

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

WORKSHEET S  
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1.  ELECTRONICALLY FILED COST REPORT DATE: 02/28/2014 TIME: 14:12  
 2.  MANUALLY SUBMITTED COST REPORT  
 3.  IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT  
 4.  MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY 5.  COST REPORT STATUS 6. DATE RECEIVED: \_\_\_\_\_ 10. NPR DATE: \_\_\_\_\_  
 1 - AS SUBMITTED 7. CONTRACTOR NO: \_\_\_\_\_ 11. CONTRACTOR'S VENDOR CODE: \_\_\_\_\_  
 2 - SETTLED WITHOUT AUDIT 8.  INITIAL REPORT FOR THIS PROVIDER CCN 12.  IF LINE 5, COLUMN 1 IS 4: ENTER  
 3 - SETTLED WITH AUDIT 9.  FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.  
 4 - REOPENED  
 5 - AMENDED

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR 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 MED CTR (14-1318) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 10/01/2012 AND ENDING 09/30/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 02/28/2014 14:12  
 ce0W4ZA0ZEzrsboHjDtJGfjRRKtpJ0  
 LfDoL0hE6KT.LZXpiBD61Yp.kndj5  
 TwjW0cAYBP0TLJOR

(SIGNED)

*Michelle S. Carter*  
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)  
*Director Debt Management & Revenue Cycle*  
 TITLE  
 2/28/2014  
 DATE

PI Encryption: 02/28/2014 14:12  
 PmyDGBvRJ5WpQSpSbc8jf4D0nwsio0  
 .eih0ZEvhnxemqlbelisdCmbapZuqj  
 p7HX0f3hBq0tE:dM  
 PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		-32,665	-204,096		1
2 SUBPROVIDER - IPF					2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF		-25,843	-15		5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC			67,936		10
11 HEALTH CLINIC - FQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		-58,508	-136,175		200

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
PERIOD FROM 10/01/2012 TO 09/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11  
02/28/2014 14:12

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

WORKSHEET S  
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CONTRACTOR 5.  COST REPORT STATUS 6. DATE RECEIVED: \_\_\_\_\_ 10. NPR DATE: \_\_\_\_\_  
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(SIGNED)

\_\_\_\_\_  
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII PART A 2	PART B 3	HIT 4	TITLE XIX 5	
1 HOSPITAL		-32,665	-204,096			1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF		-25,843	-15			5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC			67,936			10
11 HEALTH CLINIC - FQHC						11
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200 TOTAL		-58,508	-136,175			200

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VERSION: 2013.11  
 02/28/2014 14:12

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 1000 WEST HARLEM AVENUE  
 2 CITY: MONMOUTH STATE: IL

P.O. BOX: 1  
 ZIP CODE: 61462 COUNTY: WARREN 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

0	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N)		
						V	XVIII	XIX
3	HOSPITAL	14-1318	14000	1	05/01/2002	N	O	P
4	SUBPROVIDER - IPF							
5	SUBPROVIDER - IRF							
6	SUBPROVIDER - (OTHER)							
7	SWING BEDS - SNF	14-2318	14000		05/01/2002	N	O	N
8	SWING BEDS - NF							
9	HOSPITAL-BASED SNF							
10	HOSPITAL-BASED NF							
11	HOSPITAL-BASED OLTC							
12	HOSPITAL-BASED HHA							
13	SEPARATELY CERTIFIED ASC							
14	HOSPITAL-BASED HOSPICE							
15	HOSPITAL-BASED HEALTH CLINIC - RHC	14-3461	14000		02/05/2003	N	O	N
16	HOSPITAL-BASED HEALTH CLINIC - FQHC							
17	HOSPITAL-BASED (CMHC)							
18	RENAL DIALYSIS							
19	OTHER							
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 10/01/2012			TO: 09/30/2013			
21	TYPE OF CONTROL			1				

INPATIENT PPS INFORMATION

22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2) (PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.	N	N
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.		N

	IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	OUT-OF-STATE MEDICAID PAID DAYS	OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO PAID DAYS	OTHER MEDICAID DAYS
24	IF THIS PROVIDER IS AN IPFS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.					
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.					
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			2		
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.			2		
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.					
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:	ENDING:	
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.					
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:	ENDING:	
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N	N			

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

	V	XVIII	XIX
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

TEACHING HOSPITALS

	1	2	3	56
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N	57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N		58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N		60
		Y/N	IME	DIRECT GME
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. ) (SEE INSTRUCTIONS)	N		61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)			61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (EXCLUDING OB/GYN AND GENERAL SURGERY) ADDED AS A RESULT OF SECTION 5503. (SEE INSTRUCTIONS)			61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (SEE INSTRUCTIONS)			61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (SEE INSTRUCTIONS)			61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTE AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (LINE 61.04 MINUS LINE 61.03). (SEE INSTRUCTIONS)			61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (SEE INSTRUCTIONS)			61.06
	OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.		UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT
	PROGRAM NAME 1	PROGRAM CODE 2	3	4
				61.10
	OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.			61.20
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)				
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)			62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)			62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS				
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N		63

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS  
 THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER  
 JULY 1, 2009 AND BEFORE JUNE 30, 2010.

	UNWEIGHTED FTE NONPROVIDER SITE	UNWEIGHTED FTE IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			64

ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4). (SEE INSTRUCTIONS)

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTE NONPROVIDER SITE 3	UNWEIGHTED FTE IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5
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SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS  
 EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010

	UNWEIGHTED FTE NONPROVIDER SITE	UNWEIGHTED FTE IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			66

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4). (SEE INSTRUCTIONS)

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTE NONPROVIDER SITE 3	UNWEIGHTED FTE IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5
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INPATIENT PSYCHIATRIC FACILITY PPS

70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71

INPATIENT REHABILITATION FACILITY PPS

75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76

LONG TERM CARE HOSPITAL PPS

80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	80
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TEFRA PROVIDERS

85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.		N	85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.		N	86

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

TITLE V AND XIX INPATIENT SERVICES		V	XIX			
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90		
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91		
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92		
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93		
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94		
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95		
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96		
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97		
RURAL PROVIDERS						
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	Y		105		
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.	N		106		
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME 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, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.	N	N	107		
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108		
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	Y	N	Y	N	109
MISCELLANEOUS COST REPORTING INFORMATION						
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-16 2208.1.	N		115		
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116		
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117		
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118		
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 208,500 PAID LOSSES: SELF INSURANCE:			118.01		
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02		
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N		120		
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121		
TRANSPLANT CENTER INFORMATION						
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N		125		
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126		
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127		
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128		
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129		
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130		
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131		
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132		
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133		
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134		

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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

ALL PROVIDERS

140 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER. 1 2  
 Y 149006 140

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141 NAME: OSF HEALTHCARE SYSTEM CONTRACTOR'S NAME: NGS CONTRACTOR'S NUMBER: 141318 141  
 142 STREET: 800 N.E. GLEN OAK AVENUE P.O. BOX: 142  
 143 CITY: PEORIA STATE: IL ZIP CODE: 61603 143  
 144 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y 144  
 145 IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO. N 145  
 146 HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2. N 146  
 147 WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO. N 147  
 148 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO. N 148  
 149 WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO. N 149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13

	TITLE XVIII		TITLE	TITLE
	PART A	PART B	V	XIX
	1	2	3	4
155 HOSPITAL	N	N		N 155
156 SUBPROVIDER - IPF	N	N		156
157 SUBPROVIDER - IRF	N	N		157
158 SUBPROVIDER - (OTHER)	N	N		158
159 SNF	N	N		159
160 HHA	N	N		160
161 CMHC		N		161
161.10 CORF				161.10

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO. N 165

166 IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167 IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO. N 167  
 168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. 168  
 169 IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR. 169  
 170 IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD, RESPECTIVELY. (mmddyyyy) (SEE INSTRUCTIONS) 170

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.  
 ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE		
1		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N		1	
2		Y/N	DATE	V/I	
2		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N		2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3	
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
4		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES		Y/N		Y/N	
6		1		2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y/N	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			Y 12 N 13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
PS&R REPORT DATA		PART A		PART B	
16		Y/N	DATE	Y/N	DATE
16		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	12/19/2013	Y	12/19/2013
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.  
 ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

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

CAPITAL RELATED COST

22	HAVE ASSETS BEEN RELIEF FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.	N	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	27

INTEREST EXPENSE

28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	N	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	31

PURCHASED SERVICES

32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.	N	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33

PROVIDER-BASED PHYSICIANS

34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	Y	34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	Y	35

HOME OFFICE COSTS

		Y/N	DATE
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	Y	36
38	IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE.	N	38
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.	N	39
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N	40

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: JENNIFER	LAST NAME: DAVIS	TITLE: MGR THIRD PARTY REIM	41
42	EMPLOYER: OSF HEALTHCARE SYSTEM			42
43	PHONE NUMBER: (309)655-4096	E-MAIL ADDRESS: JENNIFER.Y.DAVIS@OSFHEALTHCARE		43





HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)
	1	2	3	4	5	6
SALARIES						
1	200					1
2						2
3						3
4						4
4.01						4.01
5						5
6						6
7	21					7
7.01						7.01
8						8
9	44					9
10						10
OTHER WAGES & RELATED COSTS						
11						11
12						12
13						13
14						14
15						15
16						16
WAGE-RELATED COSTS						
17						17
18						18
19						19
20						20
21						21
22						22
22.01						22.01
23						23
24						24
25						25
OVERHEAD COSTS - DIRECT SALARIES						
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36						36
37						37
38						38
39						39
40						40
41						41
42						42
43						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	5
6	TOTAL (SUM OF LINES 3 THRU 5)	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
PART IV

PART A - CORE LIST

	AMOUNT REPORTED
RETIREMENT COST	
1 401K EMPLOYER CONTRIBUTIONS	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	2
3 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	3
4 QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)	
5 401K/TSA PLAN ADMINISTRATION FEES	5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	7
HEALTH AND INSURANCE COST	
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	8
9 PRESCRIPTION DRUG PLAN	9
10 DENTAL, HEARING AND VISION PLAN	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	14
15 WORKERS' COMPENSATION INSURANCE	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	16
TAXES	
17 FICA-EMPLOYERS PORTION ONLY	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19 UNEMPLOYMENT INSURANCE	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	20
OTHER	
21 EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)	21
22 DAY CARE COSTS AND ALLOWANCES	22
23 TUITION REIMBURSEMENT	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3  
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

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PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE
		1	2
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N	1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	2

	GROUP	SNF	SWING BED	TOTAL
	1	DAYS	SNF DAYS	(COLS.
		2	3	2 + 3)
				4
3	RUX			3
4	RUL			4
5	RVX			5
6	RVL			6
7	RHX			7
8	RHL			8
9	RMX			9
10	RML			10
11	RLX			11
12	RUC			12
13	RUB			13
14	RUA			14
15	RVC			15
16	RVB			16
17	RVA			17
18	RHC			18
19	RHB			19
20	RHA			20
21	RMC			21
22	RMB			22
23	RMA			23
24	RLB			24
25	RLA			25
26	ES3			26
27	ES2			27
28	ES1			28
29	HE2			29
30	HE1			30
31	HD2			31
32	HD1			32
33	HC2			33
34	HC1			34
35	HB2			35
36	HB1			36
37	LE2			37
38	LE1			38
39	LD2			39
40	LD1			40
41	LC2			41
42	LC1			42
43	LB2			43
44	LB1			44
45	CE2			45
46	CE1			46
47	CD2			47
48	CD1			48
49	CC2			49
50	CC1			50
51	CB2			51
52	CB1			52
53	CA2			53
54	CA1			54
55	SE3			55
56	SE2			56
57	SE1			57
58	SSC			58
59	SSB			59
60	SSA			60
61	IB2			61
62	IB1			62
63	IA1			63
64	IA2			64
65	BB2			65
66	BB1			66
67	BA2			67
68	BAL			68

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
 PERIOD FROM 10/01/2012 TO 09/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

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PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

	GROUP 1	SNF DAYS 2	SWING BED SNF DAYS 3	TOTAL (COLS. 2 + 3) 4
69	PE2			69
70	PE1			70
71	PD2			71
72	PD1			72
73	PC2			73
74	PC1			74
75	PB2			75
76	PB1			76
77	PA2			77
78	PA1			78
199	AAA			199
200	TOTAL			200

	CBSA AT BEGINNING OF COST REPORTING PERIOD 1	CBSA ON/AFTER OCT 1 OF THE COST REPORTING PERIOD (IF APPLICABLE) 2	
201	ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (IF APPLICABLE).		201

A NOTICE PUBLISHED IN THE FEDERAL REGISTER VOLUME 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. FOR LINES 202 THROUGH 207: ENTER IN COLUMN 1 THE AMOUNT OF THE EXPENSE FOR EACH CATEGORY. ENTER IN COLUMN 2 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 7, COLUMN 3. IN COLUMN 3, ENTER 'Y' OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)

	EXPENSES 1	PERCENTAGE 2	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES? 3	
202	STAFFING			202
203	RECRUITMENT			203
204	RETENTION OF EMPLOYEES			204
205	TRAINING			205
206	OTHER (SPECIFY)			206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)			207

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

RHC I  
COMPONENT NO: 14-3461

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 1000 W. HARLEM 1  
2 CITY: MONMOUTH STATE: ILLINOIS ZIP CODE: 61462 COUNTY: WARREN 2  
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS:

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

10 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.  
IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. 1 2  
N N 10

FACILITY HOURS OF OPERATIONS(1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11 CLINIC			0700	2000	0700	2000	0700	2000	0700	2000	0700	2000			11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (BOTH TYPE AND HOURS 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.

