ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

Pat Quinn, Governor
Julie Hamos, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 785-0710
TTY: (800) 526-5812

September 1, 2010

Holy Family Medical Center
ATTN: Chief Executive Officer
100 North River Road
Des Plaines, IL 60016

Dear Chief Executive Officer:

The Department of Healthcare and Family Services has completed the annual determination for the supplemental payment programs listed on the following summary sheet for fiscal year 2011. The determination of eligibility and the calculation of the payment amounts were conducted in accordance with the sections of the *89 Illinois Administrative Code* as cited on the following summary sheet.

In addition, a breakout of the qualification criteria for each program and worksheets detailing the calculations for the applicable payments follow. Please examine these worksheets carefully. Your hospital's supplemental payment for each program will be sent periodically as determined by the Department during fiscal year 2011.

Appeals must be made in accordance with Section 148.310 of the 89 Illinois Administrative Code and must be made in writing no later than THIRTY (30) DAYS FROM THE DATE OF THIS LETTER. For fiscal year 2011, appeals **MUST BE SUBMITTED IN WRITING AND MUST BE RECEIVED OR POSTMARKED NO LATER THAN OCTOBER 1st, 2010.** Direct all appeals and supporting documentation to:

Illinois Department of Healthcare and Family Services
Bureau of Rate Development and Analysis
Attn: Dan Jenkins
201 South Grand Avenue East, 2nd Floor
Springfield, Illinois 62763

If you have further questions in regard to this program, please do not hesitate to contact the Bureau of Rate Development and Analysis at (217) 785-0710. Questions regarding the payment process should be directed to the Bureau of Comprehensive Health Services at (217) 782-8162.

Please provide a copy of this letter to your Chief Financial Officer and Patient Accounts Manager.

Sincerely,

Joseph R. Holler, Deputy Administrator of Finance
Illinois Department of Healthcare and Family Services

Supplemental Payment Program Summary Sheet

Holy Family Medical Center
Des Plaines, IL

Program Name	89 IL Administrative Code	Qualify ? Yes / No
Psychiatric Adjustment Payments (PAP)	148.105	No
Rural Adjustment Payments (RAP)	148.115	No
Outpatient Assistance Adjustment Payments (OAAP)	148.117	No
Safety Net Adjustment Payments (SNAP)	148.126	No
Critical Hospital Adjustment Payments (CHAP)		
Trauma Center Adjustment (TCA)	148.295(a)	No
Rehabilitation Hospital Adjustment (RHA)	148.295(b)	No
Direct Hospital Adjustment (DHA)	148.295(c)	No
Rural Critical Hospital Adjustment Payments (RCHAP)	148.295(d)	No
Tertiary Care Adjustment Payments	148.296	Yes
Pediatric Outpatient Ajdustment Payments (POAP)	148.297	No
Pediatric Inpatient Adjustment Payments (PIAP)	148.298	No

Psychiatric Adjustment Payments
For the Period of July 1, 2010 through June 30, 2011

Hospital Is Excluded By Rule.

Factors used to determine qualification and rate:	
State hospital is located in:	**N/A**
H.S.A. in which hospital is located:	**N/A**
Hospital's current psychiatric care rate:	**N/A**
Current statewide DPU default rate:	**N/A**
Hospital's MIUR:	**N/A**
Hospital's total qualified inpatient days:	**N/A**
Hospital's total qualified psychiatric care days:	**N/A**
Hospital's total beds*:	**N/A**
Hospital's total psychiatric care beds*:	**N/A**
Hospital's psychiatric care occupancy rate*:	**N/A**

***Note: As reported in the July 25th, 2001 Illinois Department of Public Health report titled**
Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois.

Rate Level Options

Qualifying Rate Level 1:	
Illinois hospital located outside H.S.A. 6, with a DPU psychiatric care per diem rate less than the statewide psychiatric DPU average default rate, with a MIUR > 60%	**$0.00**

Qualifying Rate Level 2:	
Illinois hospital located outside H.S.A. 6, with a DPU psychiatric care per diem rate less than the statewide psychiatric DPU average default rate, with a MIUR > 20%, total beds > 325, and a psychiatric care occupancy rate >50%.	**$0.00**
$125.00 - If total days are greater than or equal to 10,000	
$78.00 - If total days are less than 10,000	

Qualifying Rate Level 3:	
Illinois hospital located outside H.S.A. 6, with a DPU psychiatric care per diem rate less than the statewide psychiatric DPU average default rate, with a MIUR greater than 15%, total beds > 500, psychiatric care occupancy rate >35%, and total licensed psychiatric care beds > 50	**$0.00**

Qualifying Rate Level 4:	
Illinois hospital located outside H.S.A. 6, with a DPU psychiatric care per diem rate less than the statewide psychiatric DPU average default rate, with a MIUR > 19%, total beds < 275, psychiatric care days <1,000, total licensed psychiatric care bed <=40, and total days > 6,000	**$0.00**

Qualifying Rate Level 5:	
Illinois hospital located outside H.S.A. 6, with a DPU psychiatric care per diem rate less than the statewide psychiatric DPU average default rate, total licensed psychiatric care beds =>50, and a psychiatric occupancy rate > 60%	**$0.00**

Your hospital's total Psychiatric Adjustment Payment amount: **$0.00**
(Assigned rate x total qualified hospital days)

PLEASE NOTE: Your actual final payment amount may vary due to rounding.

