



OSF HOLY FAMILY MED CTR Provider CCN: 14-1318	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/27/2015 Run Time: 12:12 Version: 2014.10
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

**WORKSHEET S
PARTS I, II & III**

PART I - COST REPORT STATUS

PROVIDER USE ONLY		1. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT	DATE: 02/27/2015	TIME: 12:12
		2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT		
		3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT		
		4. <input checked="" type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> 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. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.	
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN		
	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 WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY OSF HOLY FAMILY MED CTR (14-1318) ((PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 10/01/2013 AND ENDING 09/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

TITLE

DATE

PART III - SETTLEMENT SUMMARY

		TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX
		1	2	3	4	5
1	HOSPITAL		215,433	110,620	1	1
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF		219,926			5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY					7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY					9
10	HEALTH CLINIC - RHC			130,178		10
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL		435,359	240,798	1	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.



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:										
1	Street: 1000 WEST HARLEM AVENUE	P.O. Box:								1
2	City: MONMOUTH	State: IL	ZIP Code: 61462	County: WARREN						2
Hospital and Hospital-Based Component Identification:										
Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
0	1	2	3	4	5	6	7	8		
3	Hospital	OSF HOLY FAMILY MED CTR	14-1318	14000	1	05/01/2002	N	O	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	OSF HOLY FAMILY SWING BEDS	14-Z318	14000		05/01/2002	N	O	N	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	OSF HOLY FAMILY CLINICS	14-3461	14000		02/05/2003	N	O	N	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 / 2013	To: 09 / 30 / 2014							20
21	Type of control (see instructions)	1								21
Inpatient PPS Information										
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.							1	2	22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)							N	N	22.01
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.								N	23
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
		1	2	3	4	5	6			
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.									24
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.									25
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.				2					26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.				2					27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.									35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				Beginning:		Ending:			36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.									37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				Beginning:		Ending:			38
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)							1	2	39



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	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	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services 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, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06
Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.					
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1	2	3	4	
Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.					
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital 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



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings-This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings-Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
67							67
Inpatient Psychiatric Facility PPS				1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.			N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/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)?	Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.	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	109
		Physical	Occupational	Speech
				Respiratory
Miscellaneous Cost Reporting Information				
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98'	N		115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	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
		Premiums	Paid Losses	Self Insurance
118.01	List amounts of malpractice premiums and paid losses:	174,845		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y		121
Transplant Center Information				
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			129
130	If this is a Medicare 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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WORKSHEET S-2
PART I

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 (see instructions)	1	2		140	
		Y	149006			
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: 14131		
142	Street: 800 N.E. GLEN OAK AVENUE	P.O. Box:				
143	City: PEORIA	State: IL	ZIP Code: 61603			
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				
		Part A	Part B	Title V	Title XIX	
			1	2	3	
155	Hospital	N	N	N	N	
156	Subprovider - IPF	N	N			
157	Subprovider - IRF	N	N			
158	Subprovider - Other					
159	SNF	N	N			
160	HHA	N	N			
161	CMHC		N			
161.10	CORF					
Multicampus						
165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N			165	
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5.				166	
	Name	County	State	ZIP Code	CBSA	FTE/Campus
	0	1	2	3	4	5
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167	
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	1			168	
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)				169	
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2014	09/30/2014		170	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
		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		
		1	2		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N			6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N			7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N			8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N			9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N			10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N			11
BAD DEBTS				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
		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	12/15/2014	Y	12/15/2014
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN RELIEVED 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.	N	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	
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	
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.	N	
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N	
COST REORT PREPARER INFORMATION			
41	FIRST NAME: CAROLE	LAST NAME: WAHL	TITLE: GOVERNMENT REPORTING SENIO
42	EMPLOYER: OSF HEALTHCARE SYSTEM		
43	PHONE NUMBER: (309)655-2855	E-MAIL ADDRESS: CAROLE.M.WAHL@OSFHEALTHCARE.ORG	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	WKST A LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
						TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	23	8,395	16,944.00		404	42	706	1
2	HMO AND OTHER (see instructions)						98			2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						653		773	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								28	6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		23	8,395	16,944.00		1,057	42	1,507	7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (see instructions)		23	8,395	16,944.00		1,057	42	1,507	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					6,715		35,660	26
27	TOTAL (sum of lines 14-26)		23							27
28	OBSERVATION BED DAYS							24	152	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	FULL TIME EQUIVALENTS			DISCHARGES				
		TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					130	17	230	1
2	HMO AND OTHER (see instructions)					30			2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)		133.26			130	17	230	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC		40.79						26
27	TOTAL (sum of lines 14-26)		174.05						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32



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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	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 instructions)						4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)						5
6	TOTAL (sum of lines 3 through 5)						6
7	TOTAL OVERHEAD COST (see instructions)						7



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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3

PART IV - WAGE RELATED COST

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 employee 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 REL		25
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

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

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

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



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HOSPITAL CONTRACT LABOR AND BENEFIT COST

**WORKSHEET S-3
PART V**

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

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



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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 DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)
	1	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	BA1			68
69	PE2			69
70	PE1			70



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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
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

SNF SERVICES

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

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

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



COMPU-MAX

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

COMPONENT CCN: 14-3461

WORKSHEET S-8

CHECK [XX] RHC [] FQHC
APPLICABLE BOX:

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 1000 W. HARLEM	1
2	CITY: MONMOUTH STATE: IL 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
9	OTHER (SPECIFY)			9

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 N	2	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 N	2	12
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)?	N		13
14	PROVIDER NAME: CCN NUMBER:			14

		Y/N	V	XVIII	XIX	TOTAL VISITS	
		1	2	3	4	5	
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)	N					15



COMPU-MAX

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.430214	1
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MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID		2,079,030	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		11,089,487	6
7	MEDICAID COST (line 1 times line 6)		4,770,853	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.		2,691,823	8

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

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

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

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

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE			17	
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS			18	
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)		2,691,823	19	
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	1,543,453	830,720	2,374,173	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	664,015	357,387	1,021,402	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	32,651	358,496	391,147	22
23	COST OF CHARITY CARE (line 21 minus line 22)	631,364	-1,109	630,255	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)		1,127,113	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)		7,880	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)		1,119,233	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)		481,510	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)		1,111,765	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)		3,803,588	31



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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		211,327	211,327	290,876	502,203		502,203	1
2	00200	CAP REL COSTS-MVBLE EQUIP				356,898	356,898		356,898	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	278,560	1,200,776	1,479,336	2,428,420	3,907,756	-157,204	3,750,552	4
5	00500	ADMINISTRATIVE & GENERAL	2,359,082	3,227,045	5,586,127	-418,220	5,167,907	1,331,451	6,499,358	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	284,843	927,469	1,212,312	-273,242	939,070		939,070	7
8	00800	LAUNDRY & LINEN SERVICE				96,844	96,844		96,844	8
9	00900	HOUSEKEEPING	287,360	199,824	487,184	-192,421	294,763		294,763	9
10	01000	DIETARY	273,984	286,362	560,346	-102,461	457,885	-25,726	432,159	10
11	01100	CAFETERIA								11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION								13
14	01400	CENTRAL SERVICES & SUPPLY								14
15	01500	PHARMACY								15
16	01600	MEDICAL RECORDS & LIBRARY	170,797	70,980	241,777	31,087	272,864	-3,094	269,770	16
17	01700	SOCIAL SERVICE								17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	891,546	325,547	1,217,093	-263,397	953,696		953,696	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	447,856	404,059	851,915	-401,293	450,622		450,622	50
53	05300	ANESTHESIOLOGY	232,863	100,611	333,474	-73,770	259,704	-259,704		53
54	05400	RADIOLOGY-DIAGNOSTIC	439,721	358,652	798,373	-164,423	633,950		633,950	54
56	05600	RADIOISOTOPE	56,478	66,686	123,164	-47,897	75,267		75,267	56
57	05700	CT SCAN		413,120	413,120	-13,537	399,583		399,583	57
58	05800	MRI		203,116	203,116	-5,751	197,365	-1,980	195,385	58
60	06000	LABORATORY	426,213	733,743	1,159,956	-147,344	1,012,612	-14,400	998,212	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY		20,440	20,440	150	20,590		20,590	65
66	06600	PHYSICAL THERAPY	321,546	112,198	433,744	-93,159	340,585		340,585	66
67	06700	OCCUPATIONAL THERAPY	82,344	16,894	99,238	-15,857	83,381		83,381	67
68	06800	SPEECH PATHOLOGY	6,784	21,311	28,095	-716	27,379		27,379	68
69	06900	ELECTROCARDIOLOGY	146,470	58,915	205,385	-40,111	165,274		165,274	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,373	35,978	53,351	313,250	366,601		366,601	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				54,573	54,573		54,573	72
73	07300	DRUGS CHARGED TO PATIENTS	257,627	1,682,094	1,939,721	98,717	2,038,438	-1,291,774	746,664	73
76	03950	DIABETIC SERVICES	65,841	8,905	74,746	11	74,757		74,757	76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	RURAL HEALTH CLINIC	3,023,728	1,342,731	4,366,459	-1,107,571	3,258,888	-16,951	3,241,937	88
91	09100	EMERGENCY	874,178	1,225,837	2,100,015	-193,810	1,906,205	-797,447	1,108,758	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	10,945,194	13,254,620	24,199,814	115,846	24,315,660	-1,236,829	23,078,831	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN								190
192	19200	PHYSICIANS' PRIVATE OFFICES	881,988	223,018	1,105,006	-115,846	989,160		989,160	192
200		TOTAL (sum of lines 118-199)	11,827,182	13,477,638	25,304,820		25,304,820	-1,236,829	24,067,991	200



