OSF
HEALTHCARE SYSTEM

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

February 28, 2011

ATTN: Kim Hintzemann
National Government Services, Inc.
6775 W. Washington St.
Milwaukee, WI 53214-5644

RE: OSF Holy Family Medical Center
Monmouth, IL
Provider No.: 14-1318, 14-Z318, 14-5528, 14-3461, 14-7627
FYE 9/30/10

Dear Ms. Hintzemann:

The following are enclosed:

- One original signature page for the HCFA-2552-96
- One electronic disk containing the following files:
  a. 2552-96 ECR file
  b. Working Trial Balance
  c. A-6 and A-8 adjustments
  d. PSR Crosswalk
  e. Medicare Bad Debt Logs
  f. Audited financial statements for year ended 9/30/10
  g. W/S A & C grouping work papers and supporting documentation
  h. W/S S-3 Pt II work papers
  i. W/S M series work papers
- HCFA 339 with supporting schedules

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, 2009 through September 30, 2010 is **$61,798.**

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

Sincerely,

Carole M. Wahl

Carole M. Wahl
Manager Third-Party Reimbursement

Enclosures
cc: Theresa Springer, OSF Holy Family Medical Center

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
KPMG LLP COMPU-MAX MICRO SYSTEM RUN DATE: 02/26/2011
PERIOD FROM 10/01/2009 TO 09/30/2010 CMS-2552-96 VERSION 2010.09

****
COMPU-MAX CMS-2552-96 EDIT REPORT
****

I. OPTIONS SELECTED:
OPTION 20, 6
OPTION 21, 4, 8,10
OPTION 60, 5

PART A
295,039
276,668
① 18,371
E-3 LN34

PART B
990560
961,101
② 29,459
E PART B LN36

RHC
7159
574
① 6,585
M-3 LN27

COMPU-MAX - CMS-2552-96 - SETTLEMENT SUMMARY, VERSION 2010.09

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XIX	
		1	2	3	4	
1	HOSPITAL		295039	990560		1
2	SUBPROVIDER I					2
3	SWING BED - SNF		-338131			3
4	SWING BED - NF					4
5	SKILLED NURSING FACILITY					5
6	NURSING FACILITY					6
7	HOME HEALTH AGENCY					7
8	O/P REHAB PROVIDER					8
9	RURAL HEALTH CLINIC I			7159		9
100	TOTAL		-43092	997719		100

SWING
(338131)
(245,514)
① 7,383
E-2 LN2

PROTESTED REIMBURSEMENT IMPACT
100s : 61,798

****
Explanation of error code types:

1000 - The '1000' level error codes (in the range from 1000-1999) are CMS-required Electronic Cost Report (ECR) edit messages. These will prohibit ECR file generation by Compu-Max for submission to your Medicare Fiscal Intermediary, and will be used by the FI as a basis of rejection should your file be received by the FI with such errors.

2000 - Errors in the range of 2000-2999 are CMS-required edits that 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).

**** - KPMG error messages check for additional possible errors not included with the CMS-required edits, and cannot be used as a basis for rejection of the ECR data file or the cost report.

(*) - Error messages marked with an asterisk (*) at the end of the message indicate a logical problem with the cost report, and data must be corrected before a valid cost report can be generated.

(I) - Messages preceded by (I) are informational and are not errors.

****

II. 1000 LEVEL ERRORS
****

III. 2000 LEVEL ERRORS
****

2027 - WKST C, PART I, LINE 63.50, COL 11 SHOULD NOT BE MORE THAN 100% OR LESS THAN .1%

IV. KPMG LEVEL ERRORS
****
(KPMG edits cannot be used as a basis of cost report or ECR file rejection.)

**** - WORKSHEET A, COLUMN 7, LINE 12 EQUALS 0 BUT THERE ARE STATISTICS IN COLUMN 12 OF WORKSHEET B-1

**** - WORKSHEET B-1, LINE 12 HAS STATISTICS, BUT THERE IS NO COST ON WORKSHEET A, COLUMN 7

V. INFORMATIONAL MESSAGES
****

(I) - THE TOTAL CALCULATED FOR WORKSHEET A-8-1, PART B, COLUMN 6, HAS BEEN TRANSFERRED TO WORKSHEET A-8, LINE 14. THE TOTAL FOR WORKSHEET A-8 THAT YOU INPUT HAS BEEN INCREASED BY $1,244,538

(I) - THE TOTAL CALCULATED FOR WORKSHEET A-8-2, COLUMN 18, HAS BEEN TRANSFERRED TO WORKSHEET A-8, LINE 12. THE TOTAL FOR WORKSHEET A-8 THAT YOU INPUT HAS BEEN DECREASED BY $660,568

(I) - A PROTESTED AMOUNT HAS BEEN ENTERED ON WORKSHEET E, PART B, LINE 36 FOR FACILITY (HOSPITAL)

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2009 TO 09/30/2010

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

VERSION: 2010.09
02/28/2011 13:43

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

WORKSHEET S
PARTS I & II

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

PART I - CERTIFICATION

CHECK APPLICABLE BOX
XX ELECTRONICALLY FILED COST REPORT
__ MANUALLY SUBMITTED COST REPORT
DATE: 02/28/2011
TIME: 13:43

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 10/01/2009 AND ENDING 09/30/2010, 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: 02/28/2011 13:43
YnApX8umh2vKa5CSdurSRnOMYejpJ0
toxQG0VQy.tJYCNdUcYqQvtdaCsgIV
e5qn0xZViV0t3NTP

PI Encryption: 02/28/2011 13:43
bW9pLUb5wJjTqe3kbGO07rwhC80Rt0
jPbSc0VJyGqbklsChr9KmPNPtC7QNs
3XTB7qf6p30qI0kK

(SIGNED) Dan G M
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

SENIOR VICE PRESIDENT, CFO
TITLE

2/28/11
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			PART A	PART B		
		1	2	3	4	
1	HOSPITAL		276668	961139		1
2	SUBPROVIDER I					2
3	SWING BED - SNF		-345514			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			574		9
100	TOTAL		-68846	961713		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.

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2009 TO 09/30/2010

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

VERSION: 2010.09
02/28/2011 13:43

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
1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	PROVIDER NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX	
	1	1	2	3	4	5	6	
2	HOSPITAL	OSF HOLY FAMILY MEDICAL CENTER	14-1318	05/01/2002	N	O	P	2
3	SUBPROVIDER I							3
4	SWING BEDS - SNF	OSF HOLY FAMILY SWING BEDS	14-Z318	05/01/2002	N	O	N	4
5	SWING BEDS - NF							5
6	HOSPITAL-BASED SNF							6
7	HOSPITAL-BASED NF							7
8	HOSPITAL-BASED OLTC							8
9	HOSPITAL-BASED HHA							9
11	SEPARATELY CERTIFIED ASC							11
12	HOSPITAL-BASED HOSPICE							12
14	HOSP-BASED RHC	OSF HOLY FAMILY CLINICS	14-3461	02/05/2003	N	O	N	14
15	OUTPATIENT REHABILITATION PROVID							15
16	RENAL DIALYSIS							16

17	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 10/01/2009	TO: 09/30/2010	17
18	TYPE OF CONTROL	1 2		18
		1		

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL		19
20	SUBPROVIDER I	1	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? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 'Y' OR 'N' FOR NO.		NO	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 OR MIPPA 147? (SEE INSTRUCTIONS). ENTER 'Y' FOR YES AND 'N' FOR NO.	NO		21.06
21.07	DOES THIS HOSPITAL QUALIFY AS AN SCH WITH 100 OR FEWER BEDS UNDER MIPPA 147? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO (SEE INSTRUCTIONS). IS THIS AN SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA SECTION 3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO (SEE INSTRUCTIONS).	NO	NO	21.07
21.08	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS? ENTER IN COLUMN 1, 1 IF IT IS BASED ON DATE OF ADMISSION, 2 IF IT IS BASED ON CENSUS DAYS, OR 3 IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE LAST COST REPORTING PERIOD? ENTER IN COLUMN 2, 'Y' FOR YES AND 'N' FOR NO.		NO	21.08
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 IN COL. 2 AND TERMINATION IN COL. 3.			23.01
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.			23.02
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.			23.03
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.			23.04
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.			23.05
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.			23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.			23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3.			24
24.01	IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.			24.01

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

OTHER INFORMATION				
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 2149? 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
26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:			26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.			26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:			26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	YES	05/01/2002	27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.			28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st			28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY. A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)			28.02
28.03	STAFFING	0.00	NO	28.03
28.04	RECRUITMENT	0.00	NO	28.04
28.05	RETENTION OF EMPLOYEES	0.00	NO	28.05
28.06	TRAINING	0.00	NO	28.06
28.07	OTHER (SPECIFY)		NO	28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	NO		29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	YES		30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.	NO		30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?	NO		30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)	NO		30.03
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.	NO		30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO		31

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

MISCELLANEOUS COST REPORTING INFORMATION

32	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	NO	32
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2.	NO	33
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?	NO	34
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO	35

PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL

		V	XVIII	XIX	
		1	2	3	
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	36
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	NO	NO	NO	36.01
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	37
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?				37.01

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 THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COL. 2 THE HOME OFFICE CHAIN NUMBER. (SEE INST.) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE ON LINES 40.01-40.03.	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? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	NO		45
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 NHCHQ 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	
		1	2	3	4	5	
47	HOSPITAL	N	N	N	N	N	47
48	SUBPROVIDER I	N	N	N	N	N	48
49	SKILLED NURSING FACILITY	N	N				49
50	HOME HEALTH AGENCY	N	N				50

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?	NO	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.	NO	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: 186000 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.	NO	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.	NO	55

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

		DATE 0	Y/N 1	LIMIT 2	Y/N 3	FEES 4	
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.	/ /	NO	0.00	NO		56
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?		NO				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.		NO				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 196 DATED AUGUST 15, 2005 PAGE 47979? 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)		NO				59
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
MULTICAMPUS							
61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.		NO				61
		COUNTY: 1	STATE: 2	ZIP CODE 3	CBSA 4	FTE/ CAMPUS 5	
SETTLEMENT DATA							
63	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y', ENTER THE 'PAID THROUGH' DATE OF THE PS&R IN COLUMN 2 (mm/dd/yyyy)		YES	12/02/2010			63

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2009 TO 09/30/2010

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

VERSION: 2010.09
02/28/2011 13:43

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH PATIENT HOURS 2.01	I/P DAYS / O/P VISITS / TRIPS TITLE V 3	TITLE XVIII 4	LTCH NONCOVERED DAYS 4.01	TITLE XIX 5	OBS. BEDS ADMITTED 5.01	
1	HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS	23	8395	37566.42		1027		109		1
2	HMO									2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					513				3
4	HOSPITAL ADULTS & PEDS - SWING BED NF									4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS	23	8395	37566.42		1540		109		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	23	8395	37566.42		1540		109		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 1					7348				24
25	TOTAL	23								25
26	OBSERVATION BED DAYS									26
27	AMBULANCE TRIPS							41		27
28	EMPLOYEE DISCOUNT DAYS									28
29	LABOR & DELIVERY DAYS									29

PROVIDER NO. 14-1318 ONE HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2009 TO 09/30/2010

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

VERSION: 2010.09
02/28/2011 13:43

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	-----I/P DAYS / O/P VISITS / TRIPS---- OBS. BEDS NOT ADMITTED 6.02	TOTAL ALL PATIENTS 6	OBS. BEDS ADMITTED 6.01	OBS. BEDS NOT ADMITTED 6.02	---INTERNS & RES FTES---- TOTAL 7	LESS I&R REPL NON-PHYS ANES 8	NET 9	--FULL TIME EQUIV-- EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		1865								1
2	HMO MIX										2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF		513								3
4	HOSPITAL ADULTS & PEDS - SWING BED NF		114								4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS		2192								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		2192								12
13	RPCH VISITS								152.75		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		40710						37.54		24
25	TOTAL								190.29		25
26	OBSERVATION BED DAYS		357								26
27	AMBULANCE TRIPS										27
28	EMPLOYEE DISCOUNT DAYS										28
29	LABOR & DELIVERY DAYS										29

PROVIDER NO. 14-1319 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2009 TO 09/30/2010

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

VERSION: 2010.09
02/28/2011 13:43

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	DISCHARGES TITLE V 12	DISCHARGES TITLE XVIII 13	DISCHARGES TITLE XIX 14	DISCHARGES TOTAL ALL PATIENTS 15	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		291	39	486	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		291	39	486	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