Rural Adjustment Payments
For the Period of July 1, 2010 through June 30, 2011

Hospital Is Excluded By Rule.

Factors used to determine qualification and rate:

Inpatient Component

A)	Your hospital's total inpatient days during the Rural Adjustment Payment base year:	N/A
B)	Your hospital's total inpatient payments during the Rural Adjustment Payment base year:	N/A
C)	Your hospital's inpatient quarterly payments during the Rural Adjustment Payment base year:	N/A
D)	Your hospital's total inpatient reimbursement per day during the Rural Adjustment Payment base year: (B+C) / A	N/A
E)	Your hospital's total inpatient charges during the Rural Adjustment Payment base year:	N/A
F)	Your hospital's cost to charge ratio: (HFY 2007 Medicaid Cost Report)	N/A
G)	Your hospital's total inpatient cost during the Rural Adjustment Payment base year: (F * E)	N/A
H)	Your hospital's total inpatient cost per day during the Rural Adjustment Payment base year: (G / A)	N/A
I)	Your hospital's inpatient cost coverage deficit per day during the Rural Adjustment Payment base year: (H - D)	N/A
J)	Rural Adjustment Payment base year inpatient total cost coverage deficit: (A * I)	N/A
K)	Aggregate Rural Adjustment Payment base year inpatient cost coverage deficit: (Sum of all qualifying hospitals inpatient total cost coverage deficits)	$7,418,936

Outpatient Component:

L)	Your hospital's total outpatient service units during the Rural Adjustment Payment base year:	N/A
M)	Your hospital's total outpatient payments during the Rural Adjustment Payment base year: (Including applicable outpatient quarterly payments)	N/A

N)	Your hospital's total outpatient reimbursement per service unit during the Rural Adjustment Payment base year: (M / L)	N/A
O)	Your hospital's total outpatient charges during the Rural Adjustment Payment base year:	N/A
P)	Your hospital's cost to charge ratio:	N/A
Q)	Your hospital's total outpatient costs during the Rural Adjustment Payment base year: (O * P)	N/A
R)	Your hospital's total outpatient costs per service unit during the Rural Adjustment Payment base year: (Q / L)	N/A
S)	Your hospital's outpatient cost coverage deficit per service unit during the Rural Adjustment Payment base year: (R - N)	N/A
T)	Rural Adjustment Payment base year outpatient total cost coverage deficit: (S * L)	N/A
U)	Aggregate Rural Adjustment Payment base year outpatient cost coverage deficit: (Sum of all qualifying hospitals outpatient total cost coverage deficits)	$81,558,067

Payment Methodology:

V)	Inpatient Pool: (K /(K + U)) * $7 Million	$583,663
W)	Outpatient Pool: (U / (K + U)) * $7 Million	$6,416,337
X)	Inpatient Cost Coverage Residual Factor: (V / K)	0.0787
Y)	Outpatient Cost Coverage Residual Factor: (W / U)	0.0787
Z)	Your Hospital's Inpatient Rural Adjustment Payment Program Allocation: (J * X)	N/A
AA)	Your Hospital's Outpatient Rural Adjustment Payment Program Allocation: (T * Y)	N/A
AB)	Your Hospital's Total Annual Rural Adjustment Payments: (Z + AA)	N/A

PLEASE NOTE: Your Actual Final Payment Amount May Vary Due to Rounding.

OUTPATIENT ASSISTANCE ADJUSTMENT PAYMENT
For the Period of July 1, 2010 through June 30, 2011

Statistics used in determining qualification for OAAP payments:

Services data used for calculation is State FY 05, adjudicated through June 30, 2006:

Disproportionate Share Hospital in Rate Year 2007:	**No**
Qualified for Medicaid Percentage Adjustment Payments for Rate Year 2007:	**No**
Emergency Care Percentage:	**68.53%**
Medicaid Outpatient Services Provided In The Base Year:	**3,502**
Hospital Type:	**Gen. Acute**

Outpatient Assistance Adjustment Payments shall be made to Illinois hospitals meeting one of the following criteria identified below:

1. A hospital that qualifies for all of the following:
   A. Qualifies for Disproportionate Share Adjustment payments for Rate Year 2007
   B. Has an emergency care percentage greater than 70%
   C. Provided greater than 10,500 Medicaid Outpatient services in the base year

   Qualifying Rate: **$0.00**

2. A hospital that qualifies for all of the following:

   A. Is a general acute care hospital
   B. Qualifies for Disproportionate Share Adjustment payments for Rate Year 2007
   C. Has an emergency care percentage greater than 85%

   Qualifying Rate: **$0.00**

3. A hospital that qualifies for all of the following:

   A. Is a general acute care hospital
   B. Located in Cook County
   C. Outside the city of Chicago
   D. Does not qualify for Medicaid Percentage Adjustment payments for Rate Year 2007
   E. Has an emergency care percentage greater than 63%
   F. Provided greater than 10,500 Medicaid Outpatient services in the base year
   G. Provided greater than 325 Medicaid surgical outpatient ambulatory procedure listing services in the base year

   Qualifying Rate: **$0.00**

4. A hospital that qualifies for all of the following:

   A. Is a general acute care hospital
   B. Located outside of Cook County
   C. Qualifies for Medicaid Percentage Adjustment payments for Rate Year 2007
   D. Is a Trauma Center, recognized by the Illinois Department of Public Health
   E. Has an emergency care percentage greater than 58%
   F. Provided greater than 1,000 Medicaid non-emergency / screening outpatient ambulatory procedure listing services in the base year

   Qualifying Rate: **$0.00**

5. Total Outpatient Assistance Adjustment Payment Rate:	**$0.00**
6. Total Outpatient Services Provided In The Base Year:	**3,502**
7. Total Annual Outpatient Assistance Adjustment Payment {Line 5 * Line 6}:	**$0.00**

PLEASE NOTE: Your actual final payment amount may vary due to rounding.