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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	MEDICAL SUPPLIES	B	MEDICAL SUPPLIES CHARGED TO P	71		320,052	1
2			DRUGS CHARGED TO PATIENTS	73		153,390	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
500	TOTAL RECLASSIFICATIONS					473,442	500
	CODE LETTER - B						
1	RT SALARIES	C	RESPIRATORY THERAPY	65	13,352		1
2							2
500	TOTAL RECLASSIFICATIONS				13,352		500
	CODE LETTER - C						
1	A&G EXPENSES	D	MEDICAL RECORDS & LIBRARY	16	51,357		1
500	TOTAL RECLASSIFICATIONS				51,357		500
	CODE LETTER - D						
1	RHC PHYSICIAN RECRUITMENT	E	RURAL HEALTH CLINIC	88		3,776	1
500	TOTAL RECLASSIFICATIONS					3,776	500
	CODE LETTER - E						
1	PROPERTY INSURANCE	F	OTHER CAP REL COSTS	3		11,945	1
2			OTHER CAP REL COSTS	3		8,437	2
500	TOTAL RECLASSIFICATIONS					20,382	500
	CODE LETTER - F						
1	EMPLOYEE BENEFIT RECLASS	G	EMPLOYEE BENEFITS DEPARTMENT	4	3,545,951		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
20							20
21							21
500	TOTAL RECLASSIFICATIONS				3,545,951		500
	CODE LETTER - G						
1	TEAM AWARDS	H	ADMINISTRATIVE & GENERAL	5	74,910		1
2			HOUSEKEEPING	9	4,800		2
3			DIETARY	10	5,080		3
4			MEDICAL RECORDS & LIBRARY	16	2,400		4
5			ADULTS & PEDIATRICS	30	8,880		5
6			OPERATING ROOM	50	4,000		6
7			RADIOLOGY-DIAGNOSTIC	54	4,680		7
8			RADIOISOTOPE	56	400		8
9			LABORATORY	60	4,400		9
10			PHYSICAL THERAPY	66	2,800		10
11			OCCUPATIONAL THERAPY	67	400		11
12			ELECTROCARDIOLOGY	69	1,200		12
13			DRUGS CHARGED TO PATIENTS	73	2,680		13
14			DIABETIC SERVICES	76	800		14
15			RURAL HEALTH CLINIC	88	18,985		15



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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
16			EMERGENCY	91	4,240		16
17			PHYSICIANS' PRIVATE OFFICES	192	2,280		17
18			EMPLOYEE BENEFITS DEPARTMENT	4		62,865	18
500	TOTAL RECLASSIFICATIONS				142,935	62,865	500
	CODE LETTER - H						
1	DEPRECIATION RECLASS	I	CAP REL COSTS-BLDG & FIXT	1		385,252	1
2			CAP REL COSTS-MVBLE EQUIP	2		348,945	2
3			ADMINISTRATIVE & GENERAL	5		58,218	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
500	TOTAL RECLASSIFICATIONS					792,415	500
	CODE LETTER - I						
1	LAUNDRY RECLASS	J	LAUNDRY & LINEN SERVICE	8	28,604		1
2			LAUNDRY & LINEN SERVICE	8		68,240	2
500	TOTAL RECLASSIFICATIONS				28,604	68,240	500
	CODE LETTER - J						
1	IMPLANTABLE DEVICES	K	IMPL. DEV. CHARGED TO PATIENT	72		54,573	1
500	TOTAL RECLASSIFICATIONS					54,573	500
	CODE LETTER - K						
1	CLINIC A&G	L	ADMINISTRATIVE & GENERAL	5		73,859	1
2							2
500	TOTAL RECLASSIFICATIONS					73,859	500
	CODE LETTER - L						
	GRAND TOTAL (INCREASES)				3,782,199	1,549,552	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.



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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	MEDICAL SUPPLIES	B	ADULTS & PEDIATRICS	30		11,349	1	
2			OPERATING ROOM	50		195,331	2	
3			ANESTHESIOLOGY	53		11,548	3	
4			RADIOLOGY-DIAGNOSTIC	54		9,621	4	
5			RADIOISOTOPE	56		31,267	5	
6			CT SCAN	57		10,141	6	
7			MRI	58		2,679	7	
8			LABORATORY	60		33,151	8	
9			RESPIRATORY THERAPY	65		13,202	9	
10			PHYSICAL THERAPY	66		4,327	10	
11			OCCUPATIONAL THERAPY	67		1,086	11	
12			ELECTROCARDIOLOGY	69		382	12	
13			DIABETIC SERVICES	76		67	13	
14			RURAL HEALTH CLINIC	88		118,041	14	
15			EMERGENCY	91		21,795	15	
16			PHYSICIANS' PRIVATE OFFICES	192		9,455	16	
500	TOTAL RECLASSIFICATIONS					473,442	500	
	CODE LETTER - B							
1	RT SALARIES	C	ADULTS & PEDIATRICS	30	9,580		1	
2			ELECTROCARDIOLOGY	69	3,772		2	
500	TOTAL RECLASSIFICATIONS				13,352		500	
	CODE LETTER - C							
1	A&G EXPENSES	D	RURAL HEALTH CLINIC	88	51,357		1	
500	TOTAL RECLASSIFICATIONS				51,357		500	
	CODE LETTER - D							
1	RHC PHYSICIAN RECRUITMENT	E	ADMINISTRATIVE & GENERAL	5		3,776	1	
500	TOTAL RECLASSIFICATIONS					3,776	500	
	CODE LETTER - E							
1	PROPERTY INSURANCE	F	ADMINISTRATIVE & GENERAL	5		20,382	12	
2							12	
500	TOTAL RECLASSIFICATIONS					20,382	500	
	CODE LETTER - F							
1	EMPLOYEE BENEFIT RECLASS	G	EMPLOYEE BENEFITS DEPARTMENT	4		974,596	1	
2			ADMINISTRATIVE & GENERAL	5		525,655	2	
3			OPERATION OF PLANT	7		78,784	3	
4			HOUSEKEEPING	9		99,142	4	
5			DIETARY	10		90,050	5	
6			MEDICAL RECORDS & LIBRARY	16		22,195	6	
7			ADULTS & PEDIATRICS	30		237,467	7	
8			OPERATING ROOM	50		113,371	8	
9			ANESTHESIOLOGY	53		44,431	9	
10			RADIOLOGY-DIAGNOSTIC	54		107,526	10	
11			RADIOISOTOPE	56		17,030	11	
12			LABORATORY	60		108,937	12	
13			PHYSICAL THERAPY	66		88,173	13	
14			OCCUPATIONAL THERAPY	67		15,171	14	
15			SPEECH PATHOLOGY	68		716	15	
16			ELECTROCARDIOLOGY	69		28,507	16	
17			DRUGS CHARGED TO PATIENTS	73		51,340	17	
18			DIABETIC SERVICES	76		722	18	
19			RURAL HEALTH CLINIC	88		696,563	19	
20			EMERGENCY	91		162,508	20	
21			PHYSICIANS' PRIVATE OFFICES	192		83,067	21	
500	TOTAL RECLASSIFICATIONS					3,545,951	500	
	CODE LETTER - G							
1	TEAM AWARDS	H	EMPLOYEE BENEFITS DEPARTMENT	4	142,935		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	



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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				WKST A-7 REF.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
15								15
16								16
17								17
18			EMPLOYEE BENEFITS DEPARTMENT	4	62,865			18
500	TOTAL RECLASSIFICATIONS				205,800			500
	CODE LETTER - H							
1	DEPRECIATION RECLASS	I	CAP REL COSTS-BLDG & FIXT	1		106,805		9
2			ADMINISTRATIVE & GENERAL	5		75,394		9
3			OPERATION OF PLANT	7		194,458		
4			HOUSEKEEPING	9		1,235		
5			DIETARY	10		17,491		
6			MEDICAL RECORDS & LIBRARY	16		475		
7			ADULTS & PEDIATRICS	30		13,881		
8			OPERATING ROOM	50		42,018		
9			ANESTHESIOLOGY	53		17,791		
10			RADIOLOGY-DIAGNOSTIC	54		51,956		
11			CT SCAN	57		3,396		
12			MRI	58		3,072		
13			LABORATORY	60		9,656		
14			PHYSICAL THERAPY	66		3,459		
15			ELECTROCARDIOLOGY	69		8,650		
16			MEDICAL SUPPLIES CHARGED TO P	71		6,802		
17			DRUGS CHARGED TO PATIENTS	73		6,013		
18			RURAL HEALTH CLINIC	88		208,447		
19			EMERGENCY	91		13,747		
20			PHYSICIANS' PRIVATE OFFICES	192		7,669		
500	TOTAL RECLASSIFICATIONS					792,415		500
	CODE LETTER - I							
1	LAUNDRY RECLASS	J	HOUSEKEEPING	9	28,604			
2			HOUSEKEEPING	9		68,240		
500	TOTAL RECLASSIFICATIONS				28,604	68,240		500
	CODE LETTER - J							
1	IMPLANTABLE DEVICES	K	OPERATING ROOM	50		54,573		
500	TOTAL RECLASSIFICATIONS					54,573		500
	CODE LETTER - K							
1	CLINIC A&G	L	RURAL HEALTH CLINIC	88		55,924		
2			PHYSICIANS' PRIVATE OFFICES	192		17,935		
500	TOTAL RECLASSIFICATIONS					73,859		500
	CODE LETTER - L							
	GRAND TOTAL (DECREASES)				299,113	5,032,638		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.