12 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? 1 2  
N N 12  
13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)?  
ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE  
NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND  
NUMBERS BELOW. N 13

14 PROVIDER NAME: CCN NUMBER: 14

15 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR  
'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF  
PROGRAM VISITS PERFORMED IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE  
NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V,  
XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS) Y/N V XVIII XIX TOTAL  
N N 15

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HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.378227	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				3,025,675	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				9,122,574	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				3,450,404	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.				424,729	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) (SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				424,729	19
UNINSURED PATIENTS						
		UNINSURED PATIENTS	INSURED PATIENTS		TOTAL	
		1	2		3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	2,636,343	1,282,100		3,918,443	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	997,136	484,925		1,482,061	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	9,035	584,736		593,771	22
23	COST OF CHARITY CARE	988,101	-99,811		888,290	23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)				1,865,688	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				291,528	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				1,574,160	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				595,390	29
30	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				1,483,680	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				1,908,409	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL	RECLASSIFI-	
		1	2	(COL. 1 +	CATIONS	
				COL. 2)	4	
				3		
GENERAL SERVICE COST CENTERS						
1	00100		197,483	197,483	292,235	1
2	00200				305,844	2
3	00300					3
4	00400	93,853	185,372	279,225	3,727,382	4
5	00500	2,230,806	3,319,410	5,550,216	-836,281	5
6	00600					6
7	00700					7
8	00800	298,028	756,968	1,054,996	-249,403	8
9	00900				103,393	9
10	01000	290,148	298,218	588,366	-266,360	10
11	01100	278,044	375,021	653,065	-161,415	11
12	01200					12
13	01300					13
14	01400					14
15	01500					15
16	01600					16
17	01700	170,656	135,437	306,093	23,347	17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	935,739	423,129	1,358,868	-381,728	30
ANCILLARY SERVICE COST CENTERS						
50	05000	435,969	563,239	999,208	-509,184	50
53	05300	280,779	95,731	376,510	-86,029	53
54	05400	460,830	446,647	907,477	-186,431	54
56	05600	52,499	84,903	137,402	-53,388	56
57	05700		409,672	409,672	-12,524	57
58	05800		217,959	217,959	-5,792	58
60	06000	419,098	781,332	1,200,430	-175,068	60
62.30	06250					62.30
65	06500		15,883	15,883	13,117	65
66	06600	320,326	153,550	473,876	-138,314	66
67	06700	80,235	21,072	101,307	-19,617	67
68	06800		20,518	20,518		68
69	06900	99,518	58,870	158,388	-57,114	69
71	07100	22,757	40,825	63,582	318,006	71
72	07200				11,683	72
73	07300	271,371	570,928	842,299	70,927	73
74	07400					74
76	03950	47,864	13,322	61,186		76
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	2,775,165	1,514,705	4,289,870	-1,298,824	88
91	09100	1,118,705	936,432	2,055,137	-248,970	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
94	09400					94
SPECIAL PURPOSE COST CENTERS						
113	11300		39,375	39,375	-39,375	113
118		10,682,390	11,676,001	22,358,391	140,117	118
NONREIMBURSABLE COST CENTERS						
190	19000					190
192	19200	829,714	258,210	1,087,924	-140,117	192
200		11,512,104	11,934,211	23,446,315		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	489,718		489,718	1
2	00200	305,844		266,469	2
3	00300		-39,375		3
4	00400				4
5	00500	4,006,607	-174,299	3,832,308	5
6	00600	4,713,935	647,892	5,361,827	6
7	00700				7
8	00800	805,593		805,593	8
9	00900	103,393		103,393	9
10	01000	322,006		322,006	10
11	01100	491,650	-30,313	461,337	11
12	01200				12
13	01300				13
14	01400				14
15	01500				15
16	01600				16
17	01700	329,440	-6,976	322,464	17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	977,140		977,140	30
ANCILLARY SERVICE COST CENTERS					
50	05000	490,024		490,024	50
53	05300	290,481	-283,799	6,682	53
54	05400	721,046		721,046	54
56	05600	84,014		84,014	56
57	05700	397,148		397,148	57
58	05800	212,167	-100,712	111,455	58
60	06000	1,025,362	-14,400	1,010,962	60
62.30	06250				62.30
65	06500	29,000		29,000	65
66	06600	335,562		335,562	66
67	06700	81,690		81,690	67
68	06800	20,518		20,518	68
69	06900	101,274		101,274	69
71	07100	381,588		381,588	71
72	07200	11,683		11,683	72
73	07300	913,226	-154,245	758,981	73
74	07400				74
76	03950	61,186		61,186	76
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
88	08800	2,991,046	-11,278	2,979,768	88
91	09100	1,806,167	-789,170	1,016,997	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
94	09400				94
SPECIAL PURPOSE COST CENTERS					
113	11300				113
118		22,498,508	-956,675	21,541,833	118
NONREIMBURSABLE COST CENTERS					
190	19000				190
192	19200	947,807		947,807	192
200		23,446,315	-956,675	22,489,640	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
	1	2	3		4	5
1 INTEREST EXPENSE	A	CAP REL COSTS-MVBLE EQUIP	2			
500 TOTAL RECLASSIFICATIONS CODE LETTER - A						39,375 1 39,375 500
1 MEDICAL SUPPLIES	B	MEDICAL SUPPLIES CHARGED TO P	71			284,227 1
2		DRUGS CHARGED TO PATIENTS	73			140,404 2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
500 TOTAL RECLASSIFICATIONS CODE LETTER - B						424,631 500
1 RT SALARIES	C	RESPIRATORY THERAPY	65		25,024	1
2						2
3						3
4						4
5						5
6						6
500 TOTAL RECLASSIFICATIONS CODE LETTER - C					25,024	500
1 A&G EXPENSES	D	MEDICAL RECORDS & LIBRARY	16		55,739	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - D					55,739	500
1 RHC PHYSICIAN RECRUITMENT	E	RURAL HEALTH CLINIC	88			35,647 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - E						35,647 500
1 PROPERTY INSURANCE	F	OTHER CAP REL COSTS	3			13,743 1
2		OTHER CAP REL COSTS	3			8,135 2
500 TOTAL RECLASSIFICATIONS CODE LETTER - F						21,878 500
1 EMPLOYEE BENEFIT RECLASS	G	EMPLOYEE BENEFITS DEPARTMENT	4		3,764,758	1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
500 TOTAL RECLASSIFICATIONS CODE LETTER - G					3,764,758	500

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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE				
		COST CENTER	LINE #	SALARY	OTHER	
	1	2	3	4	5	
1 DEPRECIATION RECLASS	I	CAP REL COSTS-BLDG & FIXT	1		435,842	1
2		CAP REL COSTS-MVBLE EQUIP	2		258,013	2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
500 TOTAL RECLASSIFICATIONS					693,855	500
CODE LETTER - I						
1 LAUNDRY RECLASS	J	LAUNDRY & LINEN SERVICE	8	28,330		1
2		LAUNDRY & LINEN SERVICE	8		75,063	2
500 TOTAL RECLASSIFICATIONS				28,330	75,063	500
CODE LETTER - J						
1 IMPLANTABLE DEVICES	K	IMPL. DEV. CHARGED TO PATIENT	72		11,683	1
2		MEDICAL SUPPLIES CHARGED TO P	71		40,581	2
500 TOTAL RECLASSIFICATIONS					52,264	500
CODE LETTER - K						
1 CLINIC A&G	L	ADMINISTRATIVE & GENERAL	5		78,152	1
2						2
500 TOTAL RECLASSIFICATIONS					78,152	500
CODE LETTER - L						
GRAND TOTAL (INCREASES)				3,873,851	1,420,865	

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE		OTHER	WKST A-7 REF.
			LINE #	SALARY		
1	1	6	7	8	9	10
1 INTEREST EXPENSE	A	INTEREST EXPENSE	113		39,375	11 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A					39,375	500
1 MEDICAL SUPPLIES	B	ADULTS & PEDIATRICS	30		675	1
2		OPERATING ROOM	50		245,093	2
3		ANESTHESIOLOGY	53		7,605	3
4		RADIOLOGY-DIAGNOSTIC	54		293	4
5		RADIOISOTOPE	56		25,725	5
6		CT SCAN	57		8,766	6
7		MRI	58		2,720	7
8		RESPIRATORY THERAPY	65		10,615	8
9		PHYSICAL THERAPY	66		2,762	9
10		OCCUPATIONAL THERAPY	67		761	10
11		EMERGENCY	91		6,658	11
12		RURAL HEALTH CLINIC	88		102,079	12
13		PHYSICIANS' PRIVATE OFFICES	192		10,879	13
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					424,631	500
1 RT SALARIES	C	ADULTS & PEDIATRICS	30	14,181		1
2		OPERATING ROOM	50	956		2
3		ANESTHESIOLOGY	53	4,010		3
4		LABORATORY	60	352		4
5		ELECTROCARDIOLOGY	69	139		5
6		EMERGENCY	91	5,386		6
500 TOTAL RECLASSIFICATIONS CODE LETTER - C				25,024		500
1 A&G EXPENSES	D	RURAL HEALTH CLINIC	88	55,739		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - D				55,739		500
1 RHC PHYSICIAN RECRUITMENT	E	ADMINISTRATIVE & GENERAL	5		35,647	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - E					35,647	500
1 PROPERTY INSURANCE	F	ADMINISTRATIVE & GENERAL	5		21,878	12 1
2						12 2
500 TOTAL RECLASSIFICATIONS CODE LETTER - F					21,878	500
1 EMPLOYEE BENEFIT RECLASS	G	EMPLOYEE BENEFITS DEPARTMENT	4		37,376	1
2		ADMINISTRATIVE & GENERAL	5		828,916	2
3		OPERATION OF PLANT	7		120,643	3
4		HOUSEKEEPING	9		161,724	4
5		DIETARY	10		144,208	5
6		MEDICAL RECORDS & LIBRARY	16		31,485	6
7		ADULTS & PEDIATRICS	30		349,463	7
8		OPERATING ROOM	50		165,344	8
9		ANESTHESIOLOGY	53		63,258	9
10		RADIOLOGY-DIAGNOSTIC	54		148,347	10
11		RADIOISOTOPE	56		27,663	11
12		LABORATORY	60		159,682	12
13		PHYSICAL THERAPY	66		118,697	13
14		OCCUPATIONAL THERAPY	67		18,856	14
15		DRUGS CHARGED TO PATIENTS	73		65,964	15
16		ELECTROCARDIOLOGY	69		41,154	16
17		RURAL HEALTH CLINIC	88		952,679	17
18		EMERGENCY	91		222,520	18
19		PHYSICIANS' PRIVATE OFFICES	192		106,779	19
500 TOTAL RECLASSIFICATIONS CODE LETTER - G					3,764,758	500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF. 10
			LINE #	SALARY	OTHER	
1	1	6	7	8	9	
1 DEPRECIATION RECLASS	I	CAP REL COSTS-BLDG & FIXT	1		157,029	9 1
2		ADMINISTRATIVE & GENERAL	5		27,992	9 2
3		HOUSEKEEPING	9		1,243	3
4		DIETARY	10		17,207	4
5		MEDICAL RECORDS & LIBRARY	16		907	5
6		ADULTS & PEDIATRICS	30		17,409	6
7		OPERATING ROOM	50		45,527	7
8		ANESTHESIOLOGY	53		11,156	8
9		RADIOLOGY-DIAGNOSTIC	54		37,791	9
10		OPERATION OF PLANT	7		128,760	10
11		CT SCAN	57		3,758	11
12		MRI	58		3,072	12
13		LABORATORY	60		15,034	13
14		RESPIRATORY THERAPY	65		1,292	14
15		PHYSICAL THERAPY	66		16,855	15
16		MEDICAL SUPPLIES CHARGED TO P	71		6,802	16
17		DRUGS CHARGED TO PATIENTS	73		3,513	17
18		ELECTROCARDIOLOGY	69		15,821	18
19		RURAL HEALTH CLINIC	88		157,274	19
20		EMERGENCY	91		14,406	20
21		PHYSICIANS' PRIVATE OFFICES	192		11,007	21
500 TOTAL RECLASSIFICATIONS					693,855	500
CODE LETTER - I						
1 LAUNDRY RECLASS	J	HOUSEKEEPING	9	28,330		1
2		HOUSEKEEPING	9		75,063	2
500 TOTAL RECLASSIFICATIONS				28,330	75,063	500
CODE LETTER - J						
1 IMPLANTABLE DEVICES	K	OPERATING ROOM	50		52,264	1
2						2
500 TOTAL RECLASSIFICATIONS					52,264	500
CODE LETTER - K						
1 CLINIC A&G	L	RURAL HEALTH CLINIC	88		66,700	1
2		PHYSICIANS' PRIVATE OFFICES	192		11,452	2
500 TOTAL RECLASSIFICATIONS					78,152	500
CODE LETTER - L						
GRAND TOTAL (DECREASES)				109,093	5,185,623	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING	ACQUISITIONS			DISPOSALS	ENDING	FULLY
	BALANCES	PURCHASE	DONATION	TOTAL	AND RETIREMENTS	BALANCE	DEPRECIATED ASSETS
	1	2	3	4	5	6	7
1 LAND	325,000					325,000	1
2 LAND IMPROVEMENTS	188,447					188,447	2
3 BUILDINGS AND FIXTURES	3,607,577	4,427,407		4,427,407		8,034,984	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	5,094,262	335,547		335,547	44,526	5,385,283	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	9,215,286	4,762,954		4,762,954	44,526	13,933,714	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	9,215,286	4,762,954		4,762,954	44,526	13,933,714	10