SAFETY NET ADJUSTMENT PAYMENT
For the Period of July 1, 2010 through June 30, 2011

Hospital Statistics:

Your hospital's Health Service Area (HSA):	**7**
Your hospital's Medicaid Inpatient Utilization Rate (MIUR):	**12.3%**
Your hospital's Combined Medicaid Inpatient Utilization Rate (CMIUR):	**44.8%**
Your hospital's fiscal year 2000 licensed beds:	**237**
Your hospital's fiscal year 2000 total obstetrical care (OB) admissions:	**441**
Your hospital's fiscal year 2000 total obstetrical care (OB) days:	**854**
Your hospital's fiscal year 2000 average length of stay (alos):	**2.58**
Your hospital's fiscal year 2000 general care admissions:	**446**
Your hospital's fiscal year 2000 total days:	**3,220**
Your hospital's fiscal year 2000 occupancy rate:	**34.7%**
Your hospital's number of graduate medical education programs from the 2000-2001 Graduate Medical Education Directory:	**0**
Your hospital's number of obstetrical graduate medical education programs from the 2000-2001 Graduate Medical Education Directory:	**0**

Qualifying Criteria:
(Hospitals located outside of Illinois, County-owned hospitals, hospitals operated by the University of Illinois, psychiatric, and long term stay hospitals are not eligible for payments associated with qualifying criteria 1 – 4)

1. For a hospital that has, as of October 1, 2001, a MIUR equal to or greater than 40%, the rate is the sum of the amounts for each of the following criteria for which it qualifies:

A. Qualifying hospital base rate:	$0.00
B. Rehabilitation hospital, as described in 89 Ill. Adm. 149.50(c)(2):	$0.00
C. Children's hospital, as described in 89 Ill. Adm. 149.50(c)(3):	$0.00
D. Children's hospital that has a MIUR greater than or equal to 80% that is:	
i. Located within HSA 6 or HSA 7:	$0.00
ii. Located outside HSA 6 or HSA 7:	$0.00

E. Children's hospital that has a MIUR less than 80%, but greater than or equal to 60%:	
i. Located within HSA 6 or HSA 7:	$0.00
ii. Located outside HSA 6 or HSA 7:	$0.00
F. Children's hospital that has a MIUR less than 60%, but greater than or equal to 45%:	
i. Located within HSA 6 or HSA 7:	$0.00
ii. Located outside HSA 6 or HSA 7:	$0.00
G. Children's hospital with more than 25 graduate medical education programs:	$0.00
H. Children's hospital that is a rural hospital:	$0.00
I. Qualifying hospital, that is neither a rehabilitation hospital nor a children's hospital, that is located in HSA 6 and that:	
i. Provides obstetrical care:	$0.00
ii. Has at least one graduate medical education program:	$0.00
iii. Has at least one obstetrical graduate medical education program:	$0.00
iv. Provided more than 5,000 obstetrical days during the safety net hospital base year:	$0.00
v. Provided fewer than 4,000 obstetrical days during the safety net hospital base year, and its average length of stay is:	
a. Less than or equal to 4.50 days:	$0.00
b. Less than 4.00 days:	$0.00
c. Less than 3.75 days:	$0.00
vi. Provides obstetrical care and has an MIUR greater than 65%:	$0.00
vii. Has greater than 700 licensed beds:	$0.00
J. Qualifying hospital, that is neither a rehabilitation hospital nor a children's hospital, that is located outside HSA 6, that has a MIUR greater than 50%, and that:	
i. Provides obstetrical care:	$0.00
ii. Does not provide obstetrical care:	$0.00
iii. Is a trauma hospital, designated by the Illinois Department of Public Health:	$0.00
K. Qualifying hospital that provided greater than 35,000 days in the safety net hospital base year:	$0.00
L. Qualifying hospital with two or more graduate medical education programs, with an average length of stay fewer than 4.00 days:	$0.00
Your hospital's total rate:	**$0.00**
2. For a hospital that has the highest number of obstetrical care days in the safety net hospital base year:	$0.00
Your hospital's total rate:	**$0.00**

3. For a hospital that is, as of October 1, 2001, a sole community hospital, as defined by the United States Department of Health and Human Services (42 CFR 412.92), the rate is the sum of the amounts for each of the following criteria for which it qualifies:

A. Qualifying hospital base rate:	$0.00
B. Hospital that has an average length of stay less than 4.00 days and:	
i. More than 150 licensed beds:	$0.00
ii. Fewer than 150 licensed beds:	$0.00
C. Qualifying hospital with the lowest average length of stay:	$0.00
D. Hospital that has a Combined Medicaid Inpatient Utilization Rate greater than 65%:	$0.00
E. Hospital that has fewer than 25 total admissions in the safety net hospital base year:	$0.00
Your hospital's total rate:	**$0.00**

4. For a hospital that is, as of October 1, 2001, a rural hospital, as described in section 148.25(g)(3), that meet all of the following criteria:
   A. Has a MIUR greater than 33%.
   B. Is designated a perinatal level two center by the Illinois Department of Public Health.
   C. Has fewer than 125 licensed beds.