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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIRE- MENTS	ENDING BALANCE	FULLY DEPREC- IATED ASSETS	
			PURCHASES	DONATION	TOTAL				
		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	8,034,984	2,010,268		2,010,268		10,045,252		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	5,385,283	1,377,787		1,377,787	6,455	6,756,615		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	13,933,714	3,388,055		3,388,055	6,455	17,315,314		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	13,933,714	3,388,055		3,388,055	6,455	17,315,314		10

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

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(1) (Sum of cols. 9 through 14)	
		DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	211,327							211,327	1
2	CAP REL COSTS-MVBLE EQUIP									2
3	TOTAL (sum of lines 1-2)	211,327							211,327	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All line numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		GROSS ASSETS	CAPITAL- IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL (sum of cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	10,558,700		10,558,700	0.609790	12,429			12,429	1
2	CAP REL COSTS-MVBLE EQU	6,756,614		6,756,614	0.390210	7,953			7,953	2
3	TOTAL (sum of lines 1-2)	17,315,314		17,315,314	1.000000	20,382			20,382	3

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(2) (sum of cols. 9 through 14)	
		DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	489,774			12,429				502,203	1
2	CAP REL COSTS-MVBLE EQUIP	348,945			7,953				356,898	2
3	TOTAL (sum of lines 1-2)	838,719			20,382				859,101	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
				COST CENTER	LINE#	WKST A-7 REF.
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3	INVESTMENT INCOME-OTHER (chapter 2)	B	-124,097	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	-4,426	ADMINISTRATIVE & GENERAL	5	7
8	TELEVISION AND RADIO SERVICE (chapter 21)	A	-5,975	ADMINISTRATIVE & GENERAL	5	8
9	PARKING LOT (chapter 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-811,847			10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	2,103,919			12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-25,283	DIETARY	10	14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-3,094	MEDICAL RECORDS & LIBRARY	16	16
17	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-1,291,774	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 OVERPAYMENTS					22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114	25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29	PHYSICIANS' ASSISTANT					29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32	CAH HIT ADJ FOR DEPRECIATION AND					32
33	RHC OTHER INCOME	B	-16,951	RURAL HEALTH CLINIC	88	33
33.01	MISCELLANEOUS INCOME	B	-7,197	ADMINISTRATIVE & GENERAL	5	33.01
33.02	MISCELLANEOUS INCOME	B	-443	DIETARY	10	33.02
34	MARKETING AND DEVELOPMENT SALARIES	A	-5,661	ADMINISTRATIVE & GENERAL	5	34
34.01	MARKETING & DEVELOPMENT BENEFITS	A	-1,999	EMPLOYEE BENEFITS DEPARTMENT	4	34.01
34.02	MARKETING & DEVELOPMENT OTHER	A	-24,039	ADMINISTRATIVE & GENERAL	5	34.02
34.03	FUND DEVELOPMENT SALARIES	A	-950	ADMINISTRATIVE & GENERAL	5	34.03
34.04	FUND DEVELOPMENT BENEFITS	A	-323	EMPLOYEE BENEFITS DEPARTMENT	4	34.04
34.05	ADVERTISING EXPENSE	A	-124,941	ADMINISTRATIVE & GENERAL	5	34.05
35	LOBBYING	A	-13,596	ADMINISTRATIVE & GENERAL	5	35
36	CRNA SALARIES	A	-259,579	ANESTHESIOLOGY	53	36
36.01	CRNA BENEFITS	A	-44,431	EMPLOYEE BENEFITS DEPARTMENT	4	36.01
36.02	CRNA CME	A	-125	ANESTHESIOLOGY	53	36.02
37	ER BENEFITS	A	-47,586	EMPLOYEE BENEFITS DEPARTMENT	4	37
38	PHYSICIAN RECRUIT	A	-18,087	ADMINISTRATIVE & GENERAL	5	38
38.01	ALCOHOLIC BEVERAGES	A	-813	ADMINISTRATIVE & GENERAL	5	38.01
38.02	PROVIDER TAX IDPA	A	-432,324	ADMINISTRATIVE & GENERAL	5	38.02
38.03	CAR ALLOWANCE	A	-7,200	ADMINISTRATIVE & GENERAL	5	38.03
39						39
40	GOODWILL	A	-5,142	ADMINISTRATIVE & GENERAL	5	40
41	TEAM AWARDS	A	-62,865	EMPLOYEE BENEFITS DEPARTMENT	4	41
42						42
43						43
44						44
45						45
46						46
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-1,236,829			50



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED	LINE#	WKST A-7 REF.	
		1	2	3	4	5	

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

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



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

WORKSHEET A-8-1

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	A&G	2,298,698	867,261	1,431,437		1
2	5	ADMINISTRATIVE & GENERAL	INTEREST EXP CORP OFFICE	674,462		674,462		2
3	5	ADMINISTRATIVE & GENERAL	PHYSICIAN RECRUITING	63,413	63,413			3
3.01	58	MRI	MOBILE MRI	182,275	182,275			3.01
3.02	58	MRI	ET MAINTENANCE AGREEMENT	113,867	115,847	-1,980		3.02
4								4
5		TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12		3,332,715	1,228,796	2,103,919		5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

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

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

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



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2		3	4	5	6	7	8	9	
1	91	EMERGENCY	EMERGENCY AGGRE	1,229,982	797,447	432,535					1
2	60	LABORATORY	LABRATORY AGGRE	14,400	14,400						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
200		TOTAL		1,244,382	811,847	432,535					200



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	10	11		12	13	14	15	16	17	18	
	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
1	91	EMERGENCY	EMERGENCY AGGRE							797,447	1
2	60	LABORATORY	LABRATORY AGGRE							14,400	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
200		TOTAL								811,847	200



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

CHECK APPLICABLE BOX: [] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)					37	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					555	2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)					37	3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE					0.35	7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		383.17				9
10	AHSEA (see instructions)		75.54				10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	37.77	37.77				11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)						14
15	THERAPISTS (column 2, line 9 times column 2, line 10)					28,945	15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)						16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					28,945	17
18	AIDES (column 4, line 9 times column 4, line 10)						18
19	TRAINEES (column 5, line 9 times column 5, line 10)						19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					28,945	20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.						
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)					75.54	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (line 2 times line 21)					41,925	22
23	TOTAL SALARY EQUIVALENCY (see instructions)					41,925	23

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

STANDARD TRAVEL ALLOWANCE							
24	THERAPISTS (line 3 times column 2, line 11)					1,397	24
25	ASSISTANTS (line 4 times column 3, line 11)						25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					1,397	26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					13	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)					1,410	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)						29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)						30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)					1,410	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)						34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)						35

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

STANDARD TRAVEL EXPENSE							
36	THERAPISTS (line 5 times column 2, line 11)						36
37	ASSISTANTS (line 6 times column 3, line 11)						37
38	SUBTOTAL (sum of lines 36 and 37)						38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)						39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)						41
42	SUBTOTAL (sum of lines 40 and 41)						42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)						43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.							
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)						44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)						45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)						46



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)	41,925	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)	1,410	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)	43,335	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)	16,066	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65



COMPU-MAX

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)					73	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					1,095	2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)					134	3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE					3.45	7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		567.28				9
10	AHSEA (see instructions)		68.80				10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	34.40	34.40				11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)						14
15	THERAPISTS (column 2, line 9 times column 2, line 10)					39,029	15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)						16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					39,029	17
18	AIDES (column 4, line 9 times column 4, line 10)						18
19	TRAINEES (column 5, line 9 times column 5, line 10)						19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					39,029	20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.						
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)					68.80	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (line 2 times line 21)					75,336	22
23	TOTAL SALARY EQUIVALENCY (see instructions)					75,336	23

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

STANDARD TRAVEL ALLOWANCE							
24	THERAPISTS (line 3 times column 2, line 11)					4,610	24
25	ASSISTANTS (line 4 times column 3, line 11)						25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					4,610	26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					462	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)					5,072	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)						29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)						30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)					5,072	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)						34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)						35

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

STANDARD TRAVEL EXPENSE							
36	THERAPISTS (line 5 times column 2, line 11)						36
37	ASSISTANTS (line 6 times column 3, line 11)						37
38	SUBTOTAL (sum of lines 36 and 37)						38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)						39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)						41
42	SUBTOTAL (sum of lines 40 and 41)						42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)						43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.							
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)						44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)						45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)						46