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

DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER	TOTAL (1)
						CAPITAL- RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14) 15
	9	10	11	(SEE INSTR.) 12	(SEE INSTR.) 13	14	15
1 CAP REL COSTS-BLDG & FIXT	197,483						197,483 1
2 CAP REL COSTS-MVBLE EQUIP							2
3 TOTAL (SUM OF LINES 1-2)	197,483						197,483 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2)	RATIO (SEE INSTR.)	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL (SUM OF COLS. 5-7) 8
	1	2	3	4	5	6	7	8
1 CAP REL COSTS-BLDG & FIXT	8,548,431		8,548,431	0.613507	13,422			13,422 1
2 CAP REL COSTS-MVBLE EQUIP	5,385,283		5,385,283	0.386493	8,456			8,456 2
3 TOTAL (SUM OF LINES 1-2)	13,933,714		13,933,714	1.000000	21,878			21,878 3

DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER	TOTAL (2)
						CAPITAL- RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14) 15
	9	10	11	(SEE INSTR.) 12	(SEE INSTR.) 13	14	15
1 CAP REL COSTS-BLDG & FIXT	476,296			13,422			489,718 1
2 CAP REL COSTS-MVBLE EQUIP	258,013			8,456			266,469 2
3 TOTAL	734,309			21,878			756,187 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
			COST CENTER	LINE NO.	WKST A-7 REF
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	B	-39,375	CAP REL COSTS-MVBLE EQUIP	2	11 2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)	B	-28,788	ADMINISTRATIVE & GENERAL	5	3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)	A	-5,027	ADMINISTRATIVE & GENERAL	5	7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-5,715	ADMINISTRATIVE & GENERAL	5	8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST				
	A-8-2	-803,570			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST				
	A-8-1	1,346,457			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-26,943	DIETARY	10	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-6,976	MEDICAL RECORDS & LIBRARY	16	16
17 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-154,245	DRUGS CHARGED TO PATIENTS	73	17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST				
	A-8-3		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST				
	A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)					
			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST				
	A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST				
	A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 RHC OTHER INCOME	B	-11,278	RURAL HEALTH CLINIC	88	33
33.01 MISCELLANEOUS INCOME	B	-1,969	ADMINISTRATIVE & GENERAL	5	33.01
33.02 MISCELLANEOUS INCOME	B	-3,370	DIETARY	10	33.02
34 MARKETING AND DEVELOPMENT SALARIES	A	-22,228	ADMINISTRATIVE & GENERAL	5	34
34.01 MARKETING & DEVELOPMENT BENEFITS	A	-6,006	EMPLOYEE BENEFITS DEPARTMENT	4	34.01
34.02 MARKETING & DEVELOPMENT OTHER	A	-25,542	ADMINISTRATIVE & GENERAL	5	34.02
34.03 FUND DEVELOPMENT SALARIES	A	-20,144	ADMINISTRATIVE & GENERAL	5	34.03
34.04 FUND DEVELOPMENT BENEFITS	A	-6,849	EMPLOYEE BENEFITS DEPARTMENT	4	34.04
34.05 ADVERTISING EXPENSE	A	-142,974	ADMINISTRATIVE & GENERAL	5	34.05
35 LOBBYING	A	-11,774	ADMINISTRATIVE & GENERAL	5	35
36 CRNA SALARIES	A	-280,779	ANESTHESIOLOGY	53	36
36.01 CRNA BENEFITS	A	-63,258	EMPLOYEE BENEFITS DEPARTMENT	4	36.01
36.02 CRNA CME	A	-3,020	ANESTHESIOLOGY	53	36.02
37 ER BENEFITS	A	-98,186	EMPLOYEE BENEFITS DEPARTMENT	4	37
38					38
38.01 ALCOHOLIC BEVERAGES	A	-1,465	ADMINISTRATIVE & GENERAL	5	38.01
38.02 PROVIDER TAX IDPA	A	-492,371	ADMINISTRATIVE & GENERAL	5	38.02
38.03 CAR ALLOWANCE	A	-7,200	ADMINISTRATIVE & GENERAL	5	38.03
39 FUND DEVELOPMENT	A	-34,080	ADMINISTRATIVE & GENERAL	5	39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

EXPENSE CLASSIFICATION ON WORKSHEET A TO/  
FROM WHICH THE AMOUNT IS TO BE ADJUSTED WKST A-7  
COST CENTER 3 LINE NO. 4 REF 5

DESCRIPTION	BASIS 1	AMOUNT 2	COST CENTER 3	LINE NO. 4	REF 5
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-956,675			50

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJUSTMENTS (COL. 4-5)	WKST A-7 REF	
1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	A&G	1,745,934	645,401	1,100,533	1
2	5	ADMINISTRATIVE & GENERAL	INTEREST EXP CORP OFFICE	346,636		346,636	2
3	5	ADMINISTRATIVE & GENERAL	PHYSICIAN RECRUITING	25,122	25,122		3
3.01	58	MRI	MOBILE MRI	164,034	211,978	-47,944	4.01
3.02	58	MRI	ET MAINTENANCE AGREEMENT	74,793	127,561	-52,768	4.02
4							4
5		TOTALS (SUM OF LINES 1-4)		2,356,519	1,010,062	1,346,457	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.					

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.

		----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----			
SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
6	B	OSF HEALTHCARE SYSTEM		100.00	
7					
8					
9					
10					

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
  - B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
  - C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
  - D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
  - E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
  - F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
  - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
LINE NO.	1	2	3	4	5	6	7	8	9	
1	91	EMERGENCY	EMERGENCY AGGRE	1,108,528	789,170	319,358				1
2	60	LABORATORY	LABRATORY AGGRE	14,400	14,400					2
200		TOTAL	TOTAL	1,122,928	803,570	319,358				200



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

WORKSHEET A-8-3  
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					17	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					255	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					18	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					0.35	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		113.50				9
10	AHSEA		74.90				10
11	STANDARD TRAVEL ALLOWANCE	37.45	37.45				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					8,501	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					8,501	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					8,501	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					74.90	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					19,100	22
23	TOTAL SALARY EQUIVALENCY					19,100	23

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
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WORKSHEET A-8-3  
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	674 24
25	ASSISTANTS	25
26	SUBTOTAL	674 26
27	STANDARD TRAVEL EXPENSE	6
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	680 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	680 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

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
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WORKSHEET A-8-3  
 PARTS V, VI & VII

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					19,100	57
58					680	58
59						59
60						60
61						61
62						62
63					19,780	63
64					4,892	64
65						65

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
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WORKSHEET A-8-3  
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					68	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					1,020	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					153	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					3.45	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		464.25				9
10	AHSEA		68.23				10
11	STANDARD TRAVEL ALLOWANCE	34.12	34.12				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					31,676	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					31,676	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					31,676	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					68.23	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					69,595	22
23	TOTAL SALARY EQUIVALENCY					69,595	23

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
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KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

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

WORKSHEET A-8-3  
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	5,220	24
25	ASSISTANTS		25
26	SUBTOTAL	5,220	26
27	STANDARD TRAVEL EXPENSE	528	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	5,748	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	5,748	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

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

WORKSHEET A-8-3  
 PARTS V, VI & VII

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					69,595	57
58					5,748	58
59						59
60						60
61						61
62						62
63					75,343	63
64					20,473	64
65						65

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 PERIOD FROM 10/01/2012 TO 09/30/2013