Your hospital's total rate:	**$0.00**

5. For a rural hospital, as described in Section 148.25(g)(3), the rate is the sum of the amounts for each of the following for which it qualifies, divided by the hospital's total days:

A. The hospital that has the highest number of obstetrical care admissions ($30,840):	$0.00
B. The greater of:	
i. The product of $115 multiplied by the number of obstetrical care admissions:	$0.00
ii. The product of $11.50 multiplied by the number of general care admissions:	$0.00
iii. Greater of B(i) or B(ii):	$0.00
C. Sum of rural hospital rates (Line A + Line B(iii))	$0.00
Qualifying hospital base rate (Line C / hospital's total days):	**$0.00**

6. The hospital meets all of the following requirements:
   A. Has a MIUR greater than 30 percent.
   B. Had an occupancy rate greater than 80 percent in the safety net hospital base year.
   C. Provided greater than 15,000 days in the safety net hospital base year.

Your hospital's total rate:	**$0.00**

7. The hospital meets all of the following requirements:
   A. Does not already qualify under subsections (a)(1) through (a)(6) of this Section.
   B. Has an MIUR greater than 25 percent.
   C. Had an occupancy rate greater than 68 percent in the safety net hospital base year.
   D. Provided greater than 12,000 total days in the safety net hospital base year.

   Your hospital's total rate: **$0.00**

8. The hospital meets all of the following requirements:
   A. The hospital is a rural hospital, as described in Section 148.25(g)(3).
   B. Has an MIUR greater than 18 percent.
   C. Has a combined MIUR greater than 45 percent.
   D. Licensed beds less than or equal to 60.
   E. Provided greater than 400 total days.
   F. Provided fewer than 125 obstetrical care days.

   Your hospital's total rate: **$0.00**

9. The hospital meets all of the following requirements:
   A. The hospital is a psychiatric hospital, as described in Section 149.50(c)(1).
   B. Licensed beds greater than 120.
   C. Has an average length of stay less than 10.00 days.

   Your hospital's total rate: **$0.00**

10. The hospital meets all of the following requirements:
   A. Does not already qualify under subsections (a)(1) through (a)(9) of this Section.
   B. Has an MIUR greater than 17 percent.
   C. Licensed beds greater than 450.
   D. Average length of stay less than 4 days.

   Your hospital's total rate: **$0.00**

11. The hospital meets all of the following requirements:
   A. Does not already qualify under subsections (a)(1) through (a)(10) of this Section.
   B. Has an MIUR greater than 21 percent.
   C. Licensed beds greater than 350.
   D. Average length of stay less than 3.15 days.

   Your hospital's total rate: **$0.00**

12. The hospital meets all of the following requirements: A. Does not already qualify under subsections (a)(1) through (a)(11) of this Section. B. Has an MIUR greater than 34 percent. C. Licensed beds greater than 350. D. Is designated a perinatal level two center by the Illinois Department of Public Health. **Your hospital's total rate:**	**$0.00**
13. The hospital meets all of the following requirements: A. Does not already qualify under subsections (a)(1) through (a)(12) of this Section. B. Has an MIUR greater than 35 percent. C. Average length of stay less than 4 days. **Your hospital's total rate:**	**$0.00**
14. The hospital meets all of the following requirements: A. Does not already qualify under subsections (a)(1) through (a)(13) of this Section. B. Has a CMIUR greater than 25 percent. C. Has an MIUR greater than 12 percent. D. Is designated a perinatal level two center by the Illinois Department of Public Health. E. Licensed beds greater than 400. F. Average length of stay less than 3.5 days. **Your hospital's total rate:**	**$0.00**
15. The hospital has an MIUR greater than 90% in the safety net hospital base year:	**$0.00**
16. The hospital meets all of the following requirements: A. Does not already qualify under subsections (a)(1) through (a)(18) of this Section. B. Has a CMIUR greater than 28 percent. C. Is designated a perinatal level two center by the Illinois Department of Public Health. D. Licensed beds greater than 320. E. Average length of stay less than 3.1 days. **Your hospital's total rate:**	**$0.00**

1. Your hospital's total SNAP rate:	**$0.00**
2. Your hospital's total SNAP rate multiplied by 2 (Line 1 * 2):	**$0.00**
3. Your hospital's fiscal year 2000 total days:	**3,220**
4. Your hospital's total annual SNAP payments (Line 2 * Line 3):	**$0.00**

PLEASE NOTE: Your actual final payment amount may vary due to rounding.

Holy Family Medical Center **Des Plaines, IL**

TRAUMA CENTER ADJUSTMENT
For the Period of July 1, 2010 through June 30, 2011

Hospital Is Excluded By Rule.