WORKSHEET S-3
PART II

PART II - WAGE DATA		AMOUNT REPORTED 1	RECLASS. OF SALARIES FROM WKST. A-6 2	ADJUSTED SALARIES (COL.1 + COL.2) 3	PAID HOURS RELATED TO SALARY IN COL.3 4	AVERAGE HOURLY WAGE (COL.3 / COL.4) 5	DATA SOURCE 6	
	SALARIES							
1	TOTAL SALARIES	11010301	3042337					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							8
8.01	EXCLUDED AREA SALARIES	963976	-28908					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)							19.01
20	INTERNS & RESIDENTS (IN APPR PGM)						CMS 339	20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS	140989	2878050					21
22	ADMINISTRATIVE & GENERAL	2008472	509452					22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT	439627	7693					24
25	LAUNDRY & LINEN SERVICE	59629	7505					25
26	HOUSEKEEPING	291387						26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	276217	6080					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							31
32	PHARMACY							32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	129004	2195					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 1	RECLASS. OF SALARIES FROM WKST. A-6 2	ADJUSTED SALARIES (COL.1 + COL.2) 3	PAID HOURS RELATED TO SALARY IN COL.3 4	AVERAGE HOURLY WAGE (COL.3 / COL.4) 5	
1	NET SALARIES	11010301	3042337	14052638			1
2	EXCLUDED AREA SALARIES	963976	-28908	835068			2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	10146325	3071245	13217570			3
4	SUBTOTAL OTHER WAGES & REL COSTS						4
5	SUBTOTAL WAGE-RELATED COSTS						5
6	TOTAL (SUM OF LINES 3 THRU 5)	10146325	3071245	13217570			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	3343325	3410965	6754290			13

NHCD DEMONSTRATION STATISTICAL DATA
STATISTICAL DATA

WORKSHEET S-7

	GROUP	MCPI REVENUE CODE	SERVICES PRIOR TO JANUARY 1 RATE	DAYS	SERVICES ON OR AFTER JANUARY 1 RATE	DAYS	TOTAL	
	1	2	3	3.01	4	4.01	5	
1	RVC/RUC							1
2	RVB/RUB							2
3	RVA/RUA							3
3.01	RUX							3.01
3.02	RUL							3.02
4	RHD/RVC							4
5	RHC/RVB							5
6	RHB/RVA							6
6.01	RVX							6.01
6.02	RVL							6.02
7	RHA/RHC							7
8	RNC/RHB							8
9	RNB/RHA							9
9.01	RHX							9.01
9.02	RHL							9.02
10	RMA/RMC							10
11	RLB/RMB							11
12	RLA/RMA							12
12.01	RMX							12.01
12.02	RML							12.02
13	SE3/RLB							13
14	SE2/RLA							14
15	SE1/SE3							15
16	SSC/SE2							16
17	SSB/SE1							17
18	SSA/SSC							18
19	CD2/SSB							19
20	CD1/SSA							20
21	CC2							21
22	CC1							22
23	CB2							23
24	CB1							24
25	CA2							25
26	CA1							26
27	IB2							27
28	IB1							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	AAA							45
45.01	ES3							45.01
45.02	ES2							45.02
45.03	ES1							45.03
45.04	HE2							45.04
45.05	HE1							45.05
45.06	HD2							45.06
45.07	HD1							45.07
45.08	HC2							45.08
45.09	HC1							45.09
45.10	HB2							45.10
45.11	HB1							45.11
45.12	LE2							45.12
45.13	LE1							45.13
45.14	LD2							45.14
45.15	LD1							45.15
45.16	LC2							45.16
45.17	LC1							45.17
45.18	LB2							45.18
45.19	LB1							45.19
45.20	CE2							45.20
45.21	CE1							45.21
45.22	CD2							45.22
45.23	CD1							45.23
46	TOTAL							46

RHC I
COMPONENT NO: 14-3461

WORKSHEET S-8

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

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 1	DATE 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 NAME	BILLING NO.	
9	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT			9
		PHYSICIAN NAME	HOURS	
10	SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD			10

11	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? NO 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)		11

FACILITY HOURS OF OPERATIONS (1)

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

(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 IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.		14
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. NO IF YES, SEE INSTRUCTIONS.		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	OLD CAP REL COSTS-BLDG & FIXT								1
2	0200	OLD CAP REL COSTS-MVBLE EQUIP								2
3	0300	NEW CAP REL COSTS-BLDG & FIXT		529964	529964	-480126	48838		48838	3
4	0400	NEW CAP REL COSTS-MVBLE EQUIP				960472	960472	-17895	942577	4
4.01	0401	NEW CAP REL COSTS-MVBLE EQUIP N								4.01
5	0500	EMPLOYEE BENEFITS	160999	52912	193901	2825138	3019039	-123606	2895433	5
6	0600	ADMINISTRATIVE & GENERAL	2008472	2820164	4828636	-378487	4450149	738742	5188891	6
7	0700	MAINTENANCE & REPAIRS								7
8	0800	OPERATION OF PLANT	438627	1236996	1665623	-260603	1405020		1405020	8
9	0900	LAUNDRY & LINEN SERVICE	50629	90709	150338	-7602	142736		142736	9
10	1000	HOUSEKEEPING	291387	211807	503194	-119295	383899		383899	10
11	1100	DIETARY	276217	365660	641877	-137637	504240	-35259	468981	11
12	1200	CAFETERIA								12
13	1300	MAINTENANCE OF PERSONNEL								13
14	1400	NURSING ADMINISTRATION								14
15	1500	CENTRAL SERVICES & SUPPLY								15
16	1600	PHARMACY								16
17	1700	MEDICAL RECORDS & LIBRARY	128004	116776	244780	-23092	221688	-7004	214684	17
18	1800	SOCIAL SERVICE								18
20	2000	NONPHYSICIAN ANESTHETISTS								20
21	2100	NURSING SCHOOL								21
22	2200	I&R SERVICES-SALARY & FRINGES A								22
23	2300	I&R SERVICES-OTHER PRGM COSTS A								23
24	2400	PARAMED ED PRGM-(SPECIFY)								24
		INPATIENT ROUTINE SERV COST CENTERS								
25	2500	ADULTS & PEDIATRICS	1049677	485412	1535089	-428224	1106865	-10609	1096256	25
		ANCILLARY SERVICE COST CENTERS								
37	3700	OPERATING ROOM	389539	613525	1003064	-504863	498201		498201	37
40	4000	ANESTHESIOLOGY	282944	115241	398185	-93317	304868	-298758	6110	40
41	4100	RADIOLOGY-DIAGNOSTIC	491222	1144475	1636697	-360343	1276354		1276354	41
44	4400	LABORATORY	379307	784926	1164233	-126846	1037387	-14400	1022987	44
46.30	4650	BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	4900	RESPIRATORY THERAPY		36995	36995	-13912	23083		23083	49
50	5000	PHYSICAL THERAPY	312036	126310	438346	-108671	329675	-72	329603	50
51	5100	OCCUPATIONAL THERAPY	75982	21422	97404	-19274	78130		78130	51
52	5200	SPEECH PATHOLOGY		7060	7060		7060		7060	52
53	5300	ELECTROCARDIOLOGY	94162	52742	146904	-46839	100065		100065	53
55	5500	MEDICAL SUPPLIES CHARGED TO PAT	19498	19660	39158	423275	462433		462433	55
55.30	5530	IMPL. DEV. CHARGED TO PATIENT								55.30
56	5600	DRUGS CHARGED TO PATIENTS	257194	455646	712840	15059	727899		727899	56
59.97	3997	CARDIAC REHABILITATION								59.97
59.98	3998	HYPERBARIC OXYGEN THERAPY								59.98
59.99	3999	LITHOTRIPSY								59.99
		OUTPATIENT SERVICE COST CENTERS								
61	6100	EMERGENCY	867606	812187	1679793	-156673	1523120	-635559	887561	61
62	6200	OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310	RHC	2582833	1309424	3892257	-1109124	2783133	-23323	2759810	63.50
63.60	6320	FQHC								63.60
		OTHER REIMBURSABLE COST CENTERS								
69.10	6910	CMHC								69.10
69.20	6920	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	6930	OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	6940	OUTPATIENT SPEECH PATHOLOGY								69.40
71	7100	HOME HEALTH AGENCY								71
		SPECIAL PURPOSE COST CENTERS								
85.01	8510	PANCREAS ACQUISITION								85.01
85.02	8520	INTESTINAL ACQUISITION								85.02
85.03	8530	ISLET CELL ACQUISITION								85.03
88	8800	INTEREST EXPENSE		67500	67500	333667	401167	-401167		88
95		SUBTOTALS	10146325	11466513	21612838	182683	21795521	-828910	20966611	95
		NONREIMBURSABLE COST CENTERS								
98	9800	PHYSICIANS' PRIVATE OFFICES	863976	222948	1086924	-182683	904241		904241	98
100	7950	CLINIC								100
100.01	7951	RENTAL SPACE								100.01
101		TOTAL	11010301	11689461	22699762		22699762	-828910	21870852	101

RECLASSIFICATIONS

WORKSHEET A-6
PAGE 1

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS INTEREST EXPENSE	A	NEW CAP REL COSTS-MVBLE EQUIP	4		67500	1
2	TO RECLASS MEDICAL SUPPLIES	B	MEDICAL SUPPLIES CHARGED TO P	55		425318	2
3		B	DRUGS CHARGED TO PATIENTS	56		85889	3
4		B					4
5		B					5
6		B					6
7		B					7
8		B					8
9		B					9
10		B					10
11		B					11
12	TO RECLASS RT SALARIES	C	RESPIRATORY THERAPY	49	11980		12
13		C					13
14		C					14
15	TO RECLASS A&G EXPENSES	D	ADMINISTRATIVE & GENERAL	6	434654		15
16		D					16
17	TO RECLASS RHC PHYSICIAN RECRUITMEN	E	RHC	63.50		26090	17
18	TO RECLASS PROPERTY INSURANCE	F	NEW CAP REL COSTS-BLDG & FIXT	3		2770	18
19		F	NEW CAP REL COSTS-MVBLE EQUIP	4		50654	19
20	EMPLOYEE BENEFIT RECLASS	G	EMPLOYEE BENEFITS	5	2878050		20
21		G					21
22		G					22
23		G					23
24		G					24
25		G					25
26		G					26
27		G					27
28		G					28
29		G					29
30		G					30
31		G					31
32		G					32
33		G					33
34		G					34
35		G					35
36	SUBTOTAL				3324684	658221	36

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE				WKST A-7 REF.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	TO RECLASS INTEREST EXPENSE	A	INTEREST EXPENSE	88		67500	11	1
2	TO RECLASS MEDICAL SUPPLIES	B	ADULTS & PEDIATRICS	25		3168		2
3		B	OPERATING ROOM	37		332554		3
4		B	ANESTHESIOLOGY	40		27147		4
5		B	RADIOLOGY-DIAGNOSTIC	41		85918		5
6		B	RESPIRATORY THERAPY	49		22792		6
7		B	PHYSICAL THERAPY	50		4471		7
8		B	OCCUPATIONAL THERAPY	51		975		8
9		B	EMERGENCY	61		5132		9
10		B	RHC	63.50		664		10
11		B	PHYSICIANS' PRIVATE OFFICES	98		28388		11
12	TO RECLASS RT SALARIES	C	ADULTS & PEDIATRICS	25	11599			12
13		C	ELECTROCARDIOLOGY	53	360			13
14		C	EMERGENCY	61	21			14
15	TO RECLASS A&G EXPENSES	D	PHYSICIANS' PRIVATE OFFICES	98	31758			15
16		D	RHC	63.50	402896			16
17	TO RECLASS RHC PHYSICIAN RECRUITM	E	ADMINISTRATIVE & GENERAL	6		26090		17
18	TO RECLASS PROPERTY INSURANCE	F	ADMINISTRATIVE & GENERAL	6		53425	11	18
19		F					11	19
20	EMPLOYEE BENEFIT RECLASS	G	EMPLOYEE BENEFITS	5		52912	11	20
21		G	ADMINISTRATIVE & GENERAL	6		532162		21
22		G	OPERATION OF PLANT	8		153077		22
23		G	LAUNDRY & LINEN SERVICE	9		15107		23
24		G	HOUSEKEEPING	10		115950		24
25		G	DIETARY	11		130458		25
26		G	MEDICAL RECORDS & LIBRARY	17		20320		26
27		G	ADULTS & PEDIATRICS	25		327794		27
28		G	OPERATING ROOM	37		112318		28
29		G	ANESTHESIOLOGY	40		58414		29
30		G	RADIOLOGY-DIAGNOSTIC	41		157765		30
31		G	LABORATORY	44		106070		31
32		G	PHYSICAL THERAPY	50		87149		32
33		G	OCCUPATIONAL THERAPY	51		18774		33
34		G	ELECTROCARDIOLOGY	53		27873		34
35		G	DRUGS CHARGED TO PATIENTS	56		72716		35
36	SUBTOTAL				446634	2647083		36