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	489,718	489,718				1
2 CAP REL COSTS-MVBLE EQUIP	266,469		266,469			2
4 EMPLOYEE BENEFITS DEPARTMENT	3,832,308			3,832,308		4
5 ADMINISTRATIVE & GENERAL	5,361,827	49,733	27,061	802,898	6,241,519	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	805,593	82,877	45,096	107,264	1,040,830	7
8 LAUNDRY & LINEN SERVICE	103,393			10,196	113,589	8
9 HOUSEKEEPING	322,006	5,839	3,177	94,232	425,254	9
10 DIETARY	461,337	33,069	17,993	100,072	612,471	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	322,464	13,146	7,153	81,483	424,246	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	977,140	53,136	28,913	331,682	1,390,871	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	490,024	25,942	14,116	156,567	686,649	50
53 ANESTHESIOLOGY	6,682				6,682	53
54 RADIOLOGY-DIAGNOSTIC	721,046	24,959	13,581	165,859	925,445	54
56 RADIOISOTOPE	84,014			18,895	102,909	56
57 CT SCAN	397,148				397,148	57
58 MRI	111,455				111,455	58
60 LABORATORY	1,010,962	9,523	5,182	150,713	1,176,380	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	29,000			9,006	38,006	65
66 PHYSICAL THERAPY	335,562	16,279	8,858	115,290	475,989	66
67 OCCUPATIONAL THERAPY	81,690	1,408	766	28,878	112,742	67
68 SPEECH PATHOLOGY	20,518	175	95		20,788	68
69 ELECTROCARDIOLOGY	101,274	6,435	3,502	35,768	146,979	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	381,588	17,682	9,621	8,191	417,082	71
72 IMPL. DEV. CHARGED TO PATIENTS	11,683				11,683	72
73 DRUGS CHARGED TO PATIENTS	758,981	5,568	3,030	97,670	865,249	73
74 RENAL DIALYSIS						74
76 DIABETIC SERVICES	61,186			17,227	78,413	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	2,979,768	78,511	42,720	978,754	4,079,753	88
91 EMERGENCY	1,016,997	26,042	14,170	223,037	1,280,246	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	21,541,833	450,324	245,034	3,533,682	21,182,378	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		6,591	3,586		10,177	190
192 PHYSICIANS' PRIVATE OFFICES	947,807	32,803	17,849	298,626	1,297,085	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	22,489,640	489,718	266,469	3,832,308	22,489,640	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
1 GENERAL SERVICE COST CENTERS						1
2 CAP REL COSTS-BLDG & FIXT						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	6,241,519					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	399,822	1,440,652				7
8 LAUNDRY & LINEN SERVICE	43,634		157,223			8
9 HOUSEKEEPING	163,356	23,555	7,640	619,805		9
10 DIETARY	235,273	133,406		58,349	1,039,499	10
11 CAFETERIA					915,955	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	162,969	53,035		23,196		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	534,286	214,363	59,190	93,757	123,544	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	263,768	104,654	18,330	45,773		50
53 ANESTHESIOLOGY	2,567					53
54 RADIOLOGY-DIAGNOSTIC	355,499	100,691	23,032	44,040		54
56 RADIOISOTOPE	39,531					56
57 CT SCAN	152,560					57
58 MRI	42,814					58
60 LABORATORY	451,892	38,416	108	16,802		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	14,600					65
66 PHYSICAL THERAPY	182,845	65,672	17,116	28,723		66
67 OCCUPATIONAL THERAPY	43,308	5,682		2,485		67
68 SPEECH PATHOLOGY	7,985	708		310		68
69 ELECTROCARDIOLOGY	56,460	25,961	583	11,355		69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	160,217	71,333		31,199		71
72 IMPL. DEV. CHARGED TO PATIENTS	4,488					72
73 DRUGS CHARGED TO PATIENTS	332,375	22,463		9,825		73
74 RENAL DIALYSIS						74
76 DIABETIC SERVICES	30,121					76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	1,567,189	316,733	1,374	138,532		88
91 EMERGENCY	491,791	105,058	28,098	45,950		91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	5,739,350	1,281,730	155,471	550,296	1,039,499	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,909	26,588		11,629		190
192 PHYSICIANS' PRIVATE OFFICES	498,260	132,334	1,752	57,880		192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	6,241,519	1,440,652	157,223	619,805	1,039,499	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	MEDICAL RECORDS + LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	915,955					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	38,639	702,085				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	132,912	38,745	2,587,668		2,587,668	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	47,617	55,539	1,222,330		1,222,330	50
53 ANESTHESIOLOGY	16,033	151	25,433		25,433	53
54 RADIOLOGY-DIAGNOSTIC	68,540	71,539	1,588,786		1,588,786	54
56 RADIOISOTOPE		7,397	149,837		149,837	56
57 CT SCAN		70,715	620,423		620,423	57
58 MRI		24,876	179,145		179,145	58
60 LABORATORY	68,380	139,337	1,891,315		1,891,315	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	4,088	6,731	63,425		63,425	65
66 PHYSICAL THERAPY	45,453	26,334	842,132		842,132	66
67 OCCUPATIONAL THERAPY	7,054	5,131	176,402		176,402	67
68 SPEECH PATHOLOGY		1,806	31,597		31,597	68
69 ELECTROCARDIOLOGY	13,548	5,017	259,903		259,903	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,207	40,802	723,840		723,840	71
72 IMPL. DEV. CHARGED TO PATIENTS		441	16,612		16,612	72
73 DRUGS CHARGED TO PATIENTS	22,205	47,932	1,300,049		1,300,049	73
74 RENAL DIALYSIS						74
76 DIABETIC SERVICES	5,772	231	114,537		114,537	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	310,156	56,875	6,470,612		6,470,612	88
91 EMERGENCY	88,100	102,486	2,141,729		2,141,729	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	871,704	702,085	20,405,775		20,405,775	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			52,303		52,303	190
192 PHYSICIANS' PRIVATE OFFICES	44,251		2,031,562		2,031,562	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	915,955	702,085	22,489,640		22,489,640	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	ADMINIS- TRATIVE & GENERAL 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	547,605	49,733	27,061	624,399	624,399	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		82,877	45,096	127,973	39,998	7
8 LAUNDRY & LINEN SERVICE					4,365	8
9 HOUSEKEEPING		5,839	3,177	9,016	16,342	9
10 DIETARY		33,069	17,993	51,062	23,537	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		13,146	7,153	20,299	16,303	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		53,136	28,913	82,049	53,450	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		25,942	14,116	40,058	26,387	50
53 ANESTHESIOLOGY					257	53
54 RADIOLOGY-DIAGNOSTIC	99,268	24,959	13,581	137,808	35,564	54
56 RADIOISOTOPE					3,955	56
57 CT SCAN	282,237			282,237	15,262	57
58 MRI					4,283	58
60 LABORATORY		9,523	5,182	14,705	45,207	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY					1,461	65
66 PHYSICAL THERAPY	640	16,279	8,858	25,777	18,292	66
67 OCCUPATIONAL THERAPY		1,408	766	2,174	4,333	67
68 SPEECH PATHOLOGY		175	95	270	799	68
69 ELECTROCARDIOLOGY		6,435	3,502	9,937	5,648	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		17,682	9,621	27,303	16,028	71
72 IMPL. DEV. CHARGED TO PATIENTS					449	72
73 DRUGS CHARGED TO PATIENTS		5,568	3,030	8,598	33,251	73
74 RENAL DIALYSIS						74
76 DIABETIC SERVICES					3,013	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC		78,511	42,720	121,231	156,779	88
91 EMERGENCY		26,042	14,170	40,212	49,199	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	929,750	450,324	245,034	1,625,108	574,162	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		6,591	3,586	10,177	391	190
192 PHYSICIANS' PRIVATE OFFICES		32,803	17,849	50,652	49,846	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	929,750	489,718	266,469	1,685,937	624,399	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	7	8	9	10	11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	167,971					7
8 LAUNDRY & LINEN SERVICE		4,365				8
9 HOUSEKEEPING	2,746	212	28,316			9
10 DIETARY	15,554		2,666	92,819		10
11 CAFETERIA				81,787	81,787	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	6,184		1,060		3,450	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	24,993	1,644	4,283	11,032	11,868	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	12,202	509	2,091		4,252	50
53 ANESTHESIOLOGY					1,432	53
54 RADIOLOGY-DIAGNOSTIC	11,740	639	2,012		6,120	54
56 RADIOISOTOPE						56
57 CT SCAN						57
58 MRI						58
60 LABORATORY	4,479	3	768		6,106	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY					365	65
66 PHYSICAL THERAPY	7,657	475	1,312		4,059	66
67 OCCUPATIONAL THERAPY	662		114		630	67
68 SPEECH PATHOLOGY	83		14			68
69 ELECTROCARDIOLOGY	3,027	16	519		1,210	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,317		1,425		286	71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS	2,619		449		1,983	73
74 RENAL DIALYSIS						74
76 DIABETIC SERVICES					515	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	36,930	38	6,329		27,693	88
91 EMERGENCY	12,249	780	2,099		7,867	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	149,442	4,316	25,141	92,819	77,836	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,100		531			190
192 PHYSICIANS' PRIVATE OFFICES	15,429	49	2,644		3,951	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	167,971	4,365	28,316	92,819	81,787	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS + LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
1 GENERAL SERVICE COST CENTERS					1
2 CAP REL COSTS-BLDG & FIXT					2
4 EMPLOYEE BENEFITS DEPARTMENT					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	47,296				16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SERVICES-SALARY & FRINGES APPRVD					21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
30 INPATIENT ROUTINE SERV COST CENTERS					30
ADULTS & PEDIATRICS	2,611	191,930		191,930	30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	3,743	89,242		89,242	50
53 ANESTHESIOLOGY	10	1,699		1,699	53
54 RADIOLOGY-DIAGNOSTIC	4,821	198,704		198,704	54
56 RADIOISOTOPE	498	4,453		4,453	56
57 CT SCAN	4,766	302,265		302,265	57
58 MRI	1,677	5,960		5,960	58
60 LABORATORY	9,369	80,637		80,637	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	454	2,280		2,280	65
66 PHYSICAL THERAPY	1,775	59,347		59,347	66
67 OCCUPATIONAL THERAPY	346	8,259		8,259	67
68 SPEECH PATHOLOGY	122	1,288		1,288	68
69 ELECTROCARDIOLOGY	338	20,695		20,695	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,750	56,109		56,109	71
72 IMPL. DEV. CHARGED TO PATIENTS	30	479		479	72
73 DRUGS CHARGED TO PATIENTS	3,230	50,130		50,130	73
74 RENAL DIALYSIS					74
76 DIABETIC SERVICES	16	3,544		3,544	76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC	3,833	352,833		352,833	88
91 EMERGENCY	6,907	119,313		119,313	91
92 OBSERVATION BEDS (NON-DISTINCT PART)					92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	47,296	1,549,167		1,549,167	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		14,199		14,199	190
192 PHYSICIANS' PRIVATE OFFICES		122,571		122,571	192
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	47,296	1,685,937		1,685,937	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	97,711					1
2 CAP REL COSTS-MVBLE EQUIP		97,711				2
4 EMPLOYEE BENEFITS DEPARTMENT			10,647,858			4
5 ADMINISTRATIVE & GENERAL	9,923	9,923	2,230,806	-6,241,519	16,248,121	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	16,536	16,536	298,028		1,040,830	7
8 LAUNDRY & LINEN SERVICE			28,330		113,589	8
9 HOUSEKEEPING	1,165	1,165	261,818		425,254	9
10 DIETARY	6,598	6,598	278,044		612,471	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	2,623	2,623	226,395		424,246	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	10,602	10,602	921,558		1,390,871	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	5,176	5,176	435,013		686,649	50
53 ANESTHESIOLOGY					6,682	53
54 RADIOLOGY-DIAGNOSTIC	4,980	4,980	460,830		925,445	54
56 RADIOISOTOPE			52,499		102,909	56
57 CT SCAN					397,148	57
58 MRI					111,455	58
60 LABORATORY	1,900	1,900	418,746		1,176,380	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			25,024		38,006	65
66 PHYSICAL THERAPY	3,248	3,248	320,326		475,989	66
67 OCCUPATIONAL THERAPY	281	281	80,235		112,742	67
68 SPEECH PATHOLOGY	35	35			20,788	68
69 ELECTROCARDIOLOGY	1,284	1,284	99,379		146,979	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,528	3,528	22,757		417,082	71
72 IMPL. DEV. CHARGED TO PATIENTS					11,683	72
73 DRUGS CHARGED TO PATIENTS	1,111	1,111	271,371		865,249	73
74 RENAL DIALYSIS						74
76 DIABETIC SERVICES			47,864		78,413	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	15,665	15,665	2,719,426		4,079,753	88
91 EMERGENCY	5,196	5,196	619,695		1,280,246	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	89,851	89,851	9,818,144	-6,241,519	14,940,859	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,315	1,315			10,177	190
192 PHYSICIANS' PRIVATE OFFICES	6,545	6,545	829,714		1,297,085	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	489,718	266,469	3,832,308		6,241,519	202
203 UNIT COST MULT-WS B PT I	5.011902	2.727114	0.359914		0.384138	203
204 COST TO BE ALLOC PER B PT II					624,399	204
205 UNIT COST MULT-WS B PT II					0.038429	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
	SQUARE FEET 7	POUNDS OF LAUNDRY 8	SQUARE FEET 9	MEALS SERVED 10	FTE'S 11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	71,252					7
8 LAUNDRY & LINEN SERVICE		108,128				8
9 HOUSEKEEPING	1,165	5,254	70,087			9
10 DIETARY	6,598		6,598	54,977		10
11 CAFETERIA				48,443	11,426	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	2,623		2,623		482	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	10,602	40,708	10,602	6,534	1,658	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	5,176	12,606	5,176		594	50
53 ANESTHESIOLOGY					200	53
54 RADIOLOGY-DIAGNOSTIC	4,980	15,840	4,980		855	54
56 RADIOISOTOPE						56
57 CT SCAN						57
58 MRI						58
60 LABORATORY	1,900	74	1,900		853	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY					51	65
66 PHYSICAL THERAPY	3,248	11,771	3,248		567	66
67 OCCUPATIONAL THERAPY			281		88	67
68 SPEECH PATHOLOGY	35		35			68
69 ELECTROCARDIOLOGY	1,284	401	1,284		169	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,528		3,528		40	71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS	1,111		1,111		277	73
74 RENAL DIALYSIS						74
76 DIABETIC SERVICES					72	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	15,665	945	15,665		3,869	88
91 EMERGENCY	5,196	19,324	5,196		1,099	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	63,392	106,923	62,227	54,977	10,874	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,315		1,315			190
192 PHYSICIANS' PRIVATE OFFICES	6,545	1,205	6,545		552	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,440,652	157,223	619,805	1,039,499	915,955	202
203 UNIT COST MULT-WS B PT I	20.219110	1.454045	8.843366	18.907889	80.164099	203
204 COST TO BE ALLOC PER B PT II	167,971	4,365	28,316	92,819	81,787	204
205 UNIT COST MULT-WS B PT II	2.357422	0.040369	0.404012	1.688324	7.157973	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MEDICAL RECORDS + LIBRARY GROSS REVENUE	
	16	
GENERAL SERVICE COST CENTERS		
1 CAP REL COSTS-BLDG & FIXT		1
2 CAP REL COSTS-MVBLE EQUIP		2
4 EMPLOYEE BENEFITS DEPARTMENT		4
5 ADMINISTRATIVE & GENERAL		5
6 MAINTENANCE & REPAIRS		6
7 OPERATION OF PLANT		7
8 LAUNDRY & LINEN SERVICE		8
9 HOUSEKEEPING		9
10 DIETARY		10
11 CAFETERIA		11
12 MAINTENANCE OF PERSONNEL		12
13 NURSING ADMINISTRATION		13
14 CENTRAL SERVICES & SUPPLY		14
15 PHARMACY		15
16 MEDICAL RECORDS & LIBRARY	53,951,107	16
17 SOCIAL SERVICE		17
19 NONPHYSICIAN ANESTHETISTS		19
20 NURSING SCHOOL		20
21 I&R SERVICES-SALARY & FRINGES APPRVD		21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD		22
23 PARAMED ED PRGM-(SPECIFY)		23
INPATIENT ROUTINE SERV COST CENTERS		
30 ADULTS & PEDIATRICS	2,977,424	30
ANCILLARY SERVICE COST CENTERS		
50 OPERATING ROOM	4,267,987	50
53 ANESTHESIOLOGY	11,608	53
54 RADIOLOGY-DIAGNOSTIC	5,497,483	54
56 RADIOISOTOPE	568,404	56
57 CT SCAN	5,434,152	57
58 MRI	1,911,658	58
60 LABORATORY	10,706,111	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65 RESPIRATORY THERAPY	517,220	65
66 PHYSICAL THERAPY	2,023,652	66
67 OCCUPATIONAL THERAPY	394,287	67
68 SPEECH PATHOLOGY	138,817	68
69 ELECTROCARDIOLOGY	385,548	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,135,515	71
72 IMPL. DEV. CHARGED TO PATIENTS	33,861	72
73 DRUGS CHARGED TO PATIENTS	3,683,362	73
74 RENAL DIALYSIS		74
76 DIABETIC SERVICES	17,718	76
76.97 CARDIAC REHABILITATION		76.97
76.98 HYPERBARIC OXYGEN THERAPY		76.98
76.99 LITHOTRIPSY		76.99
OUTPATIENT SERVICE COST CENTERS		
88 RURAL HEALTH CLINIC	4,370,630	88
91 EMERGENCY	7,875,670	91
92 OBSERVATION BEDS (NON-DISTINCT PART)		92
OTHER REIMBURSABLE COST CENTERS		
94 HOME PROGRAM DIALYSIS		94
SPECIAL PURPOSE COST CENTERS		
118 SUBTOTALS (SUM OF LINES 1-117)	53,951,107	118
NONREIMBURSABLE COST CENTERS		
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		190
192 PHYSICIANS' PRIVATE OFFICES		192
200 CROSS FOOT ADJUSTMENTS		200
201 NEGATIVE COST CENTER		201
202 COST TO BE ALLOC PER B PT I	702,085	202
203 UNIT COST MULT-WS B PT I	0.013013	203
204 COST TO BE ALLOC PER B PT II	47,296	204
205 UNIT COST MULT-WS B PT II	0.000877	205