TRAUMA CENTER	
1. Level I Trauma Center	**N/A**
2. Level II Rural Trauma Center	**N/A**
3. Level II Urban Trauma Center	**N/A**
4. Your hospital's State FY'09 trauma admissions:	**N/A**
LEVEL I TRAUMA CENTER ADJUSTMENT	
5. Mean Medicaid trauma admissions for all Level I trauma hospitals:	**86.39**
6. Your hospital's adjustment per Medicaid trauma admission: {If Line 4 = or > Line 5, then $21,365; if Line 4 < Line 5 then $14,165}	**N/A**
7. Your hospital's total Level I trauma center adjustment {Line 4 * Line 6}:	**N/A**
HOSPITALS LOCATED IN THE SAME CITY THAT ALTERNATE TRAUMA CENTER DESIGNATION IN THE STATE FISCAL YEAR	
8. Your hospital's adjustment per Medicaid trauma admission – general acute hospital:	**N/A**
9. Your hospital's adjustment per Medicaid trauma admission – children's hospital:	**N/A**
10. Your hospital's total trauma center adjustment {Line 4 * Line 8 or Line 9}:	**N/A**
LEVEL II RURAL TRAUMA CENTER ADJUSTMENT	
11. Your hospital's adjustment per Medicaid trauma admission:	**N/A**
12. Your hospital's total Level II Rural trauma center adjustment {Line 4 * Line 11}:	**N/A**
LEVEL II URBAN TRAUMA CENTER ADJUSTMENT	
13. Is your hospital located in a county with a level I trauma center? {If Yes, your hospital is not eligible}	**N/A**
14. Is your hospital located in a Health Professional Shortage Area (HPSA)?	**N/A**
15. Total trauma admissions for all Level II urban trauma hospitals:	**N/A**
16. Your hospital's Medicaid trauma admission percentage {Line 4 / Line 15}:	**N/A**
17. The mean Medicaid trauma admission percentage for all Level II urban trauma hospitals:	**N/A**
18. The mean (Line 17) plus one standard deviation for all Level II urban trauma hospitals:	**N/A**
19. Your hospital's adjustment per Medicaid trauma admission: {If Line 14 = Yes and Line 16 = or > Line 17 OR Line 14 = No and Line 16 = or > Line 18 then adjustment = $11,565}	**N/A**
20. Your hospital's total Level II urban trauma center adjustment {Line 4 * Line 19}:	**N/A**
TRAUMA CENTER ADJUSTMENT	
21. Your hospital's total trauma center adjustment {Line 7 + Line 10 + Line 12 + Line 20}:	**N/A**

NOTE: For the TCA, a Level I Trauma Center is any Illinois hospital designated by the Illinois Department of Public Health on July 1, 2010 as Level I or Level I-Pediatric. Quarterly payments may vary due to rounding.

Holy Family Medical Center **Des Plaines, IL**

REHABILITATION HOSPITAL ADJUSTMENT
For the Period of July 1, 2010 through June 30, 2011

Hospital Is Excluded By Rule.

1. Your hospital's CHAP base period rehabilitation inpatient admissions:	**N/A**
2. Your hospital's CHAP base period rehabilitation inpatient days:	**N/A**
3. Rehabilitation facility adjustment: {If Line 1 < 60 adjustment = $229,360; if = or > 60 adjustment = $527,528}	**N/A**
4. Adjustment per Medicaid rehabilitation inpatient admission:	**$4,215**
4. Rehabilitation treatment adjustment {Line 1 * Line 4 }:	**N/A**
6. Health Professional Shortage Area (HPSA) adjustment per day:	**N/A**
7. HPSA adjustment if located in a HPSA {Line 2 * Line 6}:	**N/A**
8. Your hospital's total RHA {Line 3 + Line 5 + Line 7}:	**N/A**

PLEASE NOTE: Your quarterly payments may vary due to rounding.

DIRECT HOSPITAL ADJUSTMENT
For the Period of July 1, 2010 through June 30, 2011

Hospital Statistics:

Your hospital's Health Service Area (HSA):	**7**
Your hospital's Medicaid inpatient utilization rate (MIUR):	**6.75%**
Your hospital's combined Medicaid inpatient utilization rate and Medicaid obstetrical inpatient utilization rate:	**23.73%**
Your hospital's fiscal year 1998 total days:	**2,398**
Your hospital's fiscal year 1998 total obstetrical care (OB) days:	**442**
Your hospital's fiscal year 1998 average length of stay (alos):	**3.21**

Qualifying Criteria:
(Children's, psychiatric, rehabilitation, and long term stay hospitals and hospitals operated by the University of Illinois are not eligible unless otherwise specified)

A. Hospital is located in HSA 6 and was eligible to receive the Direct Hospital Adjustment or the Supplemental CHAP adjustment as of July 1, 1999, and possessed an MIUR equal to or greater than the Illinois statewide mean as of July 1, 1999; or was a county-owned hospital as defined in *89 Illinois Administrative Code* Section 148.25(b)(1)(A) and possessed an MIUR equal to or greater than the Illinois statewide mean as of July 1, 1999: **NO**