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER	
		1	2	3	4	5	
1		G					1
2		G					2
3		G					3
4	TEAM AWARD RECLASS	H	ADMINISTRATIVE & GENERAL	6	74798		4
5		H	OPERATION OF PLANT	8	5938		5
6		H	LAUNDRY & LINEN SERVICE	9	7505		6
7		H	DIETARY	11	6080		7
8		H	MEDICAL RECORDS & LIBRARY	17	2185		8
9		H	ADULTS & PEDIATRICS	25	11258		9
10		H	OPERATING ROOM	37	4370		10
11		H	ANESTHESIOLOGY	40	475		11
12		H	RADIOLOGY-DIAGNOSTIC	41	6033		12
13		H	LABORATORY	44	4893		13
14		H	PHYSICAL THERAPY	50	3800		14
15		H	OCCUPATIONAL THERAPY	51	475		15
16		H	ELECTROCARDIOLOGY	53	1425		16
17		H	DRUGS CHARGED TO PATIENTS	56	3753		17
18		H	EMERGENCY	61	4798		18
19		H	RHC	63.50	19950		19
20		H	PHYSICIANS' PRIVATE OFFICES	98	2850		20
21	EMPLOYEE BENEFITS	I	OPERATION OF PLANT	8	1755		21
22		I	EMERGENCY	61	1946		22
23	DEPRECIATION RECLASS	J	NEW CAP REL COSTS-MVBLE EQUIP	4		842318	23
24		J	INTEREST EXPENSE	88		401167	24
25		J					25
26		J					26
27		J					27
28		J					28
29		J					29
30		J					30
31		J					31
32		J					32
33		J					33
34		J					34
35		J					35
36	SUBTOTAL				3488971	1901706	36

RECLASSIFICATION'S

	EXPLANATION OF RECLASSIFICATION ENTRY	COLE	DECREASE COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1		G	EMERGENCY	61		123609		1
2		G	RHC	63.50		656255		2
3		G	PHYSICIANS' PRIVATE OFFICES	98		109327		3
4	TEAM AWARE RECLASS	H	ADMINISTRATIVE & GENERAL	6		160583		4
5		H						5
6		H						6
7		H						7
8		H						8
9		H						9
10		H						10
11		H						11
12		H						12
13		H						13
14		H						14
15		H						15
16		H						16
17		H						17
18		H						18
19		H						19
20		H						20
21	EMPLOYEE BENEFITS	I	HOUSEKEEPING	10		1755		21
22		I	ANESTHESIOLOGY	40		1946		22
23	DEPRECIATION RECLASS	J	NEW CAP REL COSTS-BLDG & FIXT	3		482896	11	23
24		J	ADMINISTRATIVE & GENERAL	6		115679		24
25		J	OPERATION OF PLANT	8		115219		25
26		J	HOUSEKEEPING	10		1590		26
27		J	DIETARY	11		13259		27
28		J	MEDICAL RECORDS & LIBRARY	17		4957		28
29		J	ADULTS & PEDIATRICS	25		96921		29
30		J	OPERATING ROOM	37		64361		30
31		J	ANESTHESIOLOGY	40		6285		31
32		J	RADIOLOGY-DIAGNOSTIC	41		122693		32
33		J	LABORATORY	44		25669		33
34		J	RESPIRATORY THERAPY	49		3100		34
35		J	PHYSICAL THERAPY	50		20851		35
36	SUBTOTAL				446634	4774038		36

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5
1		J				
2		J				
3		J				
4		J				
5		J				
6		J				
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
32						
33						
34						
35						
36	TOTAL RECLASSIFICATIONS				3488971	1901706

	EXPLANATION OF RECLASSIFICATION ENTRY	COLE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1		J	ELECTROCARDIOLOGY	53		20031		1
2		J	MEDICAL SUPPLIES CHARGED TO P	55		2043		2
3		J	DRUGS CHARGED TO PATIENTS	56		1867		3
4		J	EMERGENCY	61		34655		4
5		J	RHC	63.50		95349		5
6		J	PHYSICIANS' PRIVATE OFFICES	98		16060		6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34								34
35								35
36	TOTAL RECLASSIFICATIONS				446634	4944043		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 PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
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 PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND	325000					325000		1
2	LAND IMPROVEMENTS	146120					146120		2
3	BUILDINGS AND FIXTURES	2607832	68947		68947		2676779		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	3854963	206567		206567		4061530		6
7	SUBTOTAL	6933915	275514		275514		7209429		7
8	RECONCILING ITEMS								8
9	TOTAL	6933915	275514		275514		7209429		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS III & IV

	DESCRIPTION	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		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	2676779		2676779	.397248					3
4	NEW CAP REL COSTS-MVBLE EQUIP	4061531		4061531	.602752					4
4.01	NEW CAP REL COSTS-MVBLE EQUIP N				.000000					4.01
5	TOTAL	6738310		6738310	1.000000					5

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		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	528964		-480126				48838	3
4	NEW CAP REL COSTS-MVBLE EQUIP			942577				942577	4
4.01	NEW CAP REL COSTS-MVBLE EQUIP NH								4.01
5	TOTAL	528964		462451				991415	5

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

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		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	528964						528964	3
4	NEW CAP REL COSTS-MVBLE EQUIP								4
4.01	NEW CAP REL COSTS-MVBLE EQUIP NH								4.01
5	TOTAL	528964						528964	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 COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
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	-17695	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	-3642	ADMINISTRATIVE & GENERAL	6		9
10	TELEVISION AND RADIO SERVICE	A	-1299	ADMINISTRATIVE & GENERAL	6		10
11	PARKING LOT						11
12	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-660568				12
13	SALE OF SCRAP, WASTE, ETC.						13
14	RELATED ORGANIZATION TRANSACTIONS	WKST A-8-1	1244538				14
15	LAUNDRY AND LINEN SERVICE						15
16	CAFETERIA - EMPLOYEES AND GUESTS	B	-32981	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	-7004	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		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	-52072	ADMINISTRATIVE & GENERAL	6		37
38	MARKETING & DEVELOPMENT FRINGE BE	A	-15586	EMPLOYEE BENEFITS	5		38
39	MARKETING & DEVELOPMENT OTHER EXP	A	-53086	ADMINISTRATIVE & GENERAL	6		39
40	CRNA CONTRACT LABOR	A	-10814	ANESTHESIOLOGY	40		40
40.10	CRNA-CME	A	-5000	ANESTHESIOLOGY	40		40.10
41	ADVERTISING EXPENSE	A	-162329	ADMINISTRATIVE & GENERAL	6		41
42	MISCELLANEOUS INCOME	B	-2278	DIETARY	11		42
42.10	MISCELLANEOUS INCOME ADD	B	-22327	ADMINISTRATIVE & GENERAL	6		42.10
43	LOBBYING	A	-10417	ADMINISTRATIVE & GENERAL	6		43
43.10	DONATIONS	A	-14765	ADMINISTRATIVE & GENERAL	6		43.10
44							44
45							45
46							46
47							47
48	PROVIDER TAX IDPA	A	-184536	ADMINISTRATIVE & GENERAL	6		48
49	CRNA SALARIES	A	-282944	ANESTHESIOLOGY	40		49
49.01	CRNA BENEFITS	A	-58414	EMPLOYEE BENEFITS	5		49.01
49.04	RHC OTHER INCOME	B	-23323	RHC	63.50		49.04
49.05	ER BENEFITS	A	-49606	EMPLOYEE BENEFITS	5		49.05
49.06	MISCELLANEOUS INCOME	B	-72	PHYSICAL THERAPY	50		49.06
49.07	ALCOHOLIC BEVERAGES	A	-1323	ADMINISTRATIVE & GENERAL	6		49.07
49.10	GOODWILL	A	-401167	INTEREST EXPENSE	88		49.10
50	TOTAL		-828910				50

PROVIDER NO. 11-[illegible] OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM [illegible] TO [illegible]

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

VERSION: 2010.09
02/28/2011 13:43

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 ADJ-USTMENTS	WKST A-7 REF	
	1	2	3	4	5	6	7	
1	6	ADMINISTRATIVE & GENERAL	A&G	1516556	566209	950347		1
2	6	ADMINISTRATIVE & GENERAL	INTEREST EXP CORP OFFICE	294191		294191		2
3	41	RADIOLOGY-DIAGNOSTIC	MOBILE MRI	163550	163550			3
4	41	RADIOLOGY-DIAGNOSTIC	ET MAINTENANCE AGREEMENT	126534	126534			4
5		TOTALS		2100831	856293	1244538		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	PERCENT OF OWNERSHIP	-------- RELATED ORGANIZATION(S) AND/OR HOME OFFICE ---------- NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
	1	3	4	4	5	6	
1	B	OSF HEALTHCARE SYSTEM	100.00				1
2							2
3							3
4							4
5							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-[illegible] OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2009 TO 09/30/2010

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

VERSION: 2010.09
02/28/2011 13:43

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2		TOTAL REMUNERATION INCL FRINGES 3	PROFESSIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	PERCENT OF UNADJUSTED RCE LIMIT 9
1	61	EMERGENCY	AGGREGATE	881298	635559	245739				
2	44	LABORATORY	AGGREGATE	14400	14400					
3	6	ADMINISTRATIVE & GENERAL		96964		96964				
4	25	ADULTS & PEDIATRICS	AGGREGATE	10609	10609					
101		TOTAL		993271	660568	332703				

PROVIDER NO. 14-[illegible] OUR HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2009 TO 09/30/2010

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

VERSION: 2010.09
02/28/2011 13:43

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUST-MENT 18
1	61	EMERGENCY	AGGREGATE							635559
2	44	LABORATORY	AGGREGATE							14400
3	6	ADMINISTRATIVE & GENERAL								
4	25	ADULTS & PEDIATRICS	AGGREGATE							10609
101		TOTAL								660568

PROVIDER NO. 14-1319 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2009 TO 09/30/2010

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

VERSION: 2010.09
02/28/2011 13:43

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 31, 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)	4	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	60	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	22	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		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	3.45	8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		3.60				9
10	AHSEA		70.96				10
11	STANDARD TRAVEL ALLOWANCE	35.48	35.48				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	213	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	213	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	213	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	71.00	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	4260	22
23	TOTAL SALARY EQUIVALENCY	4260	23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 16, 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	781	24
25	ASSISTANTS		25
26	SUBTOTAL	781	26
27	STANDARD TRAVEL EXPENSE	76	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	857	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	857	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 15, 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	OVERTIME HOURS WORKED DURING REPORTING PERIOD						47
48	OVERTIME RATE						48
49	TOTAL OVERTIME						49
	CALCULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY						50
51	ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50						51
	DETERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT						52
53	OVERTIME COST LIMITATION						53
54	MAXIMUM OVERTIME COST						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA						55
56	OVERTIME ALLOWANCE						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	4260	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	857	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	5117	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	177	64
65	EXCESS OVER LIMITATION		65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 1, 1998

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

[ ] OCCUPATIONAL [X] 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	177	66
67	TOTAL COST	177	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

PROVIDER NO. 14-[illegible] OSF HOLY FAMILY MEDICAL CENTER | KPMG LLP COMPU-MAX MICRO SYSTEM | VERSION: 2010.09
PERIOD FROM 10/01/2009 TO 09/30/2010 | IN LIEU OF FORM CMS-2552-96 (11/98) | 02/28/2011 13:43

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 15, 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)	16	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	240	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	80	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 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		100.00				9
10	AHSEA		64.62				10
11	STANDARD TRAVEL ALLOWANCE	32.31	32.31				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	6462	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	6462	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	6462	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	64.62	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	15509	22
23	TOTAL SALARY EQUIVALENCY	15509	23

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

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	2585	24
25	ASSISTANTS		25
26	SUBTOTAL	2585	26
27	STANDARD TRAVEL EXPENSE	276	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	2861	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	2861	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-[illegible] OUR HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2009 TO 09/30/2010