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,587,668		2,587,668		2,587,668	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,222,330		1,222,330		1,222,330	50
53 ANESTHESIOLOGY	25,433		25,433		25,433	53
54 RADIOLOGY-DIAGNOSTIC	1,588,786		1,588,786		1,588,786	54
56 RADIOISOTOPE	149,837		149,837		149,837	56
57 CT SCAN	620,423		620,423		620,423	57
58 MRI	179,145		179,145		179,145	58
60 LABORATORY	1,891,315		1,891,315		1,891,315	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	63,425		63,425		63,425	65
66 PHYSICAL THERAPY	842,132		842,132		842,132	66
67 OCCUPATIONAL THERAPY	176,402		176,402		176,402	67
68 SPEECH PATHOLOGY	31,597		31,597		31,597	68
69 ELECTROCARDIOLOGY	259,903		259,903		259,903	69
71 MEDICAL SUPPLIES CHARGED TO	723,840		723,840		723,840	71
72 IMPL. DEV. CHARGED TO PATIE	16,612		16,612		16,612	72
73 DRUGS CHARGED TO PATIENTS	1,300,049		1,300,049		1,300,049	73
74 RENAL DIALYSIS						74
76 DIABETIC SERVICES	114,537		114,537		114,537	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	6,470,612		6,470,612		6,470,612	88
91 EMERGENCY	2,141,729		2,141,729		2,141,729	91
92 OBSERVATION BEDS (NON-DISTI	298,221		298,221		298,221	92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	20,703,996		20,703,996		20,703,996	200
201 LESS OBSERVATION BEDS	298,221		298,221		298,221	201
202 TOTAL (SEE INSTRUCTIONS)	20,405,775		20,405,775		20,405,775	202

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
30 INPATIENT ROUTINE SERV COST CENTERS						30
ADULTS & PEDIATRICS	2,635,780		2,635,780			
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	784,124	3,483,863	4,267,987	0.286395	0.286395	0.286395 50
53 ANESTHESIOLOGY		11,609	11,609	2.190800	2.190800	2.190800 53
54 RADIOLOGY-DIAGNOSTIC	393,897	5,103,586	5,497,483	0.289002	0.289002	0.289002 54
56 RADIOISOTOPE	28,006	540,398	568,404	0.263610	0.263610	0.263610 56
57 CT SCAN	452,780	4,981,372	5,434,152	0.114171	0.114171	0.114171 57
58 MRI	17,761	1,893,897	1,911,658	0.093712	0.093712	0.093712 58
60 LABORATORY	1,147,890	9,558,222	10,706,112	0.176658	0.176658	0.176658 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	407,267	109,952	517,219	0.122627	0.122627	0.122627 65
66 PHYSICAL THERAPY	257,403	1,766,249	2,023,652	0.416145	0.416145	0.416145 66
67 OCCUPATIONAL THERAPY	118,839	275,448	394,287	0.447395	0.447395	0.447395 67
68 SPEECH PATHOLOGY	22,597	116,220	138,817	0.227616	0.227616	0.227616 68
69 ELECTROCARDIOLOGY	2,528	383,020	385,548	0.674113	0.674113	0.674113 69
71 MEDICAL SUPPLIES CHARGED TO	735,517	2,399,998	3,135,515	0.230852	0.230852	0.230852 71
72 IMPL. DEV. CHARGED TO PATIE		33,861	33,861	0.490594	0.490594	0.490594 72
73 DRUGS CHARGED TO PATIENTS	1,825,334	1,858,029	3,683,363	0.352952	0.352952	0.352952 73
74 RENAL DIALYSIS						74
76 DIABETIC SERVICES		17,718	17,718	6.464443	6.464443	6.464443 76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC		4,370,630	4,370,630			88
91 EMERGENCY	517,267	7,358,403	7,875,670	0.271942	0.271942	0.271942 91
92 OBSERVATION BEDS (NON-DISTI		341,644	341,644	0.872900	0.872900	0.872900 92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	9,346,990	44,604,119	53,951,109			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	9,346,990	44,604,119	53,951,109			202

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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1318) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES		PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS COST SERVICES SUBJECT TO DED & COINS 5	COST SVCES NOT SUBJECT TO DED & COINS 7
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	0.286395		992,035		284,114	50
53 ANESTHESIOLOGY	2.190800		11,609		25,433	53
54 RADIOLOGY-DIAGNOSTIC	0.289002		1,559,397		450,669	54
56 RADIOISOTOPE	0.263610		225,486		59,440	56
57 CT SCAN	0.114171		1,748,958		199,680	57
58 MRI	0.093712		467,203		43,783	58
60 LABORATORY	0.176658		3,997,014		706,104	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	0.122627		44,213		5,422	65
66 PHYSICAL THERAPY	0.416145		637,966		265,486	66
67 OCCUPATIONAL THERAPY	0.447395		63,795		28,542	67
68 SPEECH PATHOLOGY	0.227616		12,741		2,900	68
69 ELECTROCARDIOLOGY	0.674113		219,912		148,246	69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.230852		718,668		165,906	71
72 IMPL. DEV. CHARGED TO PATIENTS	0.490594		22,336		10,958	72
73 DRUGS CHARGED TO PATIENTS	0.352952		713,276	54	251,752	19 73
74 RENAL DIALYSIS						74
76 DIABETIC SERVICES	6.464443		7,131		46,098	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC						88
91 EMERGENCY	0.271942		2,131,664		579,689	91
92 OBSERVATION BEDS (NON-DISTINCT	0.872900		171,518		149,718	92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 SUBTOTAL (SEE INSTRUCTIONS)			13,744,922	54	3,423,940	19 200
201 LESS PBP CLINIC LAB SERVICES						201
202 NET CHARGES (LINE 200 - LINE 201)			13,744,922	54	3,423,940	19 202

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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [ ] HOSPITAL [ ] SUB (OTHER) [XX] S/B-SNF (14-2318)  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES	COST REIMB. SERVICES DED & COINS	COST REIMB. SVCS NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES DED & COINS	COST SVCS NOT SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.286395						50	
53 ANESTHESIOLOGY	2.190800						53	
54 RADIOLOGY-DIAGNOSTIC	0.289002						54	
56 RADIOISOTOPE	0.263610						56	
57 CT SCAN	0.114171						57	
58 MRI	0.093712						58	
60 LABORATORY	0.176658						60	
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
65 RESPIRATORY THERAPY	0.122627						65	
66 PHYSICAL THERAPY	0.416145						66	
67 OCCUPATIONAL THERAPY	0.447395						67	
68 SPEECH PATHOLOGY	0.227616						68	
69 ELECTROCARDIOLOGY	0.674113						69	
71 MEDICAL SUPPLIES CHARGED TO PAT	0.230852						71	
72 IMPL. DEV. CHARGED TO PATIENTS	0.490594						72	
73 DRUGS CHARGED TO PATIENTS	0.352952						73	
74 RENAL DIALYSIS							74	
76 DIABETIC SERVICES	6.464443						76	
76.97 CARDIAC REHABILITATION							76.97	
76.98 HYPERBARIC OXYGEN THERAPY							76.98	
76.99 LITHOTRIPSY							76.99	
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC							88	
91 EMERGENCY	0.271942						91	
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.872900						92	
HOME PROGRAM DIALYSIS								
94							94	
200 SUBTOTAL (SEE INSTRUCTIONS)							200	
201 LESS PBP CLINIC LAB SERVICES							201	
202 NET CHARGES (LINE 200 - LINE 201)							202	

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST	SWING-BED	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	ADJUSTMENT	(COL.1 MINUS COL.2)	DAYS	(COL.3 + COL.4)	DAYS	(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	191,930	57,843	134,087	1,370	97.87	67	6,557	30
31 INTENSIVE CARE UNIT								31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY								43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	191,930		134,087	1,370		67	6,557	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (14-1318) [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [ ] OTHER