Qualifying Hospital Base Rate:	Percent	No OB Rate	OB Rate
1. = or > Statewide Mean Combined MIUR:	37.11%	$69	$105
2. = or > Statewide Mean Combined MIUR plus one standard deviation:	56.61%	$105	$142
3. = or > Statewide Mean Combined MIUR plus one and a half standard deviations:	66.35%	$124	$160
4. = or > Statewide Mean Combined MIUR plus two standard deviations:	76.10%	$142	$179

Your hospital's base rate: **$0.00**

Add-on Rates:

County owned hospitals with more than 30,000 total days in fiscal year 1998:	**$0.00**
Qualifying hospitals, not county owned, with more than 30,000 total days in fiscal year 1998:	**$0.00**
Qualifying hospitals with more than 80,000 total days in fiscal year 1998:	**$0.00**
Qualifying hospitals with more than 4,500 obstetrical days in fiscal year 1998:	**$0.00**
Qualifying hospitals with more than 5,500 obstetrical days in fiscal year 1998:	**$0.00**
Qualifying hospitals with an MIUR greater than 74%:	**$0.00**
Qualifying hospitals with an average length of stay less than 3.9 days:	**$0.00**
Qualifying hospitals with MIUR > Statewide Mean plus one standard deviation, are designated a Perinatal Level 2 Center, and having one or more obstetrical graduate medical education programs as of July 1, 1999:	**$0.00**

Qualifying hospitals receiving payments under (A)(2) above with average length of stay less than 4 days:	**$0.00**
Qualifying hospitals receiving payments under (A)(2) above that have a MIUR > 60%:	**$0.00**
Qualifying hospitals receiving payments under (A)(4) above that have a MIUR > 70% and more than 20,000 days:	**$0.00**
Qualifying hospitals receiving payments under (A)(4) above that have a combined MIUR > 75% and more than 20,000 days, an average length of stay less than 5 days and, have at least one graduate medical program:	**$0.00**
Your hospital's total rate:	**$0.00**
B. Illinois hospital located outside of HSA 6 and possessed an MIUR greater than sixty percent, and an average length of stay less than ten days:	**NO**
Qualifying hospital base rate:	**$0.00**
Add-on rate for a qualifying hospital with more than 1,500 obstetrical days in fiscal year 1998:	**$0.00**
Your hospital's total rate:	**$0.00**
C. Hospital is recognized as a children's hospital, as defined in *89 Illinois Administrative Code* Section 149.50(c)(3) on July 1, 1999:	**NO**
Qualifying hospital base rate:	**$0.00**
Add-on rates:	
Qualifying hospital located in Illinois, outside of HSA 6, with an MIUR greater than 60%:	**$0.00**
Qualifying hospital located in Illinois, within HSA 6, with an MIUR greater than 80%:	**$0.00**
Qualifying out-of-state hospital with an MIUR greater than 45% and:	
Less than 4,000 total days:	**$0.00**
Greater than 4,000 but less than 8,000 total days:	**$0.00**
Greater than 8,000 total days:	**$0.00**
Qualifying hospital with more than 3,200 total admissions in fiscal year 1998:	**$0.00**
Your hospital's total rate:	**$0.00**
D. Hospital located in Illinois that is a major teaching hospital with more than forty graduate medical education programs as of July 1, 1999, which does not qualify under criteria A, B, or C above:	**NO**
Qualifying hospital base rate:	**$0.00**
Add-on rates:	
Qualifying hospital with an MIUR between 18% and 19.75%:	**$0.00**
Qualifying hospital with an MIUR equal to or greater than 19.75%:	**$0.00**
Qualifying hospital with a combined MIUR equal to or greater than 35%:	**$0.00**
Your hospital's total rate:	**$0.00**

E. Hospital located in Illinois that had an MIUR equal to or greater than the statewide mean plus one-half standard deviation as of July 1, 1999, provided more than 15,000 total days in fiscal year 1998, and which does not qualify under criteria A, B, C or D above:	**NO**
Qualifying hospital base rate:	**$0.00**
F. Hospital that had an MIUR greater than 40 percent as of July 1, 1999, provided more than 7,500 days in fiscal year 1998, provided obstetrical care as of July 1, 2001, and which does not qualify under A, B, C, D or E above:	**NO**
Qualifying hospital base rate:	**$0.00**
G. Illinois teaching hospital with 25 or more graduate medical education programs on July 1, 1999, that is affiliated with a Regional Alzheimer's Disease Assistance Center as designated by the Alzheimer's Disease Assistance Act, that had an MIUR less than 25 percent on July 1, 1999, and provided 75 or more Alzheimer days for patients diagnosed as having disease:	**NO**
Qualifying hospital with an MIUR greater than 19.75%:	**$0.00**
Qualifying hospital with an MIUR equal to or less than 19.75%:	**$0.00**
Qualifying hospital base rate:	**$0.00**
H. Hospital that does not qualify under sections A, B, C, D, E, F, or G above, and had an MIUR greater than 50 percent on July 1, 1999:	**NO**
Qualifying hospital base rate:	**$0.00**
I. Hospital that does not qualify under sections A, B, C, D, E, F, G or H above, and had an MIUR greater th four days, provided more than 4,200 total days and provided 100 or more Alzheimers days for patients diagnosed as having the disease.	**NO**
Qualifying hospital base rate:	**$0.00**
1 Your hospital's total DHA rate:	**$0.00**
2 Your hospital's fiscal year 1998 total days:	**2,398**
3 Your hospital's annual DHA payment {Line 1 * Line 2}:	**$0.00**

Holy Family Medical Center **Des Plaines, IL**

RURAL CRITICAL HOSPITAL ADJUSTMENT PAYMENTS
For the Period of July 1, 2010 through June 30, 2011

Hospital Is Excluded By Rule.