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)	75,336	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)	5,072	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)	80,408	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)	23,091	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	502,203	502,203					1
2	CAP REL COSTS-MVBLE EQUIP	356,898		356,898				2
4	EMPLOYEE BENEFITS DEPARTMENT	3,750,552			3,750,552			4
5	ADMINISTRATIVE & GENERAL	6,499,358	57,537	40,889	814,876	7,412,660	7,412,660	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	939,070	76,606	54,441	95,363	1,165,480	518,711	7
8	LAUNDRY & LINEN SERVICE	96,844			9,576	106,420	47,363	8
9	HOUSEKEEPING	294,763	6,003	4,266	88,236	393,268	175,029	9
10	DIETARY	432,159	33,995	24,159	93,428	583,741	259,801	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	269,770	13,515	9,604	75,178	368,067	163,813	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	953,696	54,626	38,820	298,246	1,345,388	598,781	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	450,622	28,822	20,483	151,277	651,204	289,826	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	633,950	25,855	18,374	148,781	826,960	368,048	54
56	RADIOISOTOPE	75,267			19,042	94,309	41,973	56
57	CT SCAN	399,583				399,583	177,839	57
58	MRI	195,385				195,385	86,958	58
60	LABORATORY	998,212	9,790	6,957	144,165	1,159,124	515,882	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	20,590			4,470	25,060	11,153	65
66	PHYSICAL THERAPY	340,585	16,735	11,893	108,588	477,801	212,651	66
67	OCCUPATIONAL THERAPY	83,381	1,448	1,029	27,702	113,560	50,541	67
68	SPEECH PATHOLOGY	27,379	180	128	2,271	29,958	13,333	68
69	ELECTROCARDIOLOGY	165,274	6,616	4,702	48,176	224,768	100,036	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	366,601	18,178	12,918	5,816	403,513	179,588	71
72	IMPL. DEV. CHARGED TO PATIENTS	54,573				54,573	24,288	72
73	DRUGS CHARGED TO PATIENTS	746,664	5,724	4,068	87,148	843,604	375,456	73
76	DIABETIC SERVICES	74,757	6,332	4,500	22,311	107,900	48,022	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	3,241,937	80,711	57,361	1,001,472	4,381,481	1,950,039	88
91	EMERGENCY	1,108,758	29,420	20,908	208,386	1,367,472	608,610	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	23,078,831	472,093	335,500	3,454,508	22,731,279	6,817,741	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		6,775	4,815		11,590	5,158	190
192	PHYSICIANS' PRIVATE OFFICES	989,160	23,335	16,583	296,044	1,325,122	589,761	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	24,067,991	502,203	356,898	3,750,552	24,067,991	7,412,660	202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MEDICAL RECORDS + LIBRARY	
		7	8	9	10	11	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	1,684,191						7
8	LAUNDRY & LINEN SERVICE		153,783					8
9	HOUSEKEEPING	27,467	5,036	600,800				9
10	DIETARY	155,558		56,412	1,055,512			10
11	CAFETERIA				941,991	941,991		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	61,841		22,426		37,318	653,465	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	249,959	53,078	90,646	113,521	133,062	30,939	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	131,887	18,460	47,828		51,503	44,579	50
53	ANESTHESIOLOGY					12,665	4,867	53
54	RADIOLOGY-DIAGNOSTIC	118,307	22,409	42,903		69,824	61,601	54
56	RADIOISOTOPE					6,163	7,403	56
57	CT SCAN						60,516	57
58	MRI						22,127	58
60	LABORATORY	44,795	128	16,245		70,162	129,948	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY					2,955	7,155	65
66	PHYSICAL THERAPY	76,577	15,974	27,770		45,592	26,252	66
67	OCCUPATIONAL THERAPY	6,625		2,403	7,430		6,775	67
68	SPEECH PATHOLOGY	825		299	507		2,450	68
69	ELECTROCARDIOLOGY	30,272	654	10,978		14,860	17,704	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,178		30,164		2,955	27,443	71
72	IMPL. DEV. CHARGED TO PATIENTS						1,369	72
73	DRUGS CHARGED TO PATIENTS	26,194		9,499		20,263	43,525	73
76	DIABETIC SERVICES	28,976		10,508		7,936	339	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	369,327	2,619	133,934		329,786	65,495	88
91	EMERGENCY	134,622	30,102	48,820		81,307	92,978	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,546,410	148,460	550,835	1,055,512	894,288	653,465	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,003		11,243				190
192	PHYSICIANS' PRIVATE OFFICES	106,778	5,323	38,722		47,703		192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,684,191	153,783	600,800	1,055,512	941,991	653,465	202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		24	25	26			
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	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 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	2,615,374		2,615,374			30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,235,287		1,235,287			50
53	ANESTHESIOLOGY	17,532		17,532			53
54	RADIOLOGY-DIAGNOSTIC	1,510,052		1,510,052			54
56	RADIOISOTOPE	149,848		149,848			56
57	CT SCAN	637,938		637,938			57
58	MRI	304,470		304,470			58
60	LABORATORY	1,936,284		1,936,284			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	46,323		46,323			65
66	PHYSICAL THERAPY	882,617		882,617			66
67	OCCUPATIONAL THERAPY	187,334		187,334			67
68	SPEECH PATHOLOGY	47,372		47,372			68
69	ELECTROCARDIOLOGY	399,272		399,272			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	726,841		726,841			71
72	IMPL. DEV. CHARGED TO PATIENTS	80,230		80,230			72
73	DRUGS CHARGED TO PATIENTS	1,318,541		1,318,541			73
76	DIABETIC SERVICES	203,681		203,681			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	7,232,681		7,232,681			88
91	EMERGENCY	2,363,911		2,363,911			91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	21,895,588		21,895,588			118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	58,994		58,994			190
192	PHYSICIANS' PRIVATE OFFICES	2,113,409		2,113,409			192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	24,067,991		24,067,991			202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	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	638,903	57,537	40,889	737,329	737,329		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		76,606	54,441	131,047	51,596	182,643	7
8	LAUNDRY & LINEN SERVICE					4,711		8
9	HOUSEKEEPING		6,003	4,266	10,269	17,410	2,979	9
10	DIETARY		33,995	24,159	58,154	25,842	16,870	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		13,515	9,604	23,119	16,294	6,706	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		54,626	38,820	93,446	59,560	27,107	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		28,822	20,483	49,305	28,829	14,303	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	98,856	25,855	18,374	143,085	36,610	12,830	54
56	RADIOISOTOPE					4,175		56
57	CT SCAN	281,916			281,916	17,690		57
58	MRI					8,650		58
60	LABORATORY		9,790	6,957	16,747	51,314	4,858	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY					1,109		65
66	PHYSICAL THERAPY	1,690	16,735	11,893	30,318	21,152	8,304	66
67	OCCUPATIONAL THERAPY		1,448	1,029	2,477	5,027	718	67
68	SPEECH PATHOLOGY		180	128	308	1,326	89	68
69	ELECTROCARDIOLOGY		6,616	4,702	11,318	9,950	3,283	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		18,178	12,918	31,096	17,864	9,020	71
72	IMPL. DEV. CHARGED TO PATIENTS					2,416		72
73	DRUGS CHARGED TO PATIENTS		5,724	4,068	9,792	37,346	2,841	73
76	DIABETIC SERVICES		6,332	4,500	10,832	4,777	3,142	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		80,711	57,361	138,072	193,967	40,052	88
91	EMERGENCY		29,420	20,908	50,328	60,538	14,599	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,021,365	472,093	335,500	1,828,958	678,153	167,701	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		6,775	4,815	11,590	513	3,362	190
192	PHYSICIANS' PRIVATE OFFICES		23,335	16,583	39,918	58,663	11,580	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,021,365	502,203	356,898	1,880,466	737,329	182,643	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MEDICAL RECORDS + LIBRARY	SUBTOTAL	
		8	9	10	11	16	24	
	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	4,711						8
9	HOUSEKEEPING	154	30,812					9
10	DIETARY		2,893	103,759				10
11	CAFETERIA			92,600	92,600			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY		1,150		3,668	50,937		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	1,627	4,649	11,159	13,080	2,412	213,040	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	566	2,453		5,063	3,475	103,994	50
53	ANESTHESIOLOGY				1,245	379	1,624	53
54	RADIOLOGY-DIAGNOSTIC	686	2,200		6,864	4,802	207,077	54
56	RADIOISOTOPE				606	577	5,358	56
57	CT SCAN					4,718	304,324	57
58	MRI					1,725	10,375	58
60	LABORATORY	4	833		6,897	10,125	90,778	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY				290	558	1,957	65
66	PHYSICAL THERAPY	489	1,424		4,482	2,047	68,216	66
67	OCCUPATIONAL THERAPY		123		730	528	9,603	67
68	SPEECH PATHOLOGY		15		50	191	1,979	68
69	ELECTROCARDIOLOGY	20	563		1,461	1,380	27,975	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,547		290	2,139	61,956	71
72	IMPL. DEV. CHARGED TO PATIENTS					107	2,523	72
73	DRUGS CHARGED TO PATIENTS		487		1,992	3,393	55,851	73
76	DIABETIC SERVICES		539		780	26	20,096	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	80	6,869		32,420	5,106	416,566	88
91	EMERGENCY	922	2,504		7,993	7,249	144,133	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,548	28,249	103,759	87,911	50,937	1,747,425	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		577				16,042	190
192	PHYSICIANS' PRIVATE OFFICES	163	1,986		4,689		116,999	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	4,711	30,812	103,759	92,600	50,937	1,880,466	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	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 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		213,040				30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		103,994				50
53	ANESTHESIOLOGY		1,624				53
54	RADIOLOGY-DIAGNOSTIC		207,077				54
56	RADIOISOTOPE		5,358				56
57	CT SCAN		304,324				57
58	MRI		10,375				58
60	LABORATORY		90,778				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		1,957				65
66	PHYSICAL THERAPY		68,216				66
67	OCCUPATIONAL THERAPY		9,603				67
68	SPEECH PATHOLOGY		1,979				68
69	ELECTROCARDIOLOGY		27,975				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		61,956				71
72	IMPL. DEV. CHARGED TO PATIENTS		2,523				72
73	DRUGS CHARGED TO PATIENTS		55,851				73
76	DIABETIC SERVICES		20,096				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		416,566				88
91	EMERGENCY		144,133				91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)		1,747,425				118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		16,042				190
192	PHYSICIANS' PRIVATE OFFICES		116,999				192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)		1,880,466				202