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

VERSION: 2010.09
02/28/2011 13:43

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 [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD						47
48	OVERTIME RATE						48
49	TOTAL OVERTIME CALCULATION OF LIMIT						49
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY						50
51	ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50						51
	DETERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT						52
53	OVERTIME COST LIMITATION						53
54	MAXIMUM OVERTIME COST						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA						55
56	OVERTIME ALLOWANCE						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	15509	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES	2861	59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	18370	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	6030	64
65	EXCESS OVER LIMITATION		65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-4
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 1, 1999 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	6030	66
67	TOTAL COST	6030	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	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	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	48838	48838							3
4	NEW CAP REL COSTS-MVBLE EQUIP	942577		942577						4
4.01	NEW CAP REL COSTS-MVBLE EQUIP N									4.01
5	EMPLOYEE BENEFITS	2895433			2895433					5
6	ADMINISTRATIVE & GENERAL	5188891	6001	115826	685086	5995804	5995804			6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT	2405020	9371	180866	121436	1716693	648373	2365066		8
9	LAUNDRY & LINEN SERVICE	142736			18266	161002	60808		221810	9
10	HOUSEKEEPING	343899	685	13212	79281	477077	180186	48379	17908	10
11	DIETARY	408981	3540	68320	76808	617649	233278	250171		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	214684	1347	25998	35422	277451	104790	95198		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	1096256	5776	111485	285505	1499022	566161	408230	88344	25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	498201	2497	48200	107176	656074	247791	176495	24229	37
40	ANESTHESIOLOGY	6110	119	2290	129	8648	3266	8384		40
41	RADIOLOGY-DIAGNOSTIC	1276354	2659	51322	135566	1465901	553652	187928	22007	41
44	LABORATORY	1022987	996	19218	104534	1147735	433485	70373	156	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY	23083			3260	26343	9949			49
50	PHYSICAL THERAPY	329603	1668	32193	85933	449397	169731	117881	34936	50
51	OCCUPATIONAL THERAPY	78130	144	2785	20803	101862	38472	10198		51
52	SPEECH PATHOLOGY	7060	18	347		7425	2804	1270		52
53	ELECTROCARDIOLOGY	100065	659	12726	25910	139360	52634	46601	739	53
55	MEDICAL SUPPLIES CHARGED TO PAT	402433	1812	34968	5305	504518	190550	128043		55
55.30	IMPL. DEV. CHARGED TO PATIENT									55.30
56	DRUGS CHARGED TO PATIENTS	727899	571	11012	70999	810481	306108	40322		56
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	987561	2902	56010	208257	1154730	436127	205095	28993	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC	2759910	4817	92960	598550	3456137	1305343	340397	201	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	20966611	45582	879738	2668226	20673309	5543508	2134965	217513	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES	904241	3256	62839	227207	1197543	452296	230101	4297	98
100	CLINIC									100
100.01	RENTAL SPACE									100.01
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	21870852	48838	942577	2895433	21870852	5995804	2365066	221810	103

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		10	11	12	17	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	723550							10
11	DIETARY	98134	1179232						11
12	CAFETERIA		1008571	1008571					12
13	MAINTENANCE OF PERSONNEL								13
14	NURSING ADMINISTRATION								14
15	CENTRAL SERVICES & SUPPLY								15
16	PHARMACY								16
17	MEDICAL RECORDS & LIBRARY	29732		37338	544509				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	127500	170661	188553	32505	3080976		3080976	25
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	55123		52770	45950	1258432		1258432	37
40	ANESTHESIOLOGY	2618		17206	1389	41511		41511	40
41	RADIOLOGY-DIAGNOSTIC	59694		66694	123021	2477897		2477897	41
44	LABORATORY	21979		74321	98248	1846297		1846297	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	RESPIRATORY THERAPY			4789	7396	48477		48477	49
50	PHYSICAL THERAPY	36817		49577	29787	888126		888126	50
51	OCCUPATIONAL THERAPY	3185		8159	5257	167133		167133	51
52	SPEECH PATHOLOGY	397			331	12227		12227	52
53	ELECTROCARDIOLOGY	14554		22882	4768	281538		281538	53
55	MEDICAL SUPPLIES CHARGED TO PAT	39991		3459	34199	900760		900760	55
55.30	IMPL. DEV. CHARGED TO PATIENT								55.30
56	DRUGS CHARGED TO PATIENTS	12593		26252	40329	1236085		1236085	56
59.97	CARDIAC REHABILITATION								59.97
59.98	HYPERBARIC OXYGEN THERAPY								59.98
59.99	LITHOTRIPSY								59.99
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	64055		74144	49409	2012553		2012553	61
62	OBSERVATION BEDS (NON-DISTINCT								62
63.50	RHC	106313		332939	46825	5588155		5588155	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	651685	1179232	959083	519414	19840167		19840167	95
	NONREIMBURSABLE COST CENTERS								
98	PHYSICIANS' PRIVATE OFFICES	71865		49488	25095	2030685		2030685	98
100	CLINIC								100
100.01	RENTAL SPACE								100.01
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	TOTAL	723550	1179232	1008571	544509	21870852		21870852	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	TIE ASSGNT CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	CAP REL COST TO BE ALLOC 4A	ADMINIS-TRATIVE + GENERAL 6	OPERATION OF PLANT 8	LAUNDRY + LINEN SERVICE 9	HOUSE-KEEPING 10	
	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	6001	115826	363453	363453				6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT		9371	180866	190237	39304	229541			8
9	LAUNDRY & LINEN SERVICE					3686		3686		9
10	HOUSEKEEPING		685	13212	13897	10923	4695	298	29813	10
11	DIETARY		3540	68320	71860	14141	24280		3219	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		1347	25998	27345	6352	9239		1225	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		5776	111485	117261	34320	39623	1467	5255	25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		2497	48200	50697	15021	17130	403	2271	37
40	ANESTHESIOLOGY		119	2290	2409	198	814		108	40
41	RADIOLOGY-DIAGNOSTIC		2659	51322	53981	33562	18239	366	2418	41
44	LABORATORY		996	19218	20214	26277	6830	3	906	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY					603				49
50	PHYSICAL THERAPY		1668	32193	33861	10289	11441	591	1517	50
51	OCCUPATIONAL THERAPY		144	2785	2929	2332	990		131	51
52	SPEECH PATHOLOGY		18	347	365	170	123		16	52
53	ELECTROCARDIOLOGY		659	12726	13385	3191	4523	12	600	53
55	MEDICAL SUPPLIES CHARGED TO PAT		1812	34968	36780	11551	12427		1648	55
55.30	IMPL. DEV. CHARGED TO PATIENT									55.30
56	DRUGS CHARGED TO PATIENTS		571	11012	11583	18556	3913		519	56
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		2902	56010	58912	26438	19905	482	2639	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC		4817	92960	97777	79121	33037	3	4380	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	241626	45582	879738	1166946	336035	207209	3615	26852	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES		3256	62839	66095	27418	22332	71	2961	98
100	CLINIC									100
100.01	RENTAL SPACE									100.01
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	241626	48838	942577	1233041	363453	229541	3686	29813	103

PROVIDER NO. 14-[illegible] ONE HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2009 TO 09/30/2010

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

VERSION: 2010.09
02/28/2011 13:43

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	DIETARY	CAFETERIA	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		11	12	17	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	113500						11
12	CAFETERIA	97074	97074					12
13	MAINTENANCE OF PERSONNEL							13
14	NURSING ADMINISTRATION							14
15	CENTRAL SERVICES & SUPPLY							15
16	PHARMACY							16
17	MEDICAL RECORDS & LIBRARY		3594	47755				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	16426	18148	2851	235351		235351	25
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM		5079	4030	94631		94631	37
40	ANESTHESIOLOGY		1656	122	5307		5307	40
41	RADIOLOGY-DIAGNOSTIC		6419	10790	125775		125775	41
44	LABORATORY		7153	8616	69999		69999	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO							46.30
49	RESPIRATORY THERAPY		461	649	1713		1713	49
50	PHYSICAL THERAPY		4772	2612	65073		65073	50
51	OCCUPATIONAL THERAPY		785	461	7628		7628	51
52	SPEECH PATHOLOGY			29	703		703	52
53	ELECTROCARDIOLOGY		2202	416	24331		24331	53
55	MEDICAL SUPPLIES CHARGED TO PAT		333	2999	65738		65738	55
55.30	IMPL. DEV. CHARGED TO PATIENT							55.30
56	DRUGS CHARGED TO PATIENTS		3527	3537	40635		40635	56
59.97	CARDIAC REHABILITATION							59.97
59.98	HYPERBARIC OXYGEN THERAPY							59.98
59.99	LITHOTRIPSY							59.99
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY		7136	4333	119845		119845	61
62	OBSERVATION BEDS (NON-DISTINCT							62
63.50	RHC		32046	4107	250471		250471	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	113500	92311	45554	1107200		1107200	95
	NONREIMBURSABLE COST CENTERS							
98	PHYSICIANS' PRIVATE OFFICES		4763	2201	125841		125841	98
100	CLINIC							100
100.01	RENTAL SPACE							100.01
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	TOTAL	113500	97074	47755	1233041		1233041	103

PROVIDER NO. 14-1[illegible] OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2009 TO 09/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (9/97)

VERSION: 2010.09
02/28/2011 13:43

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP BLDGS & FIXTURES SQUARE FEET	NEW CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE + GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		3	4	5	6A	6	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	95099						3
4	NEW CAP REL COSTS-MVBLE EQUIP		95099					4
4.01	NEW CAP REL COSTS-MVBLE EQUIP							4.01
5	EMPLOYEE BENEFITS			10641747				5
6	ADMINISTRATIVE & GENERAL	11686	11686	2517924	-5995804	15875048		6
7	MAINTENANCE & REPAIRS							7
8	OPERATION OF PLANT	18248	18248	446320		1716693	65165	8
9	LAUNDRY & LINEN SERVICE			67134		161002		9
10	HOUSEKEEPING	1333	1333	291387		477077	1333	10
11	DIETARY	6893	6893	282297		617649	6893	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	2623	2623	130189		277451	2623	17
19	SOCIAL SERVICE							18
20	NONPHYSICIAN ANESTHETISTS							20
21	NURSING SCHOOL							21
22	I/R SERVICES-SALARY & FRINGES							22
23	I&R SERVICES-OTHER PRGM COSTS							23
24	PARAMED ED PRGM-(SPECIFY)							24
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	11248	11248	1049336		1499022	11248	25
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	4863	4863	393909		656074	4863	37
40	ANESTHESIOLOGY	231	231	475		8648	231	40
41	RADIOLOGY-DIAGNOSTIC	5178	5178	498255		1465901	5178	41
44	LABORATORY	1939	1939	384200		1147735	1939	44
46.30	BLOOD CLOTTING FACTORS ADMIN							46.30
49	RESPIRATORY THERAPY			11980		26343		49
50	PHYSICAL THERAPY	3248	3248	315836		449397	3248	50
51	OCCUPATIONAL THERAPY	281	281	76457		101862	281	51
52	SPEECH PATHOLOGY	35	35			7425	35	52
53	ELECTROCARDIOLOGY	1284	1284	95227		139360	1284	53
55	MEDICAL SUPPLIES CHARGED TO P	3528	3528	19498		504518	3528	55
55.30	IMPL. DEV. CHARGED TO PATIENT							55.30
56	DRUGS CHARGED TO PATIENTS	1111	1111	260947		810481	1111	56
59.97	CARDIAC REHABILITATION							59.97
59.98	HYPERBARIC OXYGEN THERAPY							59.98
59.99	LITHOTRIPSY							59.99
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	5651	5651	765421		1154730	5651	61
62	OBSERVATION BEDS (NON-DISTINC							62
63.50	RHC	9379	9379	2199887		3456137	9379	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 THERA							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	88759	88759	9806679	-5995804	14677505	58825	95
	NONREIMBURSABLE COST CENTERS							
98	PHYSICIANS' PRIVATE OFFICES	6340	6340	835068		1197543	6340	98
100	CLINIC							100
100.01	RENTAL SPACE							100.01

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP BLDGS & FIXTURES SQUARE FEET 3	NEW CAP MOVABLE EQUIPMENT SQUARE FEET 4	EMPLOYEE BENEFITS GROSS SALARIES 5	RECON-CILIATION 6A	ADMINIS-TRATIVE + GENERAL ACCUM COST 6	OPERATION OF PLANT SQUARE FEET 8	
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	COST TO BE ALLOC PER B PT I	48838	942577	2895433		5995804	2365066	103
104	UNIT COST MULT-WS B PT I		9.911534				36.293501	
104	UNIT COST MULT-WS B PT I	.513549		.272082		.377687		104
105	COST TO BE ALLOC PER B PT II							104
106	UNIT COST MULT-WS B PT II							105
106	UNIT COST MULT-WS B PT II							106
107	COST TO BE ALLOC PER B PT III					363453	229541	106
108	UNIT COST MULT-WS B PT III						3.522458	107
108	UNIT COST MULT-WS B PT III					.022895		108
								108