	FY'09 Admits	RCHAP Multiplier	Total RCHAP
1. Your hospital's CHAP base period obstetrical care admissions:	**N/A**	$1,367	**N/A**
2. Your hospital's CHAP base period general care admissions:	**N/A**	$138	**N/A**
3. The greater of Line 1 or Line 2:			**N/A**
4. Maximum number of obstetrical care admissions for all hospitals:			**N/A**
5. Your hospital's total RCHAP {Line 3 plus Line 4}:			**N/A**

PLEASE NOTE: Your quarterly payment may vary due to rounding.

Tertiary Care Adjustment Payments
For the Period of July 1, 2010 through June 30, 2011

Case Mix Index Adjustment for DRG Reimbursed Hospitals Illinois hospitals that have 100 or more admissions and have a case mix that is greater than or equal to the mean for Illinois hospitals.	**NO**	
Out of State hospitals that have 100 or more admissions and have a case mix that is greater than or equal to the mean for Out of State hospitals.	**NO**	**$0.00**
DRG Adjustment for DRG Reimbursed Hospitals Hospital claims which group to a DRG that had a DRG weight Greater than 3.200 and less than 200 admissions for all hospitals.	**YES**	**$40,830.00**
Children's Hospital Adjustment A children's hospital as defined in 89 IL Adm. Code 149.50(c)(3).	**NO**	**$0.00**
Primary Care Adjustment Hospital located in Illinois that has primary care residents.	**NO**	**$0.00**
Long Term Stay Hospital Adjustment A long term stay hospital as defined in 89 IL Adm. Code 149.50(c)(4)	**NO**	**$0.00**
Rehabilitation Hospital Adjustment An Illinois rehabilitation hospital as defined in 89 IL Adm. Code 149.50(c)(2)	**NO**	**$0.00**

Total Tertiary Care Adjustment Payments	**$40,830.00**
FY 2011 Adjustment Factor	**0.455**
Total Annual Tertiary Care Adjustment Payments	**$18,578.00**

PLEASE NOTE: Your actual final payment amount may vary due to rounding.

Case Mix Index Adjustment
For the Period of July 1, 2010 through June 30, 2011

Hospital Statistics:

Your hospital's qualified admissions:	**328**
Your hospital's case mix index:	**0.7575**
Your hospital's DRG base rate:	**$4,021.70**
Your hospital's capital rate:	**$469.60**

Case Mix Index

	Illinois Hospitals	Out of State Hospitals
Mean:	0.8016	1.2025
Equal to or greater than the Mean plus 1 Standard Deviation:	0.9989	1.6051
Equal to or greater than the Mean plus 2 Standard Deviations:	1.1962	2.0077

Case Mix Index Adjustment Factor

	Illinois Hospitals	Out of State Hospitals
Equal to or greater than the Mean:	0.04	0.02
Equal to or greater than the Mean plus 1 Standard Deviation:	0.25	0.125
Equal to or greater than the Mean plus 2 Standard Deviations:	0.3	0.15

Case Mix Index Rates

A. Total per admit rate (((Hospital DRG base rate * CMI)*CMI)+ Hospital Specific capital rate)	**$2,777.28**
B. Qualified admits in base period * Per Admit Rate	**$910,947.00**
C. Applicable Case Mix Adjustment Factor	**0.00**
D. Adjusted CMI Annual Tertiary Adjustment (C * B)	**$0.00**

DRG Adjustments
For the Period of July 1, 2010 through June 30, 2011

DRG codes with a Medicaid relative weight factor greater than 3.200 and less than 200 Medicaid admissions during the Tertiary Adjustment Base Period.

Your hospital's admissions for the qualifying D.R.G.s and the resulting adjustment is listed below:

DRG Code	(A) Relative Weight	(B) (C) Total Admits	Hospital DRG Base Rate	(D) Total Adjustment (B*(C*(A*1.4)))
104	6.9288	**0**	$4,021.70	**$0.00**
105	4.6093	**0**	$4,021.70	**$0.00**
108	3.9654	**0**	$4,021.70	**$0.00**
191	3.5352	**1**	$4,021.70	**$19,905.00**
302	3.2752	**0**	$4,021.70	**$0.00**
471	3.7165	**1**	$4,021.70	**$20,925.00**
472	9.6547	**0**	$4,021.70	**$0.00**
473	3.7198	**0**	$4,021.70	**$0.00**
484	4.6032	**0**	$4,021.70	**$0.00**
485	3.2039	**0**	$4,021.70	**$0.00**
486	4.1058	**0**	$4,021.70	**$0.00**
Total of DRG Specific Adjustments				**$40,830.00**

Children's Hospital Adjustments
For the Period of July 1, 2010 through June 30, 2011

A. Your hospital is a children's hospital as defined in 89 IL Adm. Code 149.50(c)(3) **NO**

B. Your hospital's qualifying days: **0**

C. Your hospital's rate: **$0.00**

$670.00 for Illinois hospitals with greater than 5,000 days, or
Out of State hospitals with greater than 1,000 days.
$300.00 for Illinois hospitals with 5,000 or fewer days, or
Out of State hospitals with 1,000 or fewer days.