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	97,470						1
2	CAP REL COSTS-MVBLE EQUIP		97,470					2
4	EMPLOYEE BENEFITS DEPARTMENT			11,202,715				4
5	ADMINISTRATIVE & GENERAL	11,167	11,167	2,433,992	-7,412,660	16,655,331		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	14,868	14,868	284,843		1,165,480	71,435	7
8	LAUNDRY & LINEN SERVICE			28,604		106,420		8
9	HOUSEKEEPING	1,165	1,165	263,556		393,268	1,165	9
10	DIETARY	6,598	6,598	279,064		583,741	6,598	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	224,554		368,067	2,623	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	890,846		1,345,388	10,602	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	5,594	5,594	451,856		651,204	5,594	50
53	ANESTHESIOLOGY			1				53
54	RADIOLOGY-DIAGNOSTIC	5,018	5,018	444,401		826,960	5,018	54
56	RADIOISOTOPE			56,878		94,309		56
57	CT SCAN					399,583		57
58	MRI					195,385		58
60	LABORATORY	1,900	1,900	430,613		1,159,124	1,900	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			13,352		25,060		65
66	PHYSICAL THERAPY	3,248	3,248	324,346		477,801	3,248	66
67	OCCUPATIONAL THERAPY	281	281	82,744		113,560	281	67
68	SPEECH PATHOLOGY	35	35	6,784		29,958	35	68
69	ELECTROCARDIOLOGY	1,284	1,284	143,898		224,768	1,284	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,528	3,528	17,373		403,513	3,528	71
72	IMPL. DEV. CHARGED TO PATIENTS					54,573		72
73	DRUGS CHARGED TO PATIENTS	1,111	1,111	260,307		843,604	1,111	73
76	DIABETIC SERVICES	1,229	1,229	66,641		107,900	1,229	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	2,991,356		4,381,481	15,665	88
91	EMERGENCY	5,710	5,710	622,438		1,367,472	5,710	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	91,626	91,626	10,318,447	-7,412,660	15,318,619	65,591	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,315	1,315			11,590	1,315	190
192	PHYSICIANS' PRIVATE OFFICES	4,529	4,529	884,268		1,325,122	4,529	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	502,203	356,898	3,750,552		7,412,660	1,684,191	202
203	UNIT COST MULT-WS B PT I	5.152385	3.661619	0.334790		0.445062	23.576552	203
204	COST TO BE ALLOC PER B PT II					737,329	182,643	204
205	UNIT COST MULT-WS B PT II					0.044270	2.556772	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	MEDICAL RECORDS + LIBRARY GROSS REVENUE		
	8	9	10	11	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	101,808					8
9	HOUSEKEEPING	3,334	70,270				9
10	DIETARY		6,598	54,142			10
11	CAFETERIA			48,319	11,157		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY		2,623		442	50,894,597	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	35,139	10,602	5,823	1,576	2,409,595	30
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	12,221	5,594		610	3,471,861	50
53	ANESTHESIOLOGY				150	379,044	53
54	RADIOLOGY-DIAGNOSTIC	14,835	5,018		827	4,797,570	54
56	RADIOISOTOPE				73	576,545	56
57	CT SCAN					4,713,095	57
58	MRI					1,723,259	58
60	LABORATORY	85	1,900		831	10,122,233	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY				35	557,271	65
66	PHYSICAL THERAPY	10,575	3,248		540	2,044,521	66
67	OCCUPATIONAL THERAPY		281		88	527,662	67
68	SPEECH PATHOLOGY		35		6	190,782	68
69	ELECTROCARDIOLOGY	433	1,284		176	1,378,794	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		3,528		35	2,137,275	71
72	IMPL. DEV. CHARGED TO PATIENTS					106,656	72
73	DRUGS CHARGED TO PATIENTS		1,111		240	3,389,831	73
76	DIABETIC SERVICES		1,229		94	26,420	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	1,734	15,665		3,906	5,100,867	88
91	EMERGENCY	19,928	5,710		963	7,241,316	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	98,284	64,426	54,142	10,592	50,894,597	118
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,315				190
192	PHYSICIANS' PRIVATE OFFICES	3,524	4,529		565		192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	153,783	600,800	1,055,512	941,991	653,465	202
203	UNIT COST MULT-WS B PT I	1.510520	8.549879	19.495253	84.430492	0.012840	203
204	COST TO BE ALLOC PER B PT II	4,711	30,812	103,759	92,600	50,937	204
205	UNIT COST MULT-WS B PT II	0.046273	0.438480	1.916423	8.299722	0.001001	205



COMPU-MAX

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT
		PART	LINE NO.	
	1	2	3	4



COMPU-MAX

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	2,615,374		2,615,374		2,615,374	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,235,287		1,235,287		1,235,287	50
53	ANESTHESIOLOGY	17,532		17,532		17,532	53
54	RADIOLOGY-DIAGNOSTIC	1,510,052		1,510,052		1,510,052	54
56	RADIOISOTOPE	149,848		149,848		149,848	56
57	CT SCAN	637,938		637,938		637,938	57
58	MRI	304,470		304,470		304,470	58
60	LABORATORY	1,936,284		1,936,284		1,936,284	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	46,323		46,323		46,323	65
66	PHYSICAL THERAPY	882,617		882,617		882,617	66
67	OCCUPATIONAL THERAPY	187,334		187,334		187,334	67
68	SPEECH PATHOLOGY	47,372		47,372		47,372	68
69	ELECTROCARDIOLOGY	399,272		399,272		399,272	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	726,841		726,841		726,841	71
72	IMPL. DEV. CHARGED TO PATIENTS	80,230		80,230		80,230	72
73	DRUGS CHARGED TO PATIENTS	1,318,541		1,318,541		1,318,541	73
76	DIABETIC SERVICES	203,681		203,681		203,681	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	7,232,681		7,232,681		7,232,681	88
91	EMERGENCY	2,363,911		2,363,911		2,363,911	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	243,387		243,387		243,387	92
	OTHER REIMBURSABLE COST CENTERS						
200	SUBTOTAL (SEE INSTRUCTIONS)	22,138,975		22,138,975		22,138,975	200
201	LESS OBSERVATION BEDS	243,387		243,387		243,387	201
202	TOTAL (SEE INSTRUCTIONS)	21,895,588		21,895,588		21,895,588	202



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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	2,162,826		2,162,826				30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	557,377	2,914,484	3,471,861	0.355800	0.355800	0.355800	50
53	ANESTHESIOLOGY	139,491	239,553	379,044	0.046253	0.046253	0.046253	53
54	RADIOLOGY-DIAGNOSTIC	190,553	4,607,017	4,797,570	0.314754	0.314754	0.314754	54
56	RADIOISOTOPE	7,729	568,816	576,545	0.259907	0.259907	0.259907	56
57	CT SCAN	263,136	4,449,959	4,713,095	0.135354	0.135354	0.135354	57
58	MRI	12,954	1,710,305	1,723,259	0.176683	0.176683	0.176683	58
60	LABORATORY	884,462	9,237,771	10,122,233	0.191290	0.191290	0.191290	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	429,245	128,026	557,271	0.083125	0.083125	0.083125	65
66	PHYSICAL THERAPY	343,242	1,701,279	2,044,521	0.431699	0.431699	0.431699	66
67	OCCUPATIONAL THERAPY	130,202	397,460	527,662	0.355027	0.355027	0.355027	67
68	SPEECH PATHOLOGY	32,937	157,845	190,782	0.248304	0.248304	0.248304	68
69	ELECTROCARDIOLOGY	148,249	1,230,545	1,378,794	0.289581	0.289581	0.289581	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	453,508	1,683,766	2,137,274	0.340079	0.340079	0.340079	71
72	IMPL. DEV. CHARGED TO PATIENTS		106,656	106,656	0.752231	0.752231	0.752231	72
73	DRUGS CHARGED TO PATIENTS	1,715,362	1,674,469	3,389,831	0.388970	0.388970	0.388970	73
76	DIABETIC SERVICES		26,420	26,420	7.709349	7.709349	7.709349	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		5,100,867	5,100,867				88
91	EMERGENCY	338,034	6,903,282	7,241,316	0.326448	0.326448	0.326448	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		246,770	246,770	0.986291	0.986291	0.986291	92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (SEE INSTRUCTIONS)	7,809,307	43,085,290	50,894,597				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	7,809,307	43,085,290	50,894,597				202



COMPU-MAX

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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1318