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 + COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	89,242	4,267,987	0.020910		50
53 ANESTHESIOLOGY	1,699	11,609	0.146352		53
54 RADIOLOGY-DIAGNOSTIC	198,704	5,497,483	0.036145		54
56 RADIOISOTOPE	4,453	568,404	0.007834		56
57 CT SCAN	302,265	5,434,152	0.055623		57
58 MRI	5,960	1,911,658	0.003118		58
60 LABORATORY	80,637	10,706,112	0.007532		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
65 RESPIRATORY THERAPY	2,280	517,219	0.004408		65
66 PHYSICAL THERAPY	59,347	2,023,652	0.029327		66
67 OCCUPATIONAL THERAPY	8,259	394,287	0.020947		67
68 SPEECH PATHOLOGY	1,288	138,817	0.009278		68
69 ELECTROCARDIOLOGY	20,695	385,548	0.053677		69
71 MEDICAL SUPPLIES CHARGED TO P	56,109	3,135,515	0.017895		71
72 IMPL. DEV. CHARGED TO PATIENT	479	33,861	0.014146		72
73 DRUGS CHARGED TO PATIENTS	50,130	3,683,363	0.013610		73
74 RENAL DIALYSIS					74
76 DIABETIC SERVICES	3,544	17,718	0.200023		76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC	352,833	4,370,630	0.080728		88
91 EMERGENCY	119,313	7,875,670	0.015150		91
92 OBSERVATION BEDS (NON-DISTINC	31,662	341,644	0.092675		92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
200 TOTAL (SUM OF LINES 50-199)	1,388,899	51,315,329			200

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
30 INPAT ROUTINE SERV COST CTRS					30
31 ADULTS & PEDIATRICS					31
32 INTENSIVE CARE UNIT					32
33 CORONARY CARE UNIT					33
34 BURN INTENSIVE CARE UNIT					34
35 SURGICAL INTENSIVE CARE UNIT					35
40 OTHER SPECIAL CARE (SPECIFY)					40
41 SUBPROVIDER - IPF					41
42 SUBPROVIDER - IRF					42
43 SUBPROVIDER I					43
44 NURSERY					44
45 SKILLED NURSING FACILITY					45
200 NURSING FACILITY					200
TOTAL (SUM OF LINES 30-199)					

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
 PERIOD FROM 10/01/2012 TO 09/30/2013

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 + COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	1,370		67		30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	1,370		67		200

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
 PERIOD FROM 10/01/2012 TO 09/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

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

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5	COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
56 RADIOISOTOPE						56
57 CT SCAN						57
58 MRI						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHARGED TO P						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 DIABETIC SERVICES						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC						88
91 EMERGENCY						91
92 OBSERVATION BEDS (NON-DISTINC						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)						200

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
 PERIOD FROM 10/01/2012 TO 09/30/2013

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK APPLICABLE BOXES	[ ] TITLE V [ ] TITLE XVIII-PT A [XX] TITLE XIX	[XX] [ ] [ ]	HOSPITAL (14-1318) IPF IRF	[ ] [ ] [ ]	SUB (OTHER) SNF NF	[ ] [ ] [ ]	ICF/MR	[XX] [ ] [ ]	PPS TEFRA OTHER
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13		
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM	4,267,987							50
53	ANESTHESIOLOGY	11,609							53
54	RADIOLOGY-DIAGNOSTIC	5,497,483							54
56	RADIOISOTOPE	568,404							56
57	CT SCAN	5,434,152							57
58	MRI	1,911,658							58
60	LABORATORY	10,706,112							60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	517,219							65
66	PHYSICAL THERAPY	2,023,652							66
67	OCCUPATIONAL THERAPY	394,287							67
68	SPEECH PATHOLOGY	138,817							68
69	ELECTROCARDIOLOGY	385,548							69
71	MEDICAL SUPPLIES CHARGED TO	3,135,515							71
72	IMPL. DEV. CHARGED TO PATIEN	33,861							72
73	DRUGS CHARGED TO PATIENTS	3,683,363							73
74	RENAL DIALYSIS								74
76	DIABETIC SERVICES	17,718							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
88	RURAL HEALTH CLINIC	4,370,630							88
91	EMERGENCY	7,875,670							91
92	OBSERVATION BEDS (NON-DISTIN	341,644							92
OTHER REIMBURSABLE COST CENTERS									
94	HOME PROGRAM DIALYSIS								94
200	TOTAL (SUM OF LINES 50-199)	51,315,329							200

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
 PERIOD FROM 10/01/2012 TO 09/30/2013

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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1318) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [ ] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [XX] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES		PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	COST SERVICES SUBJECT TO DED & COINS 5	COST SVCES NOT SUBJECT TO DED & COINS 7
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	0.286395					50
53 ANESTHESIOLOGY	2.190800					53
54 RADIOLOGY-DIAGNOSTIC	0.289002					54
56 RADIOISOTOPE	0.263610					56
57 CT SCAN	0.114171					57
58 MRI	0.093712					58
60 LABORATORY	0.176658					60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	0.122627					65
66 PHYSICAL THERAPY	0.416145					66
67 OCCUPATIONAL THERAPY	0.447395					67
68 SPEECH PATHOLOGY	0.227616					68
69 ELECTROCARDIOLOGY	0.674113					69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.230852					71
72 IMPL. DEV. CHARGED TO PATIENTS	0.490594					72
73 DRUGS CHARGED TO PATIENTS	0.352952					73
74 RENAL DIALYSIS						74
76 DIABETIC SERVICES	6.464443					76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC						88
91 EMERGENCY	0.271942					91
92 OBSERVATION BEDS (NON-DISTINCT)	0.872900					92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 SUBTOTAL (SEE INSTRUCTIONS)						200
201 LESS PBP CLINIC LAB SERVICES						201
202 NET CHARGES (LINE 200 - LINE 201)						202

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
PERIOD FROM 10/01/2012 TO 09/30/2013

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
PART I

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1318) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
BOXES [ ] TITLE XIX-INPT [ ] IRF [ ] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	1,961	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,370	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,144	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	148	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	443	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	823	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	126	10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	380	11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	120.63	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	120.63	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,587,668	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	779,866	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,807,802	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 31)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 31)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	1,807,802	37

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
 PERIOD FROM 10/01/2012 TO 09/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II

CHECK [ ] TITLE V-INPT [XX] HOSPITAL [14-1318] [ ] SUB (OTHER)  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF  
 BOXES [ ] TITLE XIX-INPT [ ] IRF

[ ] PPS  
 [ ] TEFRA  
 [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,319.57 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,086,006 39  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 1,086,006 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 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
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					766,216 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					1,852,222 49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53

TARGET AMOUNT AND LIMIT COMPUTATION  
 54 PROGRAM DISCHARGES 54  
 55 TARGET AMOUNT PER DISCHARGE 55  
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56  
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57  
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58  
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59  
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60  
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61  
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62  
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST  
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 166,266 64  
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 501,437 65  
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 667,703 66  
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67  
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68  
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 226 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 1,319.56 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 298,221 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					
90 CAPITAL-RELATED COST	191,930	1,807,802	0.106168	298,221	31,662 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

WORKSHEET D-1  
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK  TITLE V-INPT  HOSPITAL (14-1318)  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  TITLE XVIII-PT A  IPF  SNF  TEFRA  
 BOXES  TITLE XIX-INPT  IRF  NF  OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	1,961 1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,370 2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,144 4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	148 5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	443 6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	67 9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	16
SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	120.63 19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	120.63 20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,587,668 21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)	22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)	23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	779,866 26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,807,802 27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	1,807,802 37

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II

CHECK  TITLE V-INPT  HOSPITAL (14-1318)  SUB (OTHER)  
 APPLICABLE  TITLE XVIII-PT A  IPF  
 BOXES  TITLE XIX-INPT  IRF

PPS  
 TEFRA  
 OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	1,319.57 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	88,411 39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)	40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	88,411 41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (COL. 1 ÷ COL. 2)	PROGRAM DAYS	PROGRAM COST (COL. 3 x COL. 4)
	1	2	3	4	5
42	NURSERY (TITLES V AND XIX ONLY)				42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT				43
44	CORONARY CARE UNIT				44
45	BURN INTENSIVE CARE UNIT				45
46	SURGICAL INTENSIVE CARE UNIT				46
47	OTHER SPECIAL CARE (SPECIFY)				47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)				48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)				88,411 49

PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	6,557 50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	51
52	TOTAL PROGRAM EXCLUDABLE COST	6,557 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	81,854 53

TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES	54
55	TARGET AMOUNT PER DISCHARGE	55
56	TARGET AMOUNT (LINE 54 x LINE 55)	56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	57
58	BONUS PAYMENT (SEE INSTRUCTIONS)	58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)	61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)	62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	63

PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)	67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)	68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)	69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)	226 87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2)	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	89

	ROUTINE COST (FROM LINE 27)	COL. 1 ÷ COL. 2	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	1	2	3	4
90	CAPITAL-RELATED COST			90
91	NURSING SCHOOL COST			91
92	ALLIED HEALTH COST			92
93	ALL OTHER MEDICAL EDUCATION			93

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KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

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INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [XX] HOSPITAL (14-1318) [ ] SUB (OTHER) [ ] S/B SNF [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
30 INPATIENT ROUTINE SERVICE COST CENTERS				
ADULTS & PEDIATRICS		1,200,780		30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.286395	334,981	95,937	50
53 ANESTHESIOLOGY	2.190800			53
54 RADIOLOGY-DIAGNOSTIC	0.289002	235,478	68,054	54
56 RADIOISOTOPE	0.263610	27,704	7,303	56
57 CT SCAN	0.114171	110,742	12,644	57
58 MRI	0.093712	9,065	849	58
60 LABORATORY	0.176658	576,018	101,758	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.122627	247,820	30,389	65
66 PHYSICAL THERAPY	0.416145	52,443	21,824	66
67 OCCUPATIONAL THERAPY	0.447395	18,616	8,329	67
68 SPEECH PATHOLOGY	0.227616	14,055	3,199	68
69 ELECTROCARDIOLOGY	0.674113	1,350	910	69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.230852	352,839	81,454	71
72 IMPL. DEV. CHARGED TO PATIENTS	0.490594			72
73 DRUGS CHARGED TO PATIENTS	0.352952	941,807	332,413	73
74 RENAL DIALYSIS				74
76 DIABETIC SERVICES	6.464443			76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC				88
91 EMERGENCY	0.271942	4,239	1,153	91
92 OBSERVATION BEDS (NON-DISTINCT	0.872900			92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		2,927,157	766,216	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		2,927,157		202

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
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INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [XX] S/B SNF (14-Z318) [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.286395			50
53 ANESTHESIOLOGY	2.190800			53
54 RADIOLOGY-DIAGNOSTIC	0.289002	14,514	4,195	54
56 RADIOISOTOPE	0.263610			56
57 CT SCAN	0.114171			57
58 MRI	0.093712			58
60 LABORATORY	0.176658	110,185	19,465	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.122627	51,833	6,356	65
66 PHYSICAL THERAPY	0.416145	162,665	67,692	66
67 OCCUPATIONAL THERAPY	0.447395	74,612	33,381	67
68 SPEECH PATHOLOGY	0.227616	6,197	1,411	68
69 ELECTROCARDIOLOGY	0.674113			69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.230852	40,596	9,372	71
72 IMPL. DEV. CHARGED TO PATIENTS	0.490594			72
73 DRUGS CHARGED TO PATIENTS	0.352952	301,601	106,451	73
74 RENAL DIALYSIS				74
76 DIABETIC SERVICES	6.464443			76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC				88
91 EMERGENCY	0.271942			91
92 OBSERVATION BEDS (NON-DISTINCT	0.872900			92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		762,203	248,323	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		762,203		202