D. Your hospital's annual children's hospital adjustment: **$0.00**

Primary Care Adjustments
For the Period of July 1, 2010 through June 30, 2011

A. Your hospital is located in Illinois	**YES**
B. Number of primary care residents as reported on the HCFA Form 2552-96, Worksheet E-3, Part IV, Line 1, column 1, for hospital fiscal years ending September 30, 1997, through September 29, 1998 used in the fiscal year 2002 Tertiary Care Adjustment Rate Period.	**0.00**
C. Your hospital's qualifying admissions:	**328**
D. Rate per admission:	**$1,533,400.00**
E. Admits * Rate (C * D).	
F. Primary Care residents divided by admissions (B / C).	**0**
G. Primary Care Adjustment annual amount (E * F).	**$0.00**

Long Term Stay Hospital Adjustments
For the Period of July 1, 2010 through June 30, 2011

A. Your hospital is a long term stay hospital as defined in 89 IL Adm. Code 149.50(c)(4):	**NO**
B. Your hospital's case mix index:	**0.0000**
C. Case mix index mean for all long term stay hospitals:	**1.124349**
D. Case mix index mean plus one standard deviation for all long term stay hospitals:	**1.515802**
E. Your hospital's inpatient days:	**0**
F. Your hospital's rate: $3000.00 for providers with a case mix index greater than or equal to the mean plus one standard deviation. $5.00 for providers with a case mix greater than the mean, and less than the mean plus one standard deviation.	**$0.00**
G. Your hospital's annual adjustment amount:	**$0.00**

Rehabilitation Hospital Adjustments
For the Period of July 1, 2010 through June 30, 2011

A. Your hospital is a rehabilitation hospital as defined in 89 IL Adm. Code 149.50(c)(2) and qualify for payments under the rehabilitation hospital adjustment program as defined in 89 IL Adm. Code 148.295(b).	**NO**
B. Your hospital's Medicaid level I rehab admissions occurring during the fiscal year 2001 CHAP rate period as defined in 89 IL Adm. Code 148.295.	**0**
C. Your hospital's annual adjustment amount: ($100,000.00 for less than 60 Medicaid level I admissions) ($350,000.00 for 60 or greater Medicaid level I admissions)	**$0.00**

Holy Family Medical Center **Des Plaines, IL**

PEDIATRIC OUTPATIENT ADJUSTMENT PAYMENT
For the Period of July 1, 2010 through June 30, 2011

Hospital Is Excluded By Rule.

1. Childrens Hospital:	**N/A**
2. Your hospital's FY96 Pediatric Adjustable Outpatient Services for Children less than18 years of age:	**N/A**
3. Your hospital's FY96 Total Pediatric Adjustable Outpatient Services:	**N/A**
4. Your hospital's Pediatric Medicaid Outpatient Percentage {Line 2 / Line 3}: (must be greater than 80% to qualify for payment)	**N/A**
5. Your hospital's Medicaid Inpatient Utilization Rate (MIUR):	**N/A**
6. Adjustment Multiplier (if line 4 > 80%): For IL hospital's with a MIUR < 75% = MIUR + 1 For IL hospitals with a MIUR = or > 75% = (MIUR * 1.5) + 1 For Out of State hospitals with a MIUR < 75% = MIUR + 1.15	**N/A**
7. Pediatric Adjustable Outpatient Adjustment { Line 3 * Line 6 * $169}	**N/A**
8. Additional Adjustment {If Line 5 > 80% }:	**N/A**
9. Total Pediatric Outpatient Adjustment Payment {Line 7 + Line 8}:	**N/A**

PLEASE NOTE: The calculations above and actual quarterly payments may vary due to rounding.

Holy Family Medical Center **Des Plaines, IL**

PEDIATRIC INPATIENT ADJUSTMENT PAYMENT
For the Period of July 1, 2010 through June 30, 2011

Hospital Is Excluded By Rule.

1. Hospital that was licensed by a municipality as a children's hospital on or before December 31, 1997:	**N/A**
2. FY97 Psychiatric Days for children under 18 years of age:	**N/A**
3. FY97 Rehabilitation Days for children under 18 years of age:	**N/A**
4. Total FY97 Psychiatric and Rehabilitation days {Line 2 + Line 3}*:	**N/A**
5. Pediatric Inpatient Adjustment Payment per day multiplier:	**$816**
6. Total Pediatric Inpatient Adjustment Payment in accordance with 148.298(a): {Line 4 * Line 5}	**N/A**

*Total psychiatric and rehabilitation days {Line 4} may not exceed 850 days.

7. Children's Hospital:	**N/A**
8. FY99 total Medicaid days *:	**N/A**
9. Pediatric Inpatient Adjustment Payment per day multiplier:	**$113**
10. Total Pediatric Inpatient Adjustment Payment in accordance with 148.298(b): {Line 8 * Line 9}	**N/A**

* Excludes Medicare crossover days.

11. Total Pediatric Inpatient Adjustment Payment {Line 6 + Line 10}:	**N/A**

PLEASE NOTE: The calculations above and actual quarterly payments may vary due to rounding.