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.355800		1,092,545			388,728	50
53	ANESTHESIOLOGY	0.046253		60,754			2,810	53
54	RADIOLOGY-DIAGNOSTIC	0.314754		835,776			263,064	54
56	RADIOISOTOPE	0.259907		511,505			132,944	56
57	CT SCAN	0.135354		1,360,745			184,182	57
58	MRI	0.176683		368,388			65,088	58
60	LABORATORY	0.191290		3,324,292			635,904	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.083125		45,570			3,788	65
66	PHYSICAL THERAPY	0.431699		571,258			246,612	66
67	OCCUPATIONAL THERAPY	0.355027		70,931			25,182	67
68	SPEECH PATHOLOGY	0.248304		15,232			3,782	68
69	ELECTROCARDIOLOGY	0.289581		642,134			185,950	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.340079		486,291			165,377	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.752231		1,711			1,287	72
73	DRUGS CHARGED TO PATIENTS	0.388970		637,473	566		247,958	220 73
76	DIABETIC SERVICES	7.709349		6,985			53,850	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	0.326448		1,773,587			578,984	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.986291		127,527			125,779	92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (see instructions)			11,932,704	566		3,311,269	220 200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)			11,932,704	566		3,311,269	220 202

(A) Worksheet A line numbers



COMPU-MAX

OSF HOLY FAMILY MED CTR Provider CCN: 14-1318	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/27/2015 Run Time: 12:12 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-Z318

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST		
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.355800						50
53	ANESTHESIOLOGY	0.046253						53
54	RADIOLOGY-DIAGNOSTIC	0.314754						54
56	RADIOISOTOPE	0.259907						56
57	CT SCAN	0.135354						57
58	MRI	0.176683						58
60	LABORATORY	0.191290						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.083125						65
66	PHYSICAL THERAPY	0.431699						66
67	OCCUPATIONAL THERAPY	0.355027						67
68	SPEECH PATHOLOGY	0.248304						68
69	ELECTROCARDIOLOGY	0.289581						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.340079						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.752231						72
73	DRUGS CHARGED TO PATIENTS	0.388970						73
76	DIABETIC SERVICES	7.709349						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	0.326448						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.986291						92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (see instructions)							200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)							202

(A) Worksheet A line numbers



COMPU-MAX

OSF HOLY FAMILY MED CTR Provider CCN: 14-1318	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/27/2015 Run Time: 12:12 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
	INPATIENT ROUTINE SERV COST CENTERS	1	2	3	4	5	6	7	
30	ADULTS & PEDIATRICS (General Routine Care)	213,040	101,130	111,910	858	130.43	42	5,478	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)	213,040		111,910	858		42	5,478	200

(A) Worksheet A line numbers



COMPU-MAX

OSF HOLY FAMILY MED CTR Provider CCN: 14-1318	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/27/2015 Run Time: 12:12 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-1318

WORKSHEET D
PART II

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)
		1	2	3	4	5
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	103,994	3,471,861	0.029953		50
53	ANESTHESIOLOGY	1,624	379,044	0.004284		53
54	RADIOLOGY-DIAGNOSTIC	207,077	4,797,570	0.043163		54
56	RADIOISOTOPE	5,358	576,545	0.009293		56
57	CT SCAN	304,324	4,713,095	0.064570		57
58	MRI	10,375	1,723,259	0.006021		58
60	LABORATORY	90,778	10,122,233	0.008968		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY	1,957	557,271	0.003512		65
66	PHYSICAL THERAPY	68,216	2,044,521	0.033365		66
67	OCCUPATIONAL THERAPY	9,603	527,662	0.018199		67
68	SPEECH PATHOLOGY	1,979	190,782	0.010373		68
69	ELECTROCARDIOLOGY	27,975	1,378,794	0.020289		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	61,956	2,137,274	0.028988		71
72	IMPL. DEV. CHARGED TO PATIENTS	2,523	106,656	0.023655		72
73	DRUGS CHARGED TO PATIENTS	55,851	3,389,831	0.016476		73
76	DIABETIC SERVICES	20,096	26,420	0.760636		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	416,566	5,100,867	0.081666		88
91	EMERGENCY	144,133	7,241,316	0.019904		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	37,741	246,770	0.152940		92
	OTHER REIMBURSABLE COST CENTERS					
200	TOTAL (sum of lines 50-199)	1,572,126	48,731,771			200

(A) Worksheet A line numbers



COMPU-MAX

OSF HOLY FAMILY MED CTR Provider CCN: 14-1318	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/27/2015 Run Time: 12:12 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers



COMPU-MAX

OSF HOLY FAMILY MED CTR Provider CCN: 14-1318	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/27/2015 Run Time: 12:12 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	858		42		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)	858		42		200

(A) Worksheet A line numbers



OSF HOLY FAMILY MED CTR Provider CCN: 14-1318	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/27/2015 Run Time: 12:12 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1318

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
	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 HEMOPHILIACS							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 PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
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-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

OSF HOLY FAMILY MED CTR Provider CCN: 14-1318	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/27/2015 Run Time: 12:12 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1318

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5 ÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6 ÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	3,471,861						50
53	ANESTHESIOLOGY	379,044						53
54	RADIOLOGY-DIAGNOSTIC	4,797,570						54
56	RADIOISOTOPE	576,545						56
57	CT SCAN	4,713,095						57
58	MRI	1,723,259						58
60	LABORATORY	10,122,233						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	557,271						65
66	PHYSICAL THERAPY	2,044,521						66
67	OCCUPATIONAL THERAPY	527,662						67
68	SPEECH PATHOLOGY	190,782						68
69	ELECTROCARDIOLOGY	1,378,794						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,137,274						71
72	IMPL. DEV. CHARGED TO PATIENTS	106,656						72
73	DRUGS CHARGED TO PATIENTS	3,389,831						73
76	DIABETIC SERVICES	26,420						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	5,100,867						88
91	EMERGENCY	7,241,316						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	246,770						92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)	48,731,771						200

(A) Worksheet A line numbers



COMPU-MAX

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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1318

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST		
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.355800						50
53	ANESTHESIOLOGY	0.046253						53
54	RADIOLOGY-DIAGNOSTIC	0.314754						54
56	RADIOISOTOPE	0.259907						56
57	CT SCAN	0.135354						57
58	MRI	0.176683						58
60	LABORATORY	0.191290						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.083125						65
66	PHYSICAL THERAPY	0.431699						66
67	OCCUPATIONAL THERAPY	0.355027						67
68	SPEECH PATHOLOGY	0.248304						68
69	ELECTROCARDIOLOGY	0.289581						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.340079						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.752231						72
73	DRUGS CHARGED TO PATIENTS	0.388970						73
76	DIABETIC SERVICES	7.709349						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	0.326448						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.986291						92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (see instructions)							200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)							202

(A) Worksheet A line numbers



COMPU-MAX

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1318

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	1,659	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	858	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	706	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	193	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)	580	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	7	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)	21	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	404	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)	163	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)	490	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	134.54	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	134.54	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	2,615,374	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)	942	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)	2,825	25
26	TOTAL SWING-BED COST (see instructions)	1,241,518	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,373,856	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	1,373,856	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1318

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,601.23	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					646,897	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)					646,897	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 (Worksheet D-3, column 3, line 200)					496,310	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					1,143,207	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)						50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)						52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)					261,000	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)					784,603	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)					1,045,603	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1318

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					152	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,601.23	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					243,387	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	213,040	1,373,856	0.155067	243,387	37,741	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1318

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	1,659	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	858	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	706	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	193	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)	580	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	7	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)	21	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	42	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	134.54	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	134.54	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	2,615,374	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)	942	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)	2,825	25
26	TOTAL SWING-BED COST (see instructions)	1,241,518	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,373,856	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	1,373,856	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1318

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,601.23	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					67,252	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)					67,252	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 (Worksheet D-3, column 3, line 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					67,252	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					5,478	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					5,478	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					61,774	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69



COMPU-MAX

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1318

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					152	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1318

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		579,806		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.355800	174,171	61,970	50
53	ANESTHESIOLOGY	0.046253	8,766	405	53
54	RADIOLOGY-DIAGNOSTIC	0.314754	61,824	19,459	54
56	RADIOISOTOPE	0.259907	4,997	1,299	56
57	CT SCAN	0.135354	43,071	5,830	57
58	MRI	0.176683	8,505	1,503	58
60	LABORATORY	0.191290	293,334	56,112	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.083125	147,663	12,274	65
66	PHYSICAL THERAPY	0.431699	39,430	17,022	66
67	OCCUPATIONAL THERAPY	0.355027	9,533	3,384	67
68	SPEECH PATHOLOGY	0.248304	5,888	1,462	68
69	ELECTROCARDIOLOGY	0.289581	106,149	30,739	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.340079	193,171	65,693	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.752231			72
73	DRUGS CHARGED TO PATIENTS	0.388970	562,628	218,845	73
76	DIABETIC SERVICES	7.709349			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	0.326448	960	313	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.986291			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		1,660,090	496,310	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		1,660,090		202

(A) Worksheet A line numbers



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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-Z318

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.355800			50
53	ANESTHESIOLOGY	0.046253			53
54	RADIOLOGY-DIAGNOSTIC	0.314754	21,511	6,771	54
56	RADIOISOTOPE	0.259907			56
57	CT SCAN	0.135354	9,987	1,352	57
58	MRI	0.176683	4,449	786	58
60	LABORATORY	0.191290	157,769	30,180	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.083125	83,357	6,929	65
66	PHYSICAL THERAPY	0.431699	233,868	100,961	66
67	OCCUPATIONAL THERAPY	0.355027	93,008	33,020	67
68	SPEECH PATHOLOGY	0.248304	10,889	2,704	68
69	ELECTROCARDIOLOGY	0.289581	5,576	1,615	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.340079	60,707	20,645	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.752231			72
73	DRUGS CHARGED TO PATIENTS	0.388970	392,998	152,864	73
76	DIABETIC SERVICES	7.709349			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	0.326448			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.986291			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		1,074,119	357,827	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		1,074,119		202