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INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK  TITLE V  HOSPITAL (14-1318)  SUB (OTHER)  S/B SNF  PPS  
 APPLICABLE  TITLE XVIII-PT A  IPF  SNF  S/B NF  TEFRA  
 BOXES  TITLE XIX  IRF  NF  ICF/MR  OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.286395			50
53 ANESTHESIOLOGY	2.190800			53
54 RADIOLOGY-DIAGNOSTIC	0.289002			54
56 RADIOISOTOPE	0.263610			56
57 CT SCAN	0.114171			57
58 MRI	0.093712			58
60 LABORATORY	0.176658			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.122627			65
66 PHYSICAL THERAPY	0.416145			66
67 OCCUPATIONAL THERAPY	0.447395			67
68 SPEECH PATHOLOGY	0.227616			68
69 ELECTROCARDIOLOGY	0.674113			69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.230852			71
72 IMPL. DEV. CHARGED TO PATIENTS	0.490594			72
73 DRUGS CHARGED TO PATIENTS	0.352952			73
74 RENAL DIALYSIS				74
76 DIABETIC SERVICES	6.464443			76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC				88
91 EMERGENCY	0.271942			91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.872900			92
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART B

CHECK APPLICABLE BOX:       HOSPITAL (14-1318)       IPF       IRF  
                                   SUB (OTHER)                    SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	3,423,959	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	3,423,959	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.0000000)		17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)	3,458,199	21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 \$2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	16,822	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,969,324	26
27	SUBTOTAL ((LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23) (SEE INSTRUCTIONS)	1,472,053	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	1,472,053	30
31	PRIMARY PAYER PAYMENTS	116	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	1,471,937	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	309,673	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	272,512	36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF	1,744,449	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)	1,744,449	40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	17,444	40.01
41	INTERIM PAYMENTS	1,931,101	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)	-204,096	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	74,948	44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
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KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11  
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK APPLICABLE BOX:	[XX] HOSPITAL (14-1318) [ ] IPF [ ] IRF	[ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF	INPATIENT		PART B		
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			1,646,133		2,024,118	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 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	03/18/2013	26,914		NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)			26,914		-93,017	
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)			1,673,047		1,931,101	4
TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99		NONE		NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)						
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER PROVIDER TO PROGRAM		-16,095		-186,652	6.01 6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			1,656,952		1,744,449	7
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:		NPR DATE:	8

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK [ ] HOSPITAL  
 APPLICABLE [ ] IPF  
 BOX: [ ] IRF

[ ] SUB (OTHER)  
 [ ] SNF  
 [XX] SWING BED SNF (14-Z318)

INPATIENT  
 PART A

PART B

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		884,968		15	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 03/18/2013	54,175		NONE	3.01
	.02				3.02
	PROGRAM .03				3.03
	TO .04				3.04
	PROVIDER .05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE		NONE	3.50
	.51				3.51
	PROVIDER .52				3.52
	TO .53				3.53
	PROGRAM .54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
	.99	54,175			3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		54,175			
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		939,143		15	4
TO BE COMPLETED BY CONTRACTOR					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE		NONE	5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50	NONE		NONE	5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
	.99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01				6.01
	TO PROVIDER				
	PROVIDER				
	TO .02	-16,618		-15	6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		922,525			7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK [XX] HOSPITAL (14-1318) [ ] CAH  
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA \$4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	383	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	823	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	54	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	1,144	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	53,951,109	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	3,918,443	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)		10
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)		32

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CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [ ] TITLE V [XX] SWING BED - SNF (14-2318)  
APPLICABLE [XX] TITLE XVIII [ ] SWING BED - NF  
BOXES [ ] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	674,380	1
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTRUCTIONS)		2
3	ANCILLARY SERVICES (FROM WKST D-3, COL. 3, LINE 200 FOR PART A, AND SUM OF WKST D, PART V, COLS. 5 AND 7, LINE 202 FOR PART B) (FOR CAH, SEE INSTRUCTIONS)	250,806	3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5	PROGRAM DAYS	506	5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		7
8	SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	925,186	8
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10	SUBTOTAL (LINE 8 MINUS LINE 9)	925,186	10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12	SUBTOTAL (LINE 10 MINUS LINE 11)	925,186	12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	2,661	13
14	80% OF PART B COSTS (LINE 12 x 80%)		14
15	SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	922,525	15
16	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		17
17.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		17.01
18	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19	TOTAL (SEE INSTRUCTIONS)	922,525	19
19.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	9,225	19.01
20	INTERIM PAYMENTS	939,143	15 20
21	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22	BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS LINES 19.01, 20 AND 21)	-25,843	-15 22
23	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	20,050	23

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
PART V

CHECK [XX] HOSPITAL (14-1318)  
APPLICABLE BOX: [ ] SUB (OTHER)

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)

1	INPATIENT SERVICES	1,852,222	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	1,852,222	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	1,870,744	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	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 (NOT TO EXCEED 1.000000)		13
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 14 EXCEEDS LINE 6) (SEE INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6 AND 17)	1,870,744	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	232,808	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	1,637,936	22
23	COINSURANCE		23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	1,637,936	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)		25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	21,609	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	19,016	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	1,656,952	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	1,656,952	30
30.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	16,570	30.01
31	INTERIM PAYMENTS	1,673,047	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS LINES 30.01, 31 AND 32)	-32,665	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	40,548	34

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
PART VII

CHECK  TITLE V  HOSPITAL (14-1318)  SNF  PPS  
APPLICABLE  TITLE XIX  IPF  NF  TEFRA  
BOXES:  IRF  ICF/MR  OTHER  
 SUB (OTHER)

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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1 INPATIENT HOSPITAL SNF/NF SERVICES		1
2 MEDICAL AND OTHER SERVICES		2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)		4
5 INPATIENT PRIMARY PAYER PAYMENTS		5
6 OUTPATIENT PRIMARY PAYER PAYMENTS		6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)		7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8 ROUTINE SERVICE CHARGES		8
9 ANCILLARY SERVICE CHARGES		9
10 ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11 INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12 TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)		12
CUSTOMARY CHARGES		
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)		15
16 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))		17
18 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))		18
19 INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20 COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)		21
PROSPECTIVE PAYMENT AMOUNT		
22 OTHER THAN OUTLIER PAYMENTS		22
23 OUTLIER PAYMENTS		23
24 PROGRAM CAPITAL PAYMENTS		24
25 CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26 ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27 SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28 CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29 SUM OF LINES 27 AND 21		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30 EXCESS OF REASONABLE COST (FROM LINE 18)		30
31 SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)		31
32 DEDUCTIBLES		32
33 COINSURANCE		33
34 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35 UTILIZATION REVIEW		35
36 SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)		36
37 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38 SUBTOTAL (LINE 36 ± LINE 37)		38
39 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40 TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)		40
41 INTERIM PAYMENTS		41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

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	7,314,422			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	3,481,023			4
5	OTHER RECEIVABLES	400,405			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	590,794			7
8	PREPAID EXPENSES				8
9	OTHER CURRENT ASSETS	783,180			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	12,569,824			11
FIXED ASSETS					
12	LAND	325,000			12
13	LAND IMPROVEMENTS	188,447			13
14	ACCUMULATED DEPRECIATION	-144,543			14
15	BUILDINGS	8,034,984			15
16	ACCUMULATED DEPRECIATION	-2,271,511			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT				19
20	ACCUMULATED DEPRECIATION				20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	5,385,283			23
24	ACCUMULATED DEPRECIATION	-3,193,041			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	8,324,619			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	8,127,542			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	8,127,542			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	29,021,985			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	451,261			37
38	SALARIES, WAGES & FEES PAYABLE	1,670,329			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)				40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS	1,028,617			43
44	OTHER CURRENT LIABILITIES	636,794			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	3,787,001			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE				47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	171,400			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	171,400			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	3,958,401			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	25,063,584			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	25,063,584			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	29,021,985			60

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
PERIOD FROM 10/01/2012 TO 09/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM  
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VERSION: 2013.11  
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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		21,848,478							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		3,196,751							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		25,045,229							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 CONTRIBUTIONS		4,957							5
6 CONTRIBUTIONS RELEASED		13,398							6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		18,355							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		25,063,584							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 CONTRIBUTIONS RELEASED									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		25,063,584							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	1,664,961		1,664,961	2
3 SUBPROVIDER IPF				3
4 SUBPROVIDER IRF				4
5 SWING BED - SNF				5
6 SWING BED - NF	505,461		505,461	6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	2,170,422		2,170,422	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	2,170,422		2,170,422	18
19 ANCILLARY SERVICES	6,210,151		6,210,151	19
20 OUTPATIENT SERVICES		47,451,719	47,451,719	20
21 RHC		4,370,630	4,370,630	21
22 FQHC				22
23 HOME HEALTH AGENCY				23
24 AMBULANCE				24
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	8,380,573	51,822,349	60,202,922	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		23,446,315	29
30 ADD (SPECIFY)			30
31 BAD DEBTS			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		23,446,315	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	60,202,922	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	34,244,430	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	25,958,492	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	23,446,315	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	2,512,177	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	64,249	6
7	INCOME FROM INVESTMENTS	68,261	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	28,999	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	268,263	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	5,315	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (GRANT INCOME)	220,281	24
24.01	OTHER (GAIN ON DISPOSAL)	2,712	24.01
24.02	OTHER (OTHER REVENUE)	26,494	24.02
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	684,574	25
26	TOTAL (LINE 5 PLUS LINE 25)	3,196,751	26
27	OTHER EXPENSES (SALE OF ASSETS)		27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	3,196,751	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [ ] TITLE V [XX] HOSPITAL ((14-131) [XX] PPS  
APPLICABLE [ ] TITLE XVIII-PT A [ ] SUB (OTHER) [ ] COST METHOD  
BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT	1
2	CAPITAL DRG OTHER THAN OUTLIER	2
3	CAPITAL DRG OUTLIER PAYMENTS	2
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	3
5	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	4
6	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	5
7	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	6
8	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	7
9	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (SEE INSTRUCTIONS)	8
10	SUM OF LINES 7 AND 8	9
11	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	10
12	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	11
13	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (SEE INSTRUCTIONS)	1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (SEE INSTRUCTIONS)	2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 1 PLUS LINE 2)	3
4	CAPITAL COST PAYMENT FACTOR (SEE INSTRUCTIONS)	4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 3 TIMES LINE 4)	5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (SEE INSTRUCTIONS)	1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)	2
3	NET PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)	3
4	APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)	4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)	5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)	6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)	7
8	CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 5 PLUS LINE 7)	8
9	CURRENT YEAR CAPITAL PAYMENTS (FROM PART I, LINE 12 AS APPLICABLE)	9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 8 LESS LINE 9)	10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST L, PART III, LINE 14)	11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 10 PLUS LINE 11)	12
13	CURRENT YEAR EXCEPTION PAYMENT (IF LINE 12 IS POSITIVE, ENTER THE AMOUNT ON THIS LINE)	13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (IF LINE 12 IS NEGATIVE, ENTER THE AMOUNT ON THIS LINE)	14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)	15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)	16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (SEE INSTRUCTIONS)	17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
 PART I

COST CENTER DESCRIPTION	EXTRAORDI-	SUBTOTAL	SUBTOTAL	I&R COST &	TOTAL
	NARY CAP- REL COSTS			(COLS.0-4)	
	0	2A	24	25	26
1 GENERAL SERVICE COST CENTERS					1
2 CAP REL COSTS-BLDG & FIXT					2
4 EMPLOYEE BENEFITS DEPARTMENT					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SERVICES-SALARY & FRINGES					21
22 I&R SERVICES-OTHER PRGM COSTS					22
23 PARAMED ED PRGM-(SPECIFY)					23
30 INPATIENT ROUTINE SERV COST CENTERS					30
50 ADULTS & PEDIATRICS					50
53 ANCILLARY SERVICE COST CENTERS					53
54 OPERATING ROOM					54
56 ANESTHESIOLOGY					56
57 RADIOLOGY-DIAGNOSTIC					57
58 RADIOISOTOPE					58
60 CT SCAN					60
62.30 MRI					62.30
65 LABORATORY					65
66 BLOOD CLOTTING FOR HEMOPHILIAC					66
67 RESPIRATORY THERAPY					67
68 PHYSICAL THERAPY					68
69 OCCUPATIONAL THERAPY					69
71 SPEECH PATHOLOGY					71
72 ELECTROCARDIOLOGY					72
73 MEDICAL SUPPLIES CHARGED TO PA					73
74 IMPL. DEV. CHARGED TO PATIENTS					74
76 DRUGS CHARGED TO PATIENTS					76
76.97 RENAL DIALYSIS					76.97
76.98 DIABETIC SERVICES					76.98
76.99 CARDIAC REHABILITATION					76.99
88 HYPERBARIC OXYGEN THERAPY					88
91 LITHOTRIPSY					91
92 RURAL HEALTH CLINIC					92
94 OUTPATIENT SERVICE COST CENTERS					94
113 EMERGENCY					113
118 OBSERVATION BEDS (NON-DISTINCT)					118
190 OTHER REIMBURSABLE COST CENTERS					190
192 GIFT, FLOWER, COFFEE SHOP & CA					192
200 PHYSICIANS' PRIVATE OFFICES					200
201 CROSS FOOT ADJUSTMENTS					201
202 NEGATIVE COST CENTER					202
203 TOTAL (SUM OF LINE 118 AND					203
204 LINES 190-201)					204
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
 PERIOD FROM 10/01/2012 TO 09/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11  
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ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/  
 FEDERALLY QUALIFIED HEALTH CENTER COSTS