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	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						6
7	MAINTENANCE & REPAIRS						7
8	OPERATION OF PLANT						8
9	LAUNDRY & LINEN SERVICE	138143					9
10	HOUSEKEEPING	11153	63832				10
11	DIETARY		6893	52252			11
12	CAFETERIA			44690	11372		12
13	MAINTENANCE OF PERSONNEL						13
14	NURSING ADMINISTRATION						14
15	CENTRAL SERVICES & SUPPLY						15
16	PHARMACY						16
17	MEDICAL RECORDS & LIBRARY		2623		421	48529434	17
18	SOCIAL SERVICE						18
20	NONPHYSICIAN ANESTHETISTS						20
21	NURSING SCHOOL						21
22	I&R SERVICES-SALARY & FRINGES						22
23	I&R SERVICES-OTHER PRGM COSTS						23
24	PARAMED ED PRGM-(SPECIFY)						24
	INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS	55021	11248	7562	2126	2897101	25
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM	15090	4863		595	4095323	37
40	ANESTHESIOLOGY		231		194	123772	40
41	RADIOLOGY-DIAGNOSTIC	13706	5178		752	10963604	41
44	LABORATORY	97	1939		838	8756523	44
46.30	BLOOD CLOTTING FACTORS ADMIN						46.30
49	RESPIRATORY THERAPY				54	659206	49
50	PHYSICAL THERAPY	21798	3248		559	2654857	50
51	OCCUPATIONAL THERAPY		281		92	468529	51
52	SPEECH PATHOLOGY		35			29543	52
53	ELECTROCARDIOLOGY	460	1284		258	424967	53
55	MEDICAL SUPPLIES CHARGED TO P		3528		39	3048006	55
55.30	IMPL. DEV. CHARGED TO PATIENT						55.30
56	DRUGS CHARGED TO PATIENTS		1111		296	3594353	56
59.97	CARDIAC REHABILITATION						59.97
59.98	HYPERBARIC OXYGEN THERAPY						59.98
59.99	LITHOTRIPSY						59.99
	OUTPATIENT SERVICE COST CENTERS						
61	EMERGENCY	18057	5651		836	4403651	61
62	OBSERVATION BEDS (NON-DISTINC						62
63.50	RHC	125	9379		3754	4173358	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 THERA						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	135467	57492	52252	10814	46292793	95
	NONREIMBURSABLE COST CENTERS						
98	PHYSICIANS' PRIVATE OFFICES	2676	6340		558	2236641	98
100	CLINIC						100
100.01	RENTAL SPACE						100.01

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	MEDICAL RECORDS + LIBRARY GROSS REVENUE 17	
101	CROSS FOOT ADJUSTMENTS						101
102	NEGATIVE COST CENTER						102
103	COST TO BE ALLOC PER B PT I	221410	723550	1179232	1008571	544509	103
104	UNIT COST MULT-WS B PT I	1.605655		22.568170		.011220	
104	UNIT COST MULT-WS B PT I		11.335224		88.688973		104
105	COST TO BE ALLOC PER B PT II						105
106	UNIT COST MULT-WS B PT II						
106	UNIT COST MULT-WS B PT II						106
107	COST TO BE ALLOC PER B PT III	3616	39813	113500	97074	47755	107
108	UNIT COST MULT-WS B PT III	.026682		2.172166		.000984	
108	UNIT COST MULT-WS B PT III		.467054		8.536229		108

PROVIDER NO. 14-1513 OFF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2009 TO 09/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (5/1999)

VERSION: 2010.09
02/28/2011 13:43

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	3080976		3080976		3080976	25
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM	1258432		1258432		1258432	37
40	ANESTHESIOLOGY	41511		41511		41511	40
41	RADIOLOGY-DIAGNOSTIC	2477897		2477897		2477897	41
44	LABORATORY	1846297		1846297		1846297	44
46.30	BLOOD CLOTTING FACTORS ADMI						46.30
49	RESPIRATORY THERAPY	48477		48477		48477	49
50	PHYSICAL THERAPY	888126		888126		888126	50
51	OCCUPATIONAL THERAPY	167133		167133		167133	51
52	SPEECH PATHOLOGY	12227		12227		12227	52
53	ELECTROCARDIOLOGY	281538		281538		281538	53
55	MEDICAL SUPPLIES CHARGED TO	900760		900760		900760	55
55.30	IMPL. DEV. CHARGED TO PATIE						55.30
56	DRUGS CHARGED TO PATIENTS	1236085		1236085		1236085	56
59.97	CARDIAC REHABILITATION						59.97
59.98	HYPERBARIC OXYGEN THERAPY						59.98
59.99	LITHOTRIPSY						59.99
	OUTPATIENT SERVICE COST CENTERS						
61	EMERGENCY	2012553		2012553		2012553	61
62	OBSERVATION BEDS (NON-DISTI	449752		449752		449752	62
63.50	RHC	5588155		5588155		5588155	63.50
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
101	SUBTOTAL	20289919		20289919		20289919	101
102	LESS OBSERVATION BEDS	449752		449752		449752	102
103	TOTAL	19840167		19840167		19840167	103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I (CONT)

	COST CENTER DESCRIPTION	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT 6	OUTPATIENT 7	TOTAL 8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	2897101		2897101				25
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	762933	3332390	4095323	.307285	.307285	.307285	37
40	ANESTHESIOLOGY	1379	122393	123772	.335383	.335383	.335383	40
41	RADIOLOGY-DIAGNOSTIC	1617465	9346140	10963605	.226011	.226011	.226011	41
44	LABORATORY	1507362	7249161	8756523	.210848	.210848	.210848	44
46.30	BLOOD CLOTTING FACTORS ALMI							46.30
49	RESPIRATORY THERAPY	376655	282550	659205	.073539	.073539	.073539	49
50	PHYSICAL THERAPY	270441	2384416	2654857	.334529	.334529	.334529	50
51	OCCUPATIONAL THERAPY	144454	324075	468529	.356719	.356719	.356719	51
52	SPEECH PATHOLOGY	17955	11688	29643	.413871	.413871	.413871	52
53	ELECTROCARDIOLOGY	3777	421190	424967	.662494	.662494	.662494	53
55	MEDICAL SUPPLIES CHARGED TO	905894	2142111	3048005	.295524	.295524	.295524	55
55.30	IMPL. DEV. CHARGED TO PATIE							55.30
56	DRUGS CHARGED TO PATIENTS	2193685	1410668	3594353	.343896	.343896	.343896	56
59.97	CARDIAC REHABILITATION							59.97
59.98	HYPERBARIC OXYGEN THERAPY							59.98
59.99	LITHOTRIPSY							59.99
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	2032745	2370906	4403651	.457019	.457019	.457019	61
62	OBSERVATION BEDS (NON-DISTI		368457	368457	1.220636	1.220636	1.220636	62
63.50	RHC		4173358	4173358	1.339007	1.339007	1.339007	63.50
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
101	SUBTOTAL	12721746	33939503	46661249				101
102	LESS OBSERVATION BEDS							102
103	TOTAL	12721746	33939503	46661249				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, PART II COL. 9	PART I COL. 9	PART II COL. 9	PROGRAM CHARGES - OUTPATIENT AMBULATORY SURGICAL CENTER	OUTPATIENT RADIOLOGY	OTHER OUTPATIENT DIAGNOSTIC	
		1	1.01	1.02	2	3	4	
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	.307285	.307285	.307285				37
40	ANESTHESIOLOGY	.335383	.335383	.335383				40
41	RADIOLOGY-DIAGNOSTIC	.226011	.226011	.226011				41
44	LABORATORY	.210848	.210848	.210848				44
46.30	BLOOD CLOTTING FACTORS ADMIN CO							46.30
49	RESPIRATORY THERAPY	.073539	.073539	.073539				49
50	PHYSICAL THERAPY	.334529	.334529	.334529				50
51	OCCUPATIONAL THERAPY	.356719	.356719	.356719				51
52	SPEECH PATHOLOGY	.413871	.413871	.413871				52
53	ELECTROCARDIOLOGY	.662494	.662494	.662494				53
55	MEDICAL SUPPLIES CHARGED TO PAT	.295524	.295524	.295524				55
55.30	IMPL. DEV. CHARGED TO PATIENT							55.30
56	DRUGS CHARGED TO PATIENTS	.343896	.343896	.343896				56
59.97	CARDIAC REHABILITATION							59.97
59.98	HYPERBARIC OXYGEN THERAPY							59.98
59.99	LITHOTRIPSY							59.99
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	.457019	.457019	.457019				61
62	OBSERVATION BEDS (NON-DISTINCT	1.220636	1.220636	1.220636				62
63.50	RHC	1.339007	1.339007	1.339007				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							101
102	CRNA CHARGES							102
103	LESS IEP CLINIC LAB SERV-PGM ONLY CHRGS							103
104	NET CHARGES							104

PART VI - VACCINE COST APPORTIONMENT

		1	
1	DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	.343896	1
2	VACCINE CHARGES (OTHER THAN HEPATITIS B)	120	2
2.01	VACCINE CHARGES - HEPATITIS B		2.01
3	VACCINE COSTS (OTHER THAN HEPATITIS B)	41	3
3.01	VACCINE COSTS - HEPATITIS B		3.01

PROVIDER NO. 14-1318 ONE HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2009 TO 09/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (8/2002)

VERSION: 2010.09
02/28/2011 13:43

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

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

		PROGRAM CHARGES					PROGRAM COST			
	COST CENTER DESCRIPTION	ALL OTHER (SEE INSTRU.) 5	PPS SERVICES (SEE INSTRU.) 5.01	ALL OTHER (SEE INSTRU.) 5.02	PPS SERVICES (SEE INSTRU.) 5.03	PPS SERVICES (SEE INSTRU.) 5.04	OUTPATIENT AMBULATORY SURGICAL CENTER 6	OUTPATIENT RADIOLOGY 7	OTHER OUTPATIENT DIAGNOSTIC 8	
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	872204								37
40	ANESTHESIOLOGY	988								40
41	RADIOLOGY-DIAGNOSTIC	3162776								41
44	LABORATORY	3194450								44
46.30	BLOOD CLOTTING FACTORS ADMIN C									46.30
49	RESPIRATORY THERAPY	41363								49
50	PHYSICAL THERAPY	720381								50
51	OCCUPATIONAL THERAPY	133891								51
52	SPEECH PATHOLOGY	5434								52
53	ELECTROCARDIOLOGY	348732								53
55	MEDICAL SUPPLIES CHARGED TO PA	650385								55
55.30	IMPL. DEV. CHARGED TO PATIENT									55.30
56	DRUGS CHARGED TO PATIENTS	736138								56
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	1244153								61
62	OBSERVATION BEDS (NON-DISTINCT	196462								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	11403357								101
102	CRNA CHARGES									102
103	FQHC CLINIC LAB									103
104	NET CHARGES	11403357								104

REALIGNMENT 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 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	HOSPITAL I/P PART B CHARGES (SEE INSTRU.)	HOSPITAL 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	2e+015							37
40	ANESTHESIOLOGY	331							40
41	RADIOLOGY-DIAGNOSTIC	714822							41
44	LABORATORY	694628							44
46.30	BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	RESPIRATORY THERAPY	3042							49
50	PHYSICAL THERAPY	140988							50
51	OCCUPATIONAL THERAPY	47761							51
52	SPEECH PATHOLOGY	2249							52
53	ELECTROCARDIOLOGY	231033							53
55	MEDICAL SUPPLIES CHARGED TO PAT	193978							55
55.30	IMPL. DEV. CHARGED TO PATIENT								55.30
56	DRUGS CHARGED TO PATIENTS	249716							56
59.97	CARDIAC REHABILITATION								59.97
59.98	HYPERBARIC OXYGEN THERAPY								59.98
59.99	LITHOTRIPSY								59.99
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	368602							61
62	OBSERVATION BEDS (NON-DISTINCT	219809							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	3454974							101
102	CRNA CHARGES								102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS								103
104	NET CHARGES	3454974							104

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

	COST CENTER DESCRIPTION	OLD CAPITAL: CAPITAL RELATED COST 1	OLD CAPITAL: SWING-BED ADJUSTMENT 2	OLD CAPITAL: REDUCED CAPITAL RELATED COST 3	NEW CAPITAL: CAPITAL RELATED COST 4	NEW CAPITAL: SWING-BED ADJUSTMENT 5	NEW CAPITAL: REDUCED CAPITAL RELATED COST 6	
	INPAT ROUTINE SERV COST CTRS							
25	ADULTS & PEDIATRICS				235351	50387	184964	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				235351		184964	101

