheltered Annuity (TSA) Employer Contribution | 0 |
| 3. Qualified and Non-Qualified Pension Plan Cost | 218919 |
| 4. Prior Year Pension Service Cost | 0 |

PLAN ADMINISTRATIVE COSTS (Paid to External Organization):

| | |
|--|--------|
| 5. 401K/TSA Plan Administration fees | 201550 |
| 6. Legal/Accounting/Management Fees-Pension Plan | 0 |
| 7. Employee Managed Care Program Administration Fees | 0 |

HEALTH AND INSURANCE COSTS:

| | |
|---|---------|
| 8. Health Insurance (Purchased or Self-Funded) | 1437992 |
| 9. Prescription Drug Plan | 0 |
| 10. Dental, Hearing & Vision Plans | 0 |
| 11. Life Insurance (If employee is owner or beneficiary) | 23216 |
| 12. Accident Ins. (If employee is owner or beneficiary) | 0 |
| 13. Disability Ins. (If employee is owner or beneficiary) | 0 |
| 14. Long-Term Care Ins. (If employee is owner or beneficiary) | 0 |
| 15. Workmen's Compensation Ins. | 98686 |
| 16. Retiree Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. This is the Non-Cumulative Portion.) | 0 |

TAXES:

| | |
|---|--------|
| 17. FICA-Employers portion only | 704514 |
| 18. Medicare Taxes - Employers portion only | 0 |
| 19. Unemployment Insurance | 0 |
| 20. State or Federal Unemployment Taxes | 0 |

OTHER:

| | |
|-------------------------------------|---|
| 21. Executive Deferred Compensation | 0 |
| 22. Day Care Cost and Allowances | 0 |
| 23. Tuition Reimbursement | 0 |

| | |
|--------------------------------|---------|
| TOTAL WAGE RELATED COST (CORE) | 2684877 |
|--------------------------------|---------|

PART II - OTHER WAGE RELATED COST

List below detail for each wage related cost that exceeds the 1% threshold. Each wage related cost listed below must be recognized as a wage related cost in conformity with published criteria and instructions.

| Description | Cost |
|--|---------|
| Non-Core wage related cost | 63777 |
| A-8 Adjustment for ER Employed Phys Benefits | -177158 |
| Employee Assistance Plan | 0 |
| Employee Health Department | 0 |
| Recruiting in other depts | 0 |
| TOTAL OTHER WAGE RELATED COST | -113381 |

PART III - WAGE RELATED COST RECONCILIATION TO FRINGE BENEFITS REPORTED IN COST REPORT

| Description | Cost per Medicare | Cost per GAAP |
|-------------|-------------------|---------------|
|-------------|-------------------|---------------|

Listing of Medicare Bad Debts and Appropriate Supporting Data

| Prepared by: | | Date Prepared: | | Type of Service: | | Hospital - Part A | | | | | | |
|--------------|---------------|----------------|--------|-------------------------|-------------------------------|---------------------|--|----------------------|-----------------------|----------------|--------------|-----------|
| Last Name(1) | First Name(1) | MI(1) | HIC(2) | Service(3) From Date | Service(3) Through Date | Indigency Number | Medicaid(4) Date First Bill Sent to Beneficiary | Write-Off(6) Date | Remittance(7) Date | Deductible(8)* | Co-Insur(9)* | Total(10) |