RHC I  
 COMPONENT NO: 14-3461

WORKSHEET M-1

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	1,573,573	32,459	1,606,032		1,606,032		1,606,032	1
2 PHYSICIAN ASSISTANT	479,033		479,033		479,033		479,033	2
3 NURSE PRACTITIONER								3
4 VISITING NURSE								4
5 OTHER NURSE	666,820		666,820		666,820		666,820	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)	2,719,426	32,459	2,751,885		2,751,885		2,751,885	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		132,481	132,481	-102,079	30,402		30,402	15
16 TRANSPORTATION (HEALTH CARE STAFF)		2,456	2,456		2,456		2,456	16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE		44,480	44,480		44,480		44,480	18
19 OTHER HEALTH CARE COSTS		98,514	98,514		98,514		98,514	19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		277,931	277,931	-102,079	175,852		175,852	21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	2,719,426	310,390	3,029,816	-102,079	2,927,737		2,927,737	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)								28
FACILITY OVERHEAD								
29 FACILITY COSTS								29
30 ADMINISTRATIVE COSTS	55,739	1,204,315	1,260,054	-1,196,745	63,309	-11,278	52,031	30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	55,739	1,204,315	1,260,054	-1,196,745	63,309	-11,278	52,031	31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	2,775,165	1,514,705	4,289,870	-1,298,824	2,991,046	-11,278	2,979,768	32

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
 PERIOD FROM 10/01/2012 TO 09/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC I  
 COMPONENT NO: 14-3461

WORKSHEET M-2

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	4.80	18,075	4,200	20,160	1
2	PHYSICIAN ASSISTANTS	3.80	14,008	2,100	7,980	2
3	NURSE PRACTITIONERS	0.90	2,591	2,100	1,890	3
4	SUBTOTAL (SUM OF LINES 1-3)	9.50	34,674		30,030	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER	0.88	1,070			7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	10.38	35,744			8
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				2,927,737	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)					11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				2,927,737	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				1.000000	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				52,031	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				3,490,844	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				3,542,875	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				3,542,875	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				3,542,875	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				6,470,612	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I  
 COMPONENT NO: 14-3461

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	6,470,612	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	90,858	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	6,379,754	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	35,744	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	35,744	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	178.48	7

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

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 100-04, CHAPTER 9, \$20.6 OR YOUR CONTRACTOR)	78.54	79.17	8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	178.48	178.48	178.48 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	1,757	5,273	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	313,589	941,125	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	5	14	12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)	892	2,499	13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)	669	2,030	14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)			15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)		1,257,413	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)		1,005,146	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)		6,818	16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)		8,529	16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		916,174	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		924,703	16.05
17	PRIMARY PAYOR PAYMENTS		197	17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		103,667	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		179,316	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		924,506	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		35,615	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		960,121	22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)			23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			25
26	NET REIMBURSABLE AMOUNT (SEE INSTRUCTIONS)		960,121	26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		9,601	26.01
27	INTERIM PAYMENTS		882,584	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)		67,936	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER 1, SECTION 115.2		22,628	30

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

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
 PERIOD FROM 10/01/2012 TO 09/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11  
 02/28/2014 14:12

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC I  
 COMPONENT NO: 14-3461

WORKSHEET M-4

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	2,751,885	2,751,885	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000424	0.003454	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	1,167	9,505	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	12,068	18,369	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	13,235	27,874	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	2,927,737	2,927,737	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	3,542,875	3,542,875	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.004521	0.009521	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	16,017	33,732	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	29,252	61,606	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	208	1,693	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	140.63	36.39	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	135	457	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	18,985	16,630	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		90,858	15
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		35,615	16

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
 PERIOD FROM 10/01/2012 TO 09/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11  
 02/28/2014 14:12

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 [ XX ] RHC [ ] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		856,244	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 03/18/2013	26,340	3.01
	.02		3.02
	PROGRAM .03		3.03
	TO .04		3.04
	PROVIDER .05		3.05
	.06		3.06
	.07		3.07
	.08		3.08
	.09		3.09
	.50	NONE	3.50
	.51		3.51
	PROVIDER .52		3.52
	TO .53		3.53
	PROGRAM .54		3.54
	.55		3.55
	.56		3.56
	.57		3.57
	.58		3.58
	.59		3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	.99	26,340	3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		882,584	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	NONE	5.01
	TO .02		5.02
	PROVIDER .03		5.03
	.04		5.04
	.05		5.05
	.06		5.06
	.07		5.07
	.08		5.08
	.09		5.09
	PROVIDER .50	NONE	5.50
	TO .51		5.51
	PROGRAM .52		5.52
	.53		5.53
	.54		5.54
	.55		5.55
	.56		5.56
	.57		5.57
	.58		5.58
	.59		5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)	.99		5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM .01	77,537	6.01
	TO PROVIDER .02		6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		960,121	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	8
		NPR DATE:	

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

WORKSHEET S  
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1.  ELECTRONICALLY FILED COST REPORT DATE: 02-27-2014 TIME: 16:38  
 2.  MANUALLY SUBMITTED COST REPORT  
 3.  IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT  
 4.  MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY 5.  COST REPORT STATUS 6. DATE RECEIVED: \_\_\_\_\_ 10. NPR DATE: \_\_\_\_\_  
 1 - AS SUBMITTED 7. CONTRACTOR NO: \_\_\_\_\_ 11. CONTRACTOR'S VENDOR CODE: \_\_\_\_\_  
 2 - SETTLED WITHOUT AUDIT 8.  INITIAL REPORT FOR THIS PROVIDER CCN 12.  IF LINE 5, COLUMN 1 IS 4: ENTER  
 3 - SETTLED WITH AUDIT 9.  FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.  
 4 - REOPENED  
 5 - AMENDED

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR 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 SAINT ANTHONY MEDICAL CENTER (14-0233) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 10/01/2012 AND ENDING 09/30/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) \_\_\_\_\_  
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)  
 \_\_\_\_\_  
 TITLE  
 \_\_\_\_\_  
 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL					1
2 SUBPROVIDER - IPF		-362,909	-31,534	-2,987	2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF					5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC					10
11 HEALTH CLINIC - FQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		-362,909	-31,534	-2,987	200

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

PROVIDER CCN: 14-0233 SAINT ANTHONY MEDICAL CENTER  
 PERIOD FROM 10/01/2012 TO 09/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11  
 02/27/2014 16:38

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 5666 EAST STATE STREET  
 2 CITY: ROCKFORD STATE: IL

P.O. BOX:  
 ZIP CODE: 61108-2472 COUNTY: WINNEBAGO

1  
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			
						V 6	XVIII 7	XIX 8	
3	HOSPITAL	14-0233	40420	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF								4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF								7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF								9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLTC								11
12	HOSPITAL-BASED HHA								12
13	SEPARATELY CERTIFIED ASC								13
14	HOSPITAL-BASED HOSPICE								14
15	HOSPITAL-BASED HEALTH CLINIC - RHC								15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC								16
17	HOSPITAL-BASED (CMHC)								17
18	RENAL DIALYSIS								18
19	OTHER								19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 10/01/2012			TO: 09/30/2013				20
21	TYPE OF CONTROL			1					21

INPATIENT PPS INFORMATION

22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2) (PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.	N	N	22
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.	3	N	23

	IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS 2	OUT-OF STATE MEDICAID PAID DAYS 3	OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS 4	HMO MEDICAID DAYS 5	OTHER MEDICAID DAYS 6			
								24	4,063
25							25		
26				1			26		
27				1			27		
35							35		
36			BEGINNING:		ENDING:		36		
37							37		
38			BEGINNING:		ENDING:		38		
39							1 N	2 N	39

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

	V 1	XVIII 2	XIX 3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	Y	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

TEACHING HOSPITALS

	1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N	57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N		58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	Y		60
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. ) (SEE INSTRUCTIONS)	Y/N N	IME	DIRECT GME 61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)			61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (EXCLUDING OB/GYN AND GENERAL SURGERY) ADDED AS A RESULT OF SECTION 5503. (SEE INSTRUCTIONS)			61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (SEE INSTRUCTIONS)			61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (SEE INSTRUCTIONS)			61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTE AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (LINE 61.04 MINUS LINE 61.03). (SEE INSTRUCTIONS)			61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (SEE INSTRUCTIONS)			61.06
	OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.			
	PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED IME FTE COUNT 3	UNWEIGHTED DIRECT GME FTE COUNT 4 61.10
	OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.			61.20
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)				
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)			62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)			62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS				
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N		63

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS  
 THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER  
 JULY 1, 2009 AND BEFORE JUNE 30, 2010.

64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	64
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ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS  
 EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010

66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	66
----	--	---	--------------------------------------	------------------------------------	----

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5

INPATIENT PSYCHIATRIC FACILITY PPS

70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71

INPATIENT REHABILITATION FACILITY PPS

75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76

LONG TERM CARE HOSPITAL PPS

80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	80
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TEFRA PROVIDERS

85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.		N	85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.		N	86

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

TITLE V AND XIX INPATIENT SERVICES		V	XIX
		1	2
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.		95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.		97
RURAL PROVIDERS		1	2
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	N	105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.		106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME 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, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.		107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N	108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	PHY- SICAL N	OCCUP- ATIONAL 109
MISCELLANEOUS COST REPORTING INFORMATION			
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N	115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y	117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1	118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: PAID LOSSES: SELF INSURANCE: 6,808,111		118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N	118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N 120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y	121
TRANSPLANT CENTER INFORMATION			
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N	125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.		126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.		127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.		128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.		129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.		130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.		131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.		132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.		133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.		134

PROVIDER CCN: 14-0233 SAINT ANTHONY MEDICAL CENTER  
PERIOD FROM 10/01/2012 TO 09/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11  
02/27/2014 16:38

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I (CONT)

ALL PROVIDERS

140 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER. 1 2  
Y 149006 140

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141 NAME: OSF HEALTHCARE SYSTEM CONTRACTOR'S NAME: WISCONSIN PHYSICIAN SERVICE CONTRACTOR'S NUMBER: 52280 141  
142 STREET: 800 N.E. GLEN OAK AVENUE P.O. BOX: 142  
143 CITY: PEORIA STATE: IL ZIP CODE: 61603 143  
144 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y 144  
145 IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO. N 145  
146 HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2. N 146  
147 WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO. N 147  
148 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO. N 148  
149 WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO. N 149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR \$413.13)

	TITLE XVIII		TITLE V	TITLE XIX
	PART A	PART B		
155 HOSPITAL	1	2	3	4
156 SUBPROVIDER - IPF	N	N		N 155
157 SUBPROVIDER - IRF	N	N		156
158 SUBPROVIDER - (OTHER)	N	N		157
159 SNF	N	N		158
160 HHA	N	N		159
161 CMHC		N		160
161.10 CORE				161
				161.10

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAS? ENTER 'Y' FOR YES OR 'N' FOR NO. N 165

166 IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
0	1	2	3	4	5

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167 IS THIS PROVIDER A MEANINGFUL USER UNDER \$1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO. Y 167  
168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. 168  
169 IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR. 0.50 169  
170 IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD, RESPECTIVELY. (mmddyyyy) (SEE INSTRUCTIONS) 01/01/2012 09/30/2013 170