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL: PER DIEM 9	OLD CAPITAL: INPATIENT PROGRAM CAPITAL COST 10	NEW CAPITAL: PER DIEM 11	NEW CAPITAL: INPATIENT PROGRAM CAPITAL COST 12	
	INPAT ROUTINE SERV COST CTRS							
25	ADULTS & PEDIATRICS	1922	109			96.24	10490	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	1922	109				10490	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
PART II

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

	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPATIENT PROGRAM CHARGES 4	---- OLD CAPITAL ---- RATIO OF COST TO CHARGES 5	CAPITAL COSTS 6	---- NEW CAPITAL ---- RATIO OF COST TO CHARGES 7	CAPITAL COSTS 8	
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		94631	4095323				.023107		37
40	ANESTHESIOLOGY		5307	123772				.042877		40
41	RADIOLOGY-DIAGNOSTIC		125775	10963605				.011472		41
44	LABORATORY		69999	8756523				.007994		44
46.30	BLOOD CLOTTING FACTORS ADMIN									46.30
49	RESPIRATORY THERAPY		1713	659205				.002599		49
50	PHYSICAL THERAPY		65073	2654857				.024511		50
51	OCCUPATIONAL THERAPY		7628	468529				.016281		51
52	SPEECH PATHOLOGY		703	29543				.023796		52
53	ELECTROCARDIOLOGY		24331	424967				.057254		53
55	MEDICAL SUPPLIES CHARGED TO P		65738	3048005				.021568		55
55.30	IMPL. DEV. CHARGED TO PATIENT									55.30
56	DRUGS CHARGED TO PATIENTS		40635	3594353				.011305		56
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		119845	4403651				.027215		61
62	OBSERVATION BEDS (NON-DISTINC			368457						62
63.50	RHC			4173389						63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
101	TOTAL		621378	39590790						101

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART III

CHECK APPLICABLE BOXES
[ ] TITLE V
[ ] TITLE XVIII-PT A
[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					1922		109		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									34
35	NURSING FACILITY									35
101	TOTAL					1922		109		101

REDISTRIBUTION 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	NONPHYSICIAN ANESTHETIST COST	OUTPATIENT NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST	N/A	N/A	N/A	TOTAL COSTS	
		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
55.30	IMPL. DEV. CHARGED TO PATIENT								55.30
56	DRUGS CHARGED TO PATIENTS								56
59.97	CARDIAC REHABILITATION								59.97
59.98	HYPERBARIC OXYGEN THERAPY								59.98
59.99	LITHOTRIPSY								59.99
	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 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		4095323						37
40	ANESTHESIOLOGY		123772						40
41	RADIOLOGY-DIAGNOSTIC		10963605						41
44	LABORATORY		8756523						44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
49	RESPIRATORY THERAPY		659205						49
50	PHYSICAL THERAPY		2654857						50
51	OCCUPATIONAL THERAPY		468529						51
52	SPEECH PATHOLOGY		29543						52
53	ELECTROCARDIOLOGY		424967						53
55	MEDICAL SUPPLIES CHARGED TO P		3048005						55
55.30	IMPL. DEV. CHARGED TO PATIENT								55.30
56	DRUGS CHARGED TO PATIENTS		3594353						56
59.97	CARDIAC REHABILITATION								59.97
59.98	HYPERBARIC OXYGEN THERAPY								59.98
59.99	LITHOTRIPSY								59.99
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY		4403651						61
62	OBSERVATION BEDS (NON-DISTINC		368457						62
63.50	RHC		4173358						63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
101	TOTAL		39590790						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
55.30	IMPL. DEV. CHARGED TO PATIENT						55.30
56	DRUGS CHARGED TO PATIENTS						56
59.97	CARDIAC REHABILITATION						59.97
59.98	HYPERBARIC OXYGEN THERAPY						59.98
59.99	LITHOTRIPSY						59.99
	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

	INPATIENT DAYS	HOSPITAL (OTHER) (14-1318) 1	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	SNF 1	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	2549						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	1922						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1922						4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	128						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	385						6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	29						7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	85						8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1027						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	128						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	385						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	
	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	117.00						19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	117.00						20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3080976						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	3393						24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	9945						25
26	TOTAL SWING-BED COST	659621						26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2421355						27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1931352						28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1931352						30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.253710						31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1004.87						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	2421355						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	1259.81					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1293825					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1293825					41

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
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	855463					48
49	TOTAL PROGRAM INPATIENT COSTS	2149288					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

	TARGET AMOUNT AND LIMITATION COMPUTATION	HOSPITAL (OTHER) (14-1318)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT						58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
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						58.03
58.04	RELIEF PAYMENT						58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	161256	60
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	485027	61
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	646283	62
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		63
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		64
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS		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	
		1	
66	SNF/NF/ICF/MR ROUTINE SERVICE COST		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 IGM 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 [XX] 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	357					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1259.81					84
85 OBSERVATION BED COST	449752					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

	INPATIENT DAYS	HOSPITAL (FPS) (14-1318) 1	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	NF 1	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	2549						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	1922						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1922						4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	128						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	365						6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	29						7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	85						8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	109						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	117.00						19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	117.00						20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3080976						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	3393						24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	9945						25
26	TOTAL SWING-BED COST	659621						26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2421355						27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1931352						28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1931352						30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.253710						31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1004.87						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	2421355						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	1259.81					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	137319					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	137319					41

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	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	137319					49
	PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	10490					50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52	TOTAL PROGRAM EXCLUDABLE COST	10490					52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	126829					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

	TARGET AMOUNT AND LIMITATION COMPUTATION	HOSPITAL (PPS) (14-1318) 1	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT						58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
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						58.03
58.04	RELIEF PAYMENT						58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		60
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		61
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS		62
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		63
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		64
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS		65

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	
		1	
66	SNF/NF/ICF/MR ROUTINE SERVICE COST		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 ICF 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 (FPS) (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	357					83
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1259.81					84
85	OBSERVATION BED COST	449752					85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST - HOSPITAL

		COST 1	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		2421355		449752		86
87	NEW CAPITAL-RELATED COST		2421355		449752		87
88	NON PHYSICIAN ANESTHETIST		2421355		449752		88
89	MEDICAL EDUCATION		2421355		449752		89

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-4

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

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS		1226710		25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.307265	371088	114030	37
40	ANESTHESIOLOGY	.335383			40
41	RADIOLOGY-DIAGNOSTIC	.226011	469112	106024	41
44	LABORATORY	.210848	478530	100897	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
49	RESPIRATORY THERAPY	.073539	220071	16184	49
50	PHYSICAL THERAPY	.334529	69258	23169	50
51	OCCUPATIONAL THERAPY	.356719	32149	11468	51
52	SPEECH PATHOLOGY	.413871	10013	4144	52
53	ELECTROCARDIOLOGY	.662494	1430	947	53
55	MEDICAL SUPPLIES CHARGED TO PAT	.295524	406635	120170	55
55.30	IMPL. DEV. CHARGED TO PATIENT				55.30
56	DRUGS CHARGED TO PATIENTS	.343896	1042263	358430	56
59.97	CARDIAC REHABILITATION				59.97
59.98	HYPERBARIC OXYGEN THERAPY				59.98
59.99	LITHOTRIPSY				59.99
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.457019			61
62	OBSERVATION BEDS (NON-DISTINCT	1.220636			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RHC	1.339007			63.50
63.60	FQHC				63.60
101	TOTAL		3100549	855463	101
102	LESS PBP CLINIC LAB SVCS-IGM ONLY CHARGES				102
103	NET CHARGES		3100549		103

PROVIDER NO. 14-[illegible] OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2009 TO 09/30/2010

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

VERSION: 2010.09
02/28/2011 13:43

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[ ] TITLE V
[XX] TITLE XVIII-PT A
[ ] TITLE XIX

[ ] HOSPITAL
[ ] SUB I
[ ] SUB II
[ ] SUB III
[ ] SUB IV

[ ] SNF
[ ] NF
[XX] S/B-SNF (14-Z318)
[ ] S/B-NF
[ ] ICF/MR

[ ] PPS
[ ] TEFRA
[XX] OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS				25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.307285			37
40	ANESTHESIOLOGY	.335383			40
41	RADIOLOGY-DIAGNOSTIC	.226011	21692	4903	41
44	LABORATORY	.210848	56792	11974	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
49	RESPIRATORY THERAPY	.073539	59234	4356	49
50	PHYSICAL THERAPY	.334529	137185	45892	50
51	OCCUPATIONAL THERAPY	.356719	78261	27924	51
52	SPEECH PATHOLOGY	.413871	5742	2376	52
53	ELECTROCARDIOLOGY	.662494	1800	1192	53
55	MEDICAL SUPPLIES CHARGED TO PAT	.295524	58164	17189	55
55.30	IMPL. DEV. CHARGED TO PATIENT				55.30
56	DRUGS CHARGED TO PATIENTS	.343896	293074	100787	56
59.97	CARDIAC REHABILITATION				59.97
59.98	HYPERBARIC OXYGEN THERAPY				59.98
59.99	LITHOTRIPSY				59.99
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.457019			61
62	OBSERVATION BEDS (NON-DISTINCT	1.220636			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RHC	1.339007			63.50
63.60	FQHC				63.60
101	TOTAL		711964	216593	101
102	LESS PBP CLINIC LAB SVCS-FGM ONLY CHARGES				102
103	NET CHARGES		711964		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[ ] TITLE V
[ ] TITLE XVIII-PT A
[XX] TITLE XIX

[XX] HOSPITAL (14-1316)
[ ] SUB I
[ ] SUB II
[ ] SUB III
[ ] SUB IV

[ ] SNF
[ ] NF
[ ] S/B-SNF
[ ] S/B-NF
[ ] ICF/MR

[XX] PPS
[ ] TEFRA
[ ] OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS				25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.307285			37
40	ANESTHESIOLOGY	.335383			40
41	RADIOLOGY-DIAGNOSTIC	.226011			41
44	LABORATORY	.210848			44
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
49	RESPIRATORY THERAPY	.073539			49
50	PHYSICAL THERAPY	.334529			50
51	OCCUPATIONAL THERAPY	.356719			51
52	SPEECH PATHOLOGY	.413871			52
53	ELECTROCARDIOLOGY	.662494			53
55	MEDICAL SUPPLIES CHARGED TO PAT	.295524			55
55.30	IMPL. DEV. CHARGED TO PATIENT				55.30
56	DRUGS CHARGED TO PATIENTS	.343896			56
59.97	CARDIAC REHABILITATION				59.97
59.98	HYPERBARIC OXYGEN THERAPY				59.98
59.99	LITHOTRIPSY				59.99
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.457019			61
62	OBSERVATION BEDS (NON-DISTINCT	1.220636			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RHC	1.339007			63.50
63.60	FQHC				63.60
101	TOTAL				101
102	LESS EBP 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 IS&R ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 31, 2001						1.08
2	OUTLIER PAYMENTS PRIOR TO OCTOBER 1, 1997						2
2.01	OUTLIER PAYMENTS ON OR AFTER OCTOBER 1, 1997						2.01
	INDIRECT MEDICAL EDUCATION ADJUSTMENT						
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] [S-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
				RES. IN INIT YRS			
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 3.21-3.23] [PLUS E-3,PT.VI LINE 23]						3.23
3.24	SUM OF LINES 3.21-3.23	0		0			
	DISPROPORTIONATE SHARE ADJUSTMENT						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						4.04
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES						
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, 316 AND 317						5.01
5.02	DIVIDE LINE 5.01 BY LINE 5						5.02
5.03	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING DRGs 302, 316 AND 317						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 15-1, 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 INSTR.)						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) 1	HOSPITAL (14-1318) 1.01	HOSPITAL (14-1318) 1.02	
1	MEDICAL AND OTHER SERVICES	3455015			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 II, COLUMN 9, LINE 101				1.07
2	INTERNS AND RESIDENTS				2
3	ORGAN ACQUISITIONS				3
4	COST OF TEACHING PHYSICIANS				4
5	TOTAL COST	3455015			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	3489565			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) 1	HOSPITAL (14-1318) 1.01	HOSPITAL (14-1318) 1.02	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	DEDUCTIBLES	20628			18
18.01	COINSURANCE	1684690			18.01
19	SUBTOTAL	1784247			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	1784247			23
24	PRIMARY PAYER PAYMENTS	137			24
25	SUBTOTAL	1784110			25
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26	COMPOSITE RATE ESRD				26
27	BAD DEBTS	399466			27
27.01	REDUCED REIMBURSABLE BAD DEBTS	399466			27.01
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	399466			27.02
28	SUBTOTAL	2183576			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	2183576			32
33	SEQUESTRATION ADJUSTMENT				33
34	INTERIM PAYMENTS	1222437			34
34.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)				34.01
35	BALANCE DUE PROVIDER/PROGRAM	961139			35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	29459			36
	TO BE COMPLETED BY CONTRACTOR				
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)				50
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCT				51
52	THE RATE USED TO CALCULATE THE TIME VALUE				52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)				53
54	TOTAL (SUM OF LINES 51 AND 53)				54

PROVIDER NO. 14-[illegible] OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2009 TO 09/30/2010

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

VERSION: 2010.09
02/28/2011 13:43

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
HOSPITAL (14-[illegible])

WORKSHEET E-1

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1389768		1932558	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 TO PROVIDER	.01	04/23/2010	54782	04/23/2010	71727	3.01
		.02	09/17/2010	204093			3.02
		.03	09/17/2010	25999			3.03
		.04					3.04
		.05					3.05
	PROVIDER TO PROGRAM	.50	04/23/2010	14472	04/23/2010	186017	3.50
		.51			09/17/2010	66917	3.51
		.52			09/17/2010	528914	3.52
		.53					3.53
		.54					3.54
SUBTOTAL		.99		270402		-710121	3.99
4 TOTAL INTERIM PAYMENTS				1660170		1222437	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 TO PROVIDER	.01					5.01
		.02					5.02
		.03					5.03
	PROVIDER TO PROGRAM	.50					5.50
		.51					5.51
		.52					5.52
SUBTOTAL		.99					5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01					6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY							7

NAME OF INTERMEDIARY: _____

INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____

DATE (MO/DAY/YR): _____

PROVIDER NO. 14-[illegible] ONE HOPE FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2009 TO 09/30/2010

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

VERSION: 2010.09
02/28/2011 13:43

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
SWING BED SKILLED NURSING FACILITY (14-2310)

WORKSHEET E-1

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				632392			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.		.01	04/23/2010	37659			3.01
	PROGRAM	.02	09/17/2010	541257			3.02
	TO	.03				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		578916			3.99
4 TOTAL INTERIM PAYMENTS				1211308			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 PROVIDER	.01					6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY							7

NAME OF INTERMEDIARY: _____

INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____

DATE (MO/DAY/YR): _____

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

SUPPLEMENTAL
WORKSHEET E-2

COMPUTATION OF NET COST OF COVERED SERVICES

		TITLE V S/B NF	--- TITLE XVIII --- S/B SNF PART A (14-Z315)	S/B SNF PART B (14-Z318)	--- TITLE XIX --- S/B SNF	S/B NF	
		1	1	2	1	1	
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF		652746				1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF						2
3	ANCILLARY SERVICES		218759				3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						4
5	PROGRAM DAYS		513				5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY						7
8	SUBTOTAL		871505				8
9	PRIMARY PAYER PAYMENTS						9
10	SUBTOTAL		871505				10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)						11
12	SUBTOTAL		871505				12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		5711				13
14	80% OF PART B COSTS						14
15	SUBTOTAL		865794				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		865794				18
19	SEQUESTRATION ADJUSTMENT						19
20	INTERIM PAYMENTS		1211308				20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						20.01
21	BALANCE DUE PROVIDER/PROGRAM		-345514				21
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		7383				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	2149288						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	2149288						4
5	PRIMARY PAYER PAYMENTS							5
6	TOTAL COST	2170781						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 (14-1316)	SUB I	SUB II	SUB III	SUB IV	SNF I	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT							
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS							18
19	COST OF COVERED SERVICES	2170781						19
20	DEDUCTIBLES	236716						20
21	EXCESS REASONABLE COST							21
22	SUBTOTAL	1934065						22
23	COINSURANCE							23
24	SUBTOTAL	1934065						24
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	2773						25
25.01	REDUCED REIMBURSABLE BAD DEBTS	2773						25.01
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)							25.02
26	SUBTOTAL	1936838						26
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION							27
28	AMOUNT TO ZERO OUT SNF							28
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS							29
30	SUBTOTAL	1936838						30
31	SEQUESTRATION ADJUSTMENT							31
32	INTERIM PAYMENTS	1660170						32
32.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							32.01
33	BALANCE DUE PROVIDER/PROGRAM	276668						33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	18371						34

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

		HOSPITAL (14-1318) (PPS)	SUB I	SUB II	SUB III	SUB IV	NF I	
	COMPUTATION OF NET COST OF COVERED SERVICES	1	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

		HOSPITAL (14-1318) (PPS)	SUB I	SUB II	SUB III	SUB IV	NF I	
		1	1	1	1	1	1	
	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	OTHER ADJUSTMENTS							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	3909945				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	3359796				4
5	OTHER RECEIVABLES	104700				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE					6
7	INVENTORY	622431				7
8	PREPAID EXPENSES					8
9	OTHER CURRENT ASSETS	346482				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS	8342354				11
	FIXED ASSETS					
12	LAND	326000				12
12.01	ACCUMULATED DEPRECIATION					12.01
13	LAND IMPROVEMENTS	146120				13
13.01	ACCUMULATED DEPRECIATION	-95106				13.01
14	BUILDINGS	2676779				14
14.01	ACCUMULATED DEPRECIATION	-1261731				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	4061531				18
18.01	ACCUMULATED DEPRECIATION	-2386358				18.01
19	MINOR EQUIPMENT DEPRECIABLE					19
19.01	ACCUMULATED DEPRECIATION					19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE					20
21	TOTAL FIXED ASSETS	3466235				21
	OTHER ASSETS					
22	INVESTMENTS					22
23	DEPOSITS ON LEASES					23
24	DUE FROM OWNERS/OFFICERS					24
25	OTHER ASSETS	6946872				25
26	TOTAL OTHER ASSETS	6946872				26
27	TOTAL ASSETS	18755461				27

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	723371				28
29	SALARIES, WAGES & FEES PAYABLE	1021751				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	295190				34
35	OTHER CURRENT LIABILITIES	1525419				35
36	TOTAL CURRENT LIABILITIES	3565731				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	3717581				43
	CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	15037880				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	15037880				51
52	TOTAL LIABILITIES AND FUND BALANCES	18755461				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	14934335				1
2	NET INCOME (LOSS)	88314				2
3	TOTAL	15022649				3
4	ADDITIONS (CREDIT ADJUSTMENTS)	15231				4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS	15231				10
11	SUBTOTAL	15037880				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	15037880				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	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	1931352		1931352	1
2	SUBPROVIDER I				2
4	SWING BED - SNF	459729		459729	4
5	SWING BED - NF				5
6	SKILLED NURSING FACILITY				6
7	NURSING FACILITY				7
8	OTHER LONG TERM CARE				8
9	TOTAL GENERAL INPATIENT CARE SERVICES	2391081		2391081	9
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
10	INTENSIVE CARE UNIT				10
11	CORONARY CARE UNIT				11
12	BURN INTENSIVE CARE UNIT				12
13	SURGICAL INTENSIVE CARE UNIT				13
14	OTHER SPECIAL CARE (SPECIFY)				14
15	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE				15
16	TOTAL INPATIENT ROUTINE CARE SERVICES	2391081		2391081	16
17	ANCILLARY SERVICES	6779831		6779831	17
18	OUTPATIENT SERVICES		38638845	38638845	18
18.50	RHC		4173358	4173358	18.50
18.60	FQHC				18.60
19	HOME HEALTH AGENCY				19
20	AMBULANCE				20
21	CORF				21
22	ASC				22
23	HOSPICE				23
24					24
25	TOTAL PATIENT REVENUES	9170912	42812203	51983115	25

PART II - OPERATING EXPENSES

		1	2	
26	OPERATING EXPENSES		22699762	26
27	ADD (SPECIFY)			27
28	BAD DEBT	1673518		28
29				29
30				30
31				31
32				32
33	TOTAL ADDITIONS		1673518	33
34	DEDUCT (SPECIFY)			34
35				35
36				36
37				37
38				38
39	TOTAL DEDUCTIONS			39
40	TOTAL OPERATING EXPENSES		24373280	40

STATEMENT OF REVENUES AND EXPENSES — WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES	51983115	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	27720720	2
3	NET PATIENT REVENUES	24262395	3
4	LESS - TOTAL OPERATING EXPENSES	24373280	4
5	NET INCOME FROM SERVICE TO PATIENTS	-110885	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	19192	6
7	INCOME FROM INVESTMENTS	17908	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	33269	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	7148	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	13332	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER INCOME	62987	24
24.01	GRANT INCOME	45363	24.01
24.02	WORKERS COMP		24.02
25	TOTAL OTHER INCOME	199199	25
26	TOTAL	88314	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	88314	31

CALCULATION OF CAPITAL PAYMENT - TITLE XIX - COST METHOD WORKSHEET L

		HOSPITAL (14-1315) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
	PART I - FULLY PROSPECTIVE METHOD						
1	CAPITAL HOSPITAL SPECIFIC RATE PAYMENTS CAPITAL FEDERAL AMOUNT						1
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 INDIRECT MEDICAL EDUCATION ADJUSTMENT						3.01
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 EDUCATON 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	EXTRAORDINARY CAPREL 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						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						22
23	I&R SERVICES-OTHER PRGM COSTS						23
24	PARAMED ED PRGM-(SPECIFY)						24
	INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS						25
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM						37
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
46.30	BLOOD CLOTTING FACTORS ADMIN C						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 PA						55
55.30	IMPL. DEV. CHARGED TO PATIENT						55.30
56	DRUGS CHARGED TO PATIENTS						56
59.97	CARDIAC REHABILITATION						59.97
59.98	HYPERBARIC OXYGEN THERAPY						59.98
59.99	LITHOTRIPSY						59.99
	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 THERAP						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						
98	PHYSICIANS' PRIVATE OFFICES						98
100	CLINIC						100
100.01	RENTAL SPACE						100.01
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

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

RHC 1
COMPONENT NO: 14-3461

WORKSHEET M-1

CHECK APPLICABLE BOX: [XX] RHC [ ] 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	1537016	26846	1563862		1563862		1563862	1
2	PHYSICIAN ASSISTANT	312778		312778		312778		312778	2
3	NURSE PRACTITIONER								3
4	VISITING NURSE								4
5	OTHER NURSE	330142		330142		330142		330142	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)	2179936	26846	2206782		2206782		2206782	10
	COSTS UNDER AGREEMENT								
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)								14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		32607	32607	-664	31943		31943	15
16	TRANSPORTATION (HEALTH CARE STAFF)		5033	5033		5033		5033	16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE		42000	42000		42000		42000	18
19	OTHER HEALTH CARE COSTS		261203	261203		261203		261203	19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		340843	340843	-664	340179		340179	21
22	TOTAL COSTS OF HEALTH CARE SERVICES	2179936	367689	2547625	-664	2546961		2546961	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY		84352	84352		84352		84352	23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS		6802	6802		6802		6802	26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS		91154	91154		91154		91154	28
	FACILITY OVERHEAD								
29	FACILITY COSTS								29
30	ADMINISTRATIVE COSTS	402896	850582	1253478	-1108460	145018	-23323	121695	30
31	TOTAL FACILITY OVERHEAD	402896	850582	1253478	-1108460	145018	-23323	121695	31
32	TOTAL FACILITY COSTS	3589832	1309425	3892257	-1109124	2783133	-23323	2759810	32

RHC I
COMPONENT NO: 14-3461

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX: [XX] RHC [ ] 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	6.03	26394	4200	25326		1
2	PHYSICIAN ASSISTANTS	3.02	14290	2100	6342		2
3	NURSE PRACTITIONERS			2100			3
4	SUBTOTAL	9.05	40684		31668	40684	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER		26			26	7
8	TOTAL FTEs AND VISITS	9.05	40710			40710	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES	2546961	10
11	TOTAL NONREIMBURSABLE COSTS	91154	11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD)	2638115	12
13	RATIO OF RHC/FQHC SERVICES	0.965447	13
14	TOTAL FACILITY OVERHEAD	121695	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY	2928345	15
16	TOTAL OVERHEAD	2950040	16
17	ALLOWABLE GME OVERHEAD		17
18	SUBTRACT LINE 17 FROM LINE 16	2950040	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES	2848107	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	5395068	20

