This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-1318 Worksheet S Peri od: From 10/01/2022 Parts I-III AND SETTLEMENT SUMMARY 09/30/2023 Date/Time Prepared: 2/20/2024 3:03 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 2/20/2024 3: 03 pm] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by OSF HOLY FAMILY MED CTR (14-1318) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1	2	SIGNATURE STATEMENT	
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

		Title	XVIII			
	Title V	Part A	Part B	HI T	Title XIX	
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1. 00 HOSPI TAL	0	41, 815	486, 176	0	0	1.00
2. 00 SUBPROVI DER - I PF	0	0	0		0	2.00
3. 00 SUBPROVI DER - I RF	0	0	0		0	3.00
5.00 SWING BED - SNF	0	125, 025	0		0	5.00
6.00 SWING BED - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		54, 885		0	10.00
10. 01 RURAL HEALTH CLINIC II	0		20, 256		0	10.01
200. 00 TOTAL	0	166, 840	561, 317	0	0	200.00

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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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 the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

позет і	AL AND HOSPITAL HEALTH CARE COMPLEX	Provid		N. 14-1316		rom 10/01/2022 Part I To 09/30/2023 Date/Time Pre 2/20/2024 3:0				
	1.00	2.00		3. 00			4. 00			
1. 00 2. 00	Hospital and Hospital Health Care Co Street: 1000 WEST HARLEM AVENUE City: MONMOUTH	omplex Address: PO Box: State: IL	Zip Cod	le: 614	62 Cou	nty: WARREN				1. 00 2. 00
		Component Name	CCN Number	CBS Numb				nt Syst O, or XVIII	N)	
		1. 00	2.00	3.0	00 4.00	5. 00	6.00	7. 00	8. 00	
3. 00 4. 00 5. 00 6. 00 7. 00	Hospital and Hospital-Based Componer Hospital Subprovider - IPF Subprovider - IRF Subprovider - (Other) Swing Beds - SNF	nt Identification: OSF HOLY FAMILY MED CTR OSF HOLY FAMILY SWING	141318 14Z318	999		05/01/2002		0	P	3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Swing Beds - NF Hospital -Based SNF Hospital -Based NF Hospital -Based OLTC Hospital -Based HHA Separately Certified ASC Hospital -Based Hospice Hospital -Based Health Clinic - RHC Hospital -Based Health Clinic - RHC	BEDS OSF HOLY FAMILY CLINICS OSF ROSEVILLE RHC	143461 148621	999		02/05/2003 02/18/2021		0 0	N N	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01
16. 00 17. 00 18. 00 19. 00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I Renal Dialysis Other									16. 00 17. 00 18. 00 19. 00
From: To: 1.00 2.00										
	20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2022 09/30/2023					20.00				
					1. 00	2.00		3. (00	
	Inpatient PPS Information									
22. 00							22.00			
22. 01	Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or cost reporting period occurring on c instructions)	n column 1, "Y" for yes on ng period occurring prior ""N" for no for the port	or "N" fo to Octo	r no ber	N	N				22. 01
	Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in for the portion of the cost reportir	? (see instructions) Ent ne portion of the cost re column 2, "Y" for yes or ng period on or after Oct	er in co eporting "N" for cober 1.	no,	N	N				22. 02
22. 03	for the portion of the cost reporting period on or after October 1. O3 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period 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) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for						22. 03			
22. 04	yes or "N" for no.						22. 04			
23. 00	which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, enter	of admission, 2 if censu of identifying the days method used in the prior	is days, in this cost	or 3		0				23.00

"N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems OSF HOLY FAMILY MED CTR In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1318 Peri od: Worksheet S-2 From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/20/2024 3: 03 pm | XVIII | XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME IME Direct GME 1. 00 2.00 3. 00 4. 00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61 02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 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) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 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. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 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. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	OSF HO	LY FAMILY MED CTR		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: rom 10/01/2022	Worksheet S-2 Part I Date/Time Pre	
			Unweighted	Unwei ghted	2/20/2024 3:0 Ratio (col.	3 pm
			FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col . 1 + col . 2))	
			1.00	2. 00	3. 00	
Section 5504 of the ACA Base Yea			This base year	is your cost	reporti ng	
period that begins on or after of 64.00 Enter in column 1, if line 63 is in the base year period, the number resident FTEs attributable to resident FTEs that trained in your of (column 1 divided by (column).	s yes, or your faciliaber of unweighted now tations occurring in a number of unweighted our hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64. 00
je: (ee: a	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
(5.00 5.1	1. 00	2. 00	3. 00	4. 00	5. 00	45.00
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. 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)			0.00	0.00	0.000000	65. 00
			FTEs	FTEs in	1/ (col. 1 +	
			Nonprovider Site	Hospi tal	col. 2))	
			1.00	2. 00	3. 00	
Section 5504 of the ACA Current		n Nonprovider Setting				
beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima occurring in all nonpo unweighted non-prima cal. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. 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)			0.00	0. 00	0. 000000	67. 00

Health Financial Systems OSF HOLY FAMILY MED CTR In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1318 Peri od: Worksheet S-2 From 10/01/2022 Part I Date/Time Prepared: 09/30/2023 2/20/2024 3:03 pm 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 68.00 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your 68.00 MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)? 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 71.00 | If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) 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 or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for 76.00 0 76.00 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 or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. N 80.00 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 "Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87.00 N 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Adiustment Permanent (Y/N)Adjustments 1