(A) Worksheet A line numbers



COMPU-MAX

OSF HOLY FAMILY MED CTR Provider CCN: 14-1318	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/27/2015 Run Time: 12:12 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1318

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.355800			50
53	ANESTHESIOLOGY	0.046253			53
54	RADIOLOGY-DIAGNOSTIC	0.314754			54
56	RADIOISOTOPE	0.259907			56
57	CT SCAN	0.135354			57
58	MRI	0.176683			58
60	LABORATORY	0.191290			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.083125			65
66	PHYSICAL THERAPY	0.431699			66
67	OCCUPATIONAL THERAPY	0.355027			67
68	SPEECH PATHOLOGY	0.248304			68
69	ELECTROCARDIOLOGY	0.289581			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.340079			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.752231			72
73	DRUGS CHARGED TO PATIENTS	0.388970			73
76	DIABETIC SERVICES	7.709349			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	0.326448			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.986291			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers



COMPU-MAX

OSF HOLY FAMILY MED CTR Provider CCN: 14-1318	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/27/2015 Run Time: 12:12 Version: 2014.10
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1318

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	3,311,489			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)	3,311,489			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)				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)	3,344,604			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	15,957			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	1,717,088			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	1,611,559			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)	1,611,559			30
31	PRIMARY PAYER PAYMENTS	390			31
32	SUBTOTAL (line 30 minus line 31)	1,611,169			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)	9,152			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	6,956			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)	1,618,125			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	1,618,125			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	32,363			40.01
41	INTERIM PAYMENTS	1,475,142			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	110,620			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (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



COMPU-MAX

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-1318

WORKSHEET E-1
PART I

CHECK HOSPITAL SUB (OTHER)
 APPLICABLE IPF SNF
 BOXES: IRF SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
		1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		821,714		1,605,664	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT					
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					
						3.01
						3.02
		PROGRAM				3.03
		TO				3.04
		PROVIDER				3.05
						3.06
						3.07
						3.08
						3.09
						3.10
			05/23/2014	20,173	05/23/2014	3.50
			09/25/2014	2,561	09/25/2014	3.51
		PROVIDER				3.52
		TO				3.53
		PROGRAM				3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99	-22,734		-130,522	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		798,980		1,475,142	4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					
						5.01
						5.02
		PROGRAM				5.03
		TO				5.04
		PROVIDER				5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.10
						5.11
		PROVIDER				5.52
		TO				5.53
		PROGRAM				5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01	236,135		142,983	6.01
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		1,035,115		1,618,125	7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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



COMPU-MAX

OSF HOLY FAMILY MED CTR Provider CCN: 14-1318	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/27/2015 Run Time: 12:12 Version: 2014.10
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-Z318

WORKSHEET E-1
PART I

CHECK HOSPITAL SUB (OTHER)
 APPLICABLE IPF SNF
 BOXES: IRF SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,200,113		1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO				2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT				3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM				3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM			3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO			3.04
		PROVIDER			3.05
					3.06
					3.07
					3.08
					3.09
					3.10
					3.50
			05/23/2014	32,605	
			09/25/2014	5,171	
		PROVIDER			3.51
		TO			3.52
		PROGRAM			3.53
					3.54
					3.55
					3.56
					3.57
					3.58
					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		-37,776	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			1,162,337	4
TO BE COMPLETED BY CONTRACTOR					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT				5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.				5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM			5.03
		TO			5.04
		PROVIDER			5.05
					5.06
					5.07
					5.08
					5.09
					5.10
					5.50
					5.51
		PROVIDER			5.52
		TO			5.53
		PROGRAM			5.54
					5.55
					5.56
					5.57
					5.58
					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)	.01		248,135	6.01
	BASED ON THE COST REPORT (1)	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			1,410,472	7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)	
					8

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



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OSF HOLY FAMILY MED CTR Provider CCN: 14-1318	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/27/2015 Run Time: 12:12 Version: 2014.10
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL [] 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	230	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	404	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	98	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	706	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	50,894,597	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	2,374,173	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	1	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	1	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	1	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	1	32



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CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

COMPONENT CCN: 14-Z318

WORKSHEET E-2

CHECK TITLE V SWING BED - SNF
 APPLICABLE TITLE XVIII SWING BED - NF
 BOXES: TITLE XIX

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (see instructions)	1,056,059		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)	361,405		3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			4
5	PROGRAM DAYS	653		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)	1,417,464		8
9	PRIMARY PAYER PAYMENTS (see instructions)			9
10	SUBTOTAL (line 8 minus line 9)	1,417,464		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (exclude amounts applicable to physician professional services)			11
12	SUBTOTAL (line 10 minus line 11)	1,417,464		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (exclude coinsurance for physician professional services)	6,992		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)	1,410,472		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)	1,410,472		19
19.01	SEQUESTRATION ADJUSTMENT (see instructions)	28,209		19.01
20	INTERIM PAYMENTS	1,162,337		20
21	TENTATIVE SETTLEMENT (for contractor use only)			21
22	BALANCE DUE PROVIDER/PROGRAM (line 19 minus lines 19.01, 20 and 21)	219,926		22
23	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			23



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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART V

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

1	INPATIENT SERVICES		1,143,207	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)			2
3	ORGAN ACQUISITION			3
4	SUBTOTAL (sum of lines 1-3)		1,143,207	4
5	PRIMARY PAYER PAYMENTS			5
6	TOTAL COST (line 4 less line 5) (for CAH, see instructions)		1,154,639	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)		0.000000	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 instructions)			15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 6 exceeds line 14) (see instructions)			16
17	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)			17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49)			18
19	COST OF COVERED SERVICES (sum of lines 6 and 17)		1,154,639	19
20	DEDUCTIBLES (exclude professional component)		120,448	20
21	EXCESS REASONABLE COST (from line 16)			21
22	SUBTOTAL (line 19 minus the sum of lines 20 and 21)		1,034,191	22
23	COINSURANCE			23
24	SUBTOTAL (line 22 minus line 23)		1,034,191	24
25	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)		1,216	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)		924	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			27
28	SUBTOTAL (sum of lines 24 and 26)		1,035,115	28
29	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			29
30	SUBTOTAL (line 28 plus or minus line 29)		1,035,115	30
30.01	SEQUESTRATION ADJUSTMENT (see instructions)		20,702	30.01
31	INTERIM PAYMENTS		798,980	31
32	TENTATIVE SETTLEMENT (for contractor use only)			32
33	BALANCE DUE PROVIDER/PROGRAM (line 30 minus lines 30.01, 31 and 32)		215,433	33
34	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			34



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1318

WORKSHEET E-3
PART VII

CHECK TITLE V HOSPITAL NF PPS
 APPLICABLE TITLE XIX SUB (OTHER) ICF/MR TEFRA
 BOXES: SNF OTHER

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9			9
10			10
11			11
12			12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16			16
17			17
18			18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
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



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BALANCE SHEET

WORKSHEET G

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

ASSETS (Omit Cents)		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
CURRENT ASSETS						
1	CASH ON HAND AND IN BANKS	7,267,891				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	3,194,844				4
5	OTHER RECEIVABLES	1,209,441				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE					6
7	INVENTORY	470,138				7
8	PREPAID EXPENSES					8
9	OTHER CURRENT ASSETS	195,936				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	12,338,250				11
FIXED ASSETS						
12	LAND	325,000				12
13	LAND IMPROVEMENTS	188,447				13
14	ACCUMULATED DEPRECIATION	-156,175				14
15	BUILDINGS	10,045,252				15
16	ACCUMULATED DEPRECIATION	-2,749,654				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	6,756,615				23
24	ACCUMULATED DEPRECIATION	-3,532,530				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)	10,876,955				30
OTHER ASSETS						
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	7,254,158				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	7,254,158				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	30,469,363				36
LIABILITIES AND FUND BALANCES (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	ACCOUNTS PAYABLE	365,214				37
38	SALARIES, WAGES & FEES PAYABLE	1,879,298				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	542,079				43
44	OTHER CURRENT LIABILITIES	222,838				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	3,009,429				45
LONG TERM LIABILITIES						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	179,543				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	179,543				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	3,188,972				51
CAPITAL ACCOUNTS						
52	GENERAL FUND BALANCE	27,280,391				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	27,280,391				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	30,469,363				60



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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		25,063,584			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		2,176,536			2
3	TOTAL (sum of line 1 and line 2)		27,240,120			3
4	ADDITIONS (credit adjustments)					4
5	CONTRIBUTIONS	646,610				5
6	CONTRIBUTIONS RELEASED					6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)		646,610			10
11	SUBTOTAL (line 3 plus line 10)		27,886,730			11
12	DEDUCTIONS (debit adjustments)					12
13	CONTRIBUTIONS RELEASED	606,339				13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		606,339			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		27,280,391			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sum of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5	CONTRIBUTIONS					5
6	CONTRIBUTIONS RELEASED					6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13	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)					19