RHC I WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-3461

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	5395068	1
2	COST OF VACCINES AND THEIR ADMINISTRATION	137	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	5394931	3
4	TOTAL VISITS	40710	4
5	PHYSICIANS VISITS UNDER AGREEMENT		5
6	TOTAL ADJUSTED VISITS	40710	6
7	ADJUSTED COST PER VISIT	132.52	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 (1)	ON OR AFTER JANUARY 1 (2)	(SEE INSTR.) (3)	
8	PER VISIT PAYMENT LIMIT	76.84	76.84		8
9	RATE FOR PROGRAM COVERED VISITS	132.52	132.52		9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	7348		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	973757		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		973757	16
16.01	PRIMARY PAYOR PAYMENTS			16.01
17	LESS: BENEFICIARY DEDUCTIBLE		110889	17
18	NET PROGRAM COST EXCLUDING VACCINES		862868	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE		690294	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION		26	20
21	TOTAL REIMBURSABLE PROGRAM COST		690320	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		690320	24
25	INTERIM PAYMENTS		689746	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			25.01
26	BALANCE DUE COMPONENT/PROGRAM		574	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2		6585	27

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC I
COMPONENT NO: 14-3461

WORKSHEET M-4

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

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	H1N1 VACCINE (SERVICES ON/AFTER 10/1/2009) 2.01	COMBINATION INFLUENZA & H1N1 IN SAME VISIT 2.02	
1	HEALTH CARE STAFF COSTS	2206782	2206782	2206782	2206782	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	48	11			4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	50	13			5
6	TOTAL DIRECT COST OF THE FACILITY	2546961	2546961	2546961	2546961	6
7	TOTAL OVERHEAD	2950040	2950040	2950040	2950040	7
8	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST	0.000020	0.000005			8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	59	15			9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	109	29			10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	398	1126			11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	0.27	0.02			12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	74	321			13
14	MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	20	6			14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		137			15
16	TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		26			16

PROVIDER NO. 14-[illegible] CUT HOLD FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2009 TO 09/30/2010

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

VERSION: 2010.09
02/28/2011 13:43

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 APPLICABLE BOX: [X] RHC [ ] FQHC

DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				667146	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.		.01	04/23/2010	22600	3.01
	PROGRAM TO	.02			3.02
	PROVIDER	.03			3.03
		.04			3.04
		.05			3.05
		.50			3.50
	PROVIDER TO	.51			3.51
	PROGRAM	.52		NONE	3.52
		.53			3.53
		.54			3.54
SUBTOTAL		.99		22600	3.99
4 TOTAL INTERIM PAYMENTS				689746	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 TO	.01			5.01
	PROVIDER	.02			5.02
		.03			5.03
	PROVIDER TO	.50			5.50
	PROGRAM	.51			5.51
		.52			5.52
SUBTOTAL		.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01			6.01
	PROVIDER TO PROGRAM	.02			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 PART A 1	TITLE XVIII PART B 2	TITLE XIX INPATIENT 3	TITLE XIX OUTPATIENT 4	TITLE V INPATIENT 5	TITLE V OUTPATIENT 6	TOTAL THIRD PARTY UTIL 7	
UTILIZATION PERCENTAGES BASED ON DAYS									
25	ADULTS & PEDIATRICS	53.43		5.67				59.10	25
UTILIZATION PERCENTAGES BASED ON CHARGES									
37	OPERATING ROOM	9.06	21.30					30.36	37
40	ANESTHESIOLOGY		0.80					0.80	40
41	RADIOLOGY-DIAGNOSTIC	4.28	28.85					33.13	41
44	LABORATORY	5.46	37.62					43.08	44
49	RESPIRATORY THERAPY	33.39	6.27					39.65	49
50	PHYSICAL THERAPY	2.61	27.13					29.74	50
51	OCCUPATIONAL THERAPY	6.86	28.58					35.44	51
52	SPEECH PATHOLOGY	33.89	18.39					52.28	52
53	ELECTROCARDIOLOGY	0.34	82.06					82.40	53
55	MEDICAL SUPPLIES CHARGED TO PAT	13.34	21.53					34.87	55
56	DRUGS CHARGED TO PATIENTS	29.00	20.20					49.20	56
61	EMERGENCY		28.25					28.25	61
62	OBSERVATION BEDS (NON-DISTINCT		53.32					53.32	62
101	TOTAL CHARGES	6.64	24.44					31.08	101

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
	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	48838	.22	-48838	-.42			3
4	NEW CAP REL COSTS-MVBLE EQUIP	942577	4.31	-942577	-8.06			4
4.01	NEW CAP REL COSTS-MVBLE EQUIP N							4.01
5	EMPLOYEE BENEFITS	2895433	13.24	-2895433	-24.77			5
6	ADMINISTRATIVE & GENERAL	5188891	23.73	-5188891	-44.38			6
7	MAINTENANCE & REPAIRS							7
8	OPERATION OF PLANT	1405020	6.42	-1405020	-12.02			8
9	LAUNDRY & LINEN SERVICE	142736	.65	-142736	-1.22			9
10	HOUSEKEEPING	383899	1.76	-383899	-3.28			10
11	DIETARY	468981	2.14	-468981	-4.01			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	214684	.98	-214684	-1.84			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	1096256	5.01	1984720	16.98	3080976	14.09	25
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	498201	2.28	760231	6.50	1258432	5.75	37
40	ANESTHESIOLOGY	6110	.03	35401	.30	41511	.19	40
41	RADIOLOGY-DIAGNOSTIC	1276354	5.84	1201543	10.28	2477897	11.33	41
44	LABORATORY	1022987	4.68	823310	7.04	1846297	8.44	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO							46.30
49	RESPIRATORY THERAPY	23083	.11	25394	.22	48477	.22	49
50	PHYSICAL THERAPY	329603	1.51	558523	4.78	888126	4.06	50
51	OCCUPATIONAL THERAPY	78130	.36	89003	.76	167133	.76	51
52	SPEECH PATHOLOGY	7060	.03	5167	.04	12227	.06	52
53	ELECTROCARDIOLOGY	100065	.46	181473	1.55	281538	1.29	53
55	MEDICAL SUPPLIES CHARGED TO PAT	462433	2.11	438327	3.75	900760	4.12	55
55.30	IMPL. DEV. CHARGED TO PATIENT							55.30
56	DRUGS CHARGED TO PATIENTS	727899	3.33	508186	4.35	1236085	5.65	56
59.97	CARDIAC REHABILITATION							59.97
59.98	HYPERBARIC OXYGEN THERAPY							59.98
59.99	LITHOTRIPSY							59.99
61	EMERGENCY	887561	4.06	1124992	9.62	2012553	9.20	61
62	OBSERVATION BEDS (NON-DISTINCT							62
63.50	RHC	2759810	12.62	2828345	24.19	5588155	25.55	63.50

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE 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
	NONREIMBURSABLE COST CENTERS							
98	PHYSICIANS' PRIVATE OFFICES	904241	4.13	1126444	9.64	2030685	9.28	98
100	CLINIC							100
100.01	RENTAL SPACE							100.01
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	TOTAL	21870952	100.00	0	.00	21870952	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 OPPS. (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)	3163976
2.	TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (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)	10543651
3.	RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.300

ECR TO COMPU-MAX FILE CONVERSION UTILITY
TRANSMITTAL #02 - CMS-2552-96

ELECTRONIC FILE NAME: C:\255296\CMTEMP\EC141319.10A

COMPU-MAX FILE NAME: C:\255296\CMTEMP\CMXTEMP

PROVIDER NUMBER: 14-1319

SOFTWARE VENDOR: 501
KPMG LLP - COMPU-MAX MICRO - DATE APPROVED: 02/19/10

CREATION DATE: 3/29/2011

CREATION TIME: 13:43

PROVIDER NAME: OSF HOLY FAMILY MEDICAL CENTER

FISCAL YEAR BEGINNING: 10/01/2009

FISCAL YEAR ENDING: 09/30/2010

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	
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	
52	SPEECH PATHOLOGY	5200	

****
ELECTRONIC REPORTING FILE VALIDATION AND EDIT REPORT (CONTINUED)
****

CMS EDIT NO.			
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
5930	IMPL. DEV. CHARGED TO PATIENT	5930	**
56	DRUGS CHARGED TO PATIENTS	5600	
5997	CARDIAC REHABILITATION	3997	**
599W	HYPERBARIC OXYGEN THERAPY	399W	**
5999	LITHOTRIPSY	3990	**
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
6310	RHC	6310	
6311	FQHC	6311	**
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	
98	PHYSICIANS' PRIVATE OFFICES	9800	
100	CLINIC	7950	**
100 1	RENTAL SPACE	7951	**

****
ELECTRONIC REPORTING FILE VALIDATION AND EDIT REPORT (CONTINUED)
****

CMS
EDIT NO.

WORKSHEET E-1 - INTERIM PAYMENT SUMMARY

		PART A	PART B	TOTAL
1	HOSPITAL	1660170	1222437	2882607
2	SUBPROVIDER I			
3	SWING-BED SNF	1211308		1211308
4	SKILLED NURSING FAC			
5	HOME HEALTH AGENCY I			
6	CORF			
	TOTAL	2871478	1222437	4093915

WORKSHEET S - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XIX	
		1	2	3	4	
1	HOSPITAL		276668	961139		1
2	SUBPROVIDER I					2
3	SWING BED - SNF		-345514			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			574		9
100	TOTAL		-68846	961713		100

****
COMPU-MAX CMS-2552-96 EDIT REPORT
****

I. OPTIONS SELECTED:
OPTION 20, 6
OPTION 21, 4, 8,10
OPTION 60, 5

COMPU-MAX - CMS-2552-96 - SETTLEMENT SUMMARY, VERSION 2010.09

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XIX	
		1	2	3	4	
1	HOSPITAL		276668	961139		1
2	SUBPROVIDER I					2
3	SWING BED - SNF		-345514			3
4	SWING BED - NF					4
5	SKILLED NURSING FACILITY					5
6	NURSING FACILITY					6
7	HOME HEALTH AGENCY					7
8	O/P REHAB PROVIDER					8
9	RURAL HEALTH CLINIC I			574		9
100	TOTAL		-68846	961713		100

****
Explanation of error code types:

1000 - The '1000' level error codes (in the range from 1000-1999) are CMS-required Electronic Cost Report (ECR) edit messages. These will prohibit ECR file completion by Compu-Max for submission to your Medicare Fiscal Intermediary, and will be used by the FI as a basis of rejection should your file be received by the FI with such errors.

2000 - Errors in the range of 2000-2999 are CMS-required edits that 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).

**** - KPMG error messages check for additional possible errors not included with the CMS-required edits, and cannot be used as a basis for rejection of the ECR data file or the cost report.

(*) - Error messages marked with an asterisk (*) at the end of the message indicate a logical problem with the cost report, and data must be corrected before a valid cost report can be generated.

(I) - Messages preceded by (I) are informational and are not errors.

****

II. 1000 LEVEL ERRORS
****

III. 2000 LEVEL ERRORS
****

2027 - WKST C, PART I, LINE 63.50, COL 11 SHOULD NOT BE MORE THAN 100% OR LESS THAN .1%

IV. KPMG LEVEL ERRORS
****
(KPMG edits cannot be used as a basis of cost report or ECR file rejection.)

**** - WORKSHEET A, COLUMN 7, LINE 12 EQUALS 0 BUT THERE ARE STATISTICS IN COLUMN 12 OF WORKSHEET B-1

**** - WORKSHEET B-1, LINE 12 HAS STATISTICS, BUT THERE IS NO COST ON WORKSHEET A, COLUMN 7

V. INFORMATIONAL MESSAGES
****

(I) - THE TOTAL CALCULATED FOR WORKSHEET A-8-1, PART B, COLUMN 6, HAS BEEN TRANSFERRED TO WORKSHEET A-8, LINE 14. THE TOTAL FOR WORKSHEET A-8 THAT YOU INPUT HAS BEEN INCREASED BY $1,244,538

(I) - THE TOTAL CALCULATED FOR WORKSHEET A-8-2, COLUMN 18, HAS BEEN TRANSFERRED TO WORKSHEET A-8, LINE 12. THE TOTAL FOR WORKSHEET A-8 THAT YOU INPUT HAS BEEN DECREASED BY $660,568

(I) - A PROTESTED AMOUNT HAS BEEN ENTERED ON WORKSHEET E, PART B, LINE 36 FOR FACILITY (HOSPITAL)

(I) - A PROTESTED AMOUNT HAS BEEN ENTERED ON WORKSHEET E-2, LINE 22, COL 1
FOR FACILITY (SWING BED-S.N.F.), TITLE 18

(I) - A PROTESTED AMOUNT HAS BEEN ENTERED ON WORKSHEET E-3, PART II, LINE 34
FOR FACILITY (HOSPITAL)