OSF HOLY FAMILY MED CTR Provider CCN: 14-1318	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/27/2015 Run Time: 12:12 Version: 2014.10
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	1,211,661		1,211,661	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF	542,742		542,742	5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	1,754,403		1,754,403	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	1,754,403		1,754,403	17
18	ANCILLARY SERVICES	5,242,075		5,242,075	18
19	OUTPATIENT SERVICES		44,837,375	44,837,375	19
20	RHC		5,100,867	5,100,867	20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	6,996,478	49,938,242	56,934,720	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		25,304,820	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 Worksheet G-3, line 4)		25,304,820	43



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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	56,934,720	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	32,208,192	2
3	NET PATIENT REVENUES (line 1 minus line 2)	24,726,528	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	25,304,820	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-578,292	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	654,695	6
7	INCOME FROM INVESTMENTS	124,097	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	25,726	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	373	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	1,868,050	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	1,833	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (GRANT INCOME)	49,438	24
24.01	OTHER (GAIN ON DISPOSAL)		24.01
24.02	OTHER (OTHER REVENUE)	30,616	24.02
25	TOTAL OTHER INCOME (sum of lines 6-24)	2,754,828	25
26	TOTAL (line 5 plus line 25)	2,176,536	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	2,176,536	29



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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-1318

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER		1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS		2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)		3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 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 (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17



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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	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 APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
	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 HEMOPHILIACS							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 PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
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-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202



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

COMPONENT CCN: 14-3461

WORKSHEET M-1

CHECK APPLICABLE BOX: [XX] RHC I

[] FQHC

		COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	1,536,430		1,536,430		1,536,430		1,536,430	1
2	PHYSICIAN ASSISTANT	356,593		356,593		356,593		356,593	2
3	NURSE PRACTITIONER								3
4	VISITING NURSE								4
5	OTHER NURSE	1,079,348		1,079,348		1,079,348		1,079,348	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)	2,972,371		2,972,371		2,972,371		2,972,371	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		31,189	31,189	-8,988	22,201		22,201	15
16	TRANSPORTATION (Health Care Staff)		2,431	2,431		2,431		2,431	16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSIONAL LIABILITY INSURANCE		34,720	34,720		34,720		34,720	18
19	OTHER HEALTH CARE COSTS		187,479	187,479		187,479		187,479	19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (sum of lines 15-20)		255,819	255,819	-8,988	246,831		246,831	21
22	TOTAL COST OF HEALTH CARE SERVICES (sum of lines 10, 14, and 21)	2,972,371	255,819	3,228,190	-8,988	3,219,202		3,219,202	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY		109,053	109,053	-109,053				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)		109,053	109,053	-109,053				28
	FACILITY OVERHEAD								
29	FACILITY COSTS								29
30	ADMINISTRATIVE COSTS	51,357	977,859	1,029,216	-989,530	39,686	-16,951	22,735	30
31	TOTAL FACILITY OVERHEAD (sum of lines 29 and 30)	51,357	977,859	1,029,216	-989,530	39,686	-16,951	22,735	31
32	TOTAL FACILITY COSTS (sum of lines 22, 28 and 31)	3,023,728	1,342,731	4,366,459	-1,107,571	3,258,888	-16,951	3,241,937	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.



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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3461

WORKSHEET M-2

CHECK APPLICABLE BOX: RHC FQHC FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD (1)	MINIMUM VISITS (col. 1 x col. 3)	GREATER OF COL. 2 OR COL. 4	
	POSITIONS	1	2	3	4	5	
1	PHYSICIANS	5.69	20,120	4,200	23,898		1
2	PHYSICIAN ASSISTANTS	3.57	11,872	2,100	7,497		2
3	NURSE PRACTITIONERS	0.88	2,554	2,100	1,848		3
4	SUBTOTAL (sum of lines 1-3)	10.14	34,546		33,243	34,546	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER	0.88	1,114			1,114	7
7.01	MEDICAL NUTRITION THERAPIST (FQHC only)						7.01
7.02	DIABETES SELF MANAGEMENT TRAINING (FQHC only)						7.02
8	TOTAL FTEs AND VISITS (sum of lines 4-7)	11.02	35,660			35,660	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (from Worksheet M-1, column 7, line 22)		3,219,202	10
11	TOTAL NONREIMBURSABLE COSTS (from Worksheet M-1, column 7, line 28)			11
12	COST OF ALL SERVICES (excluding overhead) (sum of lines 10 and 11)		3,219,202	12
13	RATIO OF RHC/FQHC SERVICES (line 10 divided by line 12)		1.000000	13
14	TOTAL FACILITY OVERHEAD (from Worksheet M-1, column 7, line 31)		22,735	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (see instructions)		3,990,744	15
16	TOTAL OVERHEAD (sum of lines 14 and 15)		4,013,479	16
17	ALLOWABLE DIRECT GME OVERHEAD (see instructions)			17
18	SUBTRACT LINE 17 FROM LINE 16		4,013,479	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (line 13 x line 18)		4,013,479	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (sum of lines 10 and 19)		7,232,681	20

- (1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1 thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.



COMPU-MAX

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-3461

WORKSHEET M-3

CHECK [XX] RHC I [] 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 Worksheet M-2, line 20)	7,232,681	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 15)	66,223	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (line 1 minus line 2)	7,166,458	3
4	TOTAL VISITS (from Worksheet M-2, column 5, line 8)	35,660	4
5	PHYSICIANS VISITS UNDER AGREEMENT (from Worksheet M-2, column 5, line 9)		5
6	TOTAL ADJUSTED VISITS (line 4 plus line 5)	35,660	6
7	ADJUSTED COST PER VISIT (line 3 divided by line 6)	200.97	7

		CALCULATION OF LIMIT (1)		
		PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1	(SEE INSTR.)
		1	2	3
8	PER VISIT PAYMENT LIMIT (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.80	8
9	RATE FOR PROGRAM COVERED VISITS (see instructions)	200.97	200.97	9
CALCULATION OF SETTLEMENT				
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (from contractor records)	1,686	5,058	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (line 9 x line 10)	338,835	1,016,506	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (from contractor records)			12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (line 9 x line 12)			13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (see instructions)			14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (see instructions)			15
16	TOTAL PROGRAM COST (sum of lines 11, 14, and 15, columns 1, 2, and 3)		1,355,341	16
16.01	TOTAL PROGRAM CHARGES (see instructions)(from contractor's records)		1,087,669	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (see instructions)(from provider's records)		4,035	16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS (see instructions)		5,028	16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS (see instructions)		991,476	16.04
16.05	TOTAL PROGRAM COST (see instructions)		996,504	16.05
17	PRIMARY PAYER PAYMENTS		736	17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (see instructions)(from contractor records)		110,968	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (see instructions) (from contractor records)		194,533	19
20	NET MEDICARE COST EXCLUDING VACCINES (see instructions)		995,768	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 16)		27,142	21
22	TOTAL REIMBURSABLE PROGRAM COST (line 20 plus line 21)		1,022,910	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)		1,022,910	26
26.01	SEQUESTRATION ADJUSTMENT (see instructions)		20,458	26.01
27	INTERIM PAYMENTS		872,274	27
28	TENTATIVE SETTLEMENT (for contractor use only)			28
29	BALANCE DUE COMPONENT/PROGRAM (line 26 minus lines 26.01, 27 and 28)		130,178	29
30	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, CHAPTER 1, SECTION 115.2			30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.



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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-3461

WORKSHEET M-4

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

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	HEALTH CARE STAFF COST (from Worksheet M-1, column 7, line 10)	2,972,371	2,972,371	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000200	0.002193	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (line 1 x line 2)	594	6,518	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (from your records)	7,565	14,799	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (line 3 plus line 4)	8,159	21,317	5
6	TOTAL DIRECT COST OF THE FACILITY (from Worksheet M-1, column 7, line 22)	3,219,202	3,219,202	6
7	TOTAL OVERHEAD (from Worksheet M-2, line 16)	4,013,479	4,013,479	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (line 5 divided by line 6)	0.002534	0.006622	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (line 7 x line 8)	10,170	26,577	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (sum of lines 5 and 9)	18,329	47,894	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (from your records)	123	1,364	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (line 10/line 11)	149.02	35.11	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	82	425	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (line 12 x line 13)	12,220	14,922	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		66,223	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		27,142	16



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

COMPONENT CCN: 14-3461

WORKSHEET M-5

CHECK APPLICABLE BOX: RHC FQHC

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			840,839	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO				2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)				
		.01	05/23/2014	22,469	3.01
		.02	09/25/2014	8,966	3.02
		PROGRAM			3.03
		TO			3.04
		PROVIDER			3.05
					3.06
					3.07
					3.08
					3.09
					3.10
		.50			3.50
		.51			3.51
		PROVIDER			3.52
		TO			3.53
		PROGRAM			3.54
					3.55
					3.56
					3.57
					3.58
		.59			3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		31,435	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. J-3, line 27)			872,274	
TO BE COMPLETED BY CONTRACTOR					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)				
		.01			5.01
		.02			5.02
		PROGRAM			5.03
		TO			5.04
		PROVIDER			5.05
					5.06
					5.07
					5.08
					5.09
					5.10
		.50			5.50
		.51			5.51
		PROVIDER			5.52
		TO			5.53
		PROGRAM			5.54
					5.55
					5.56
					5.57
					5.58
		.59			5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01		150,636	6.01
		.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			1,022,910	
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER	NPR DATE (Month/Day/Year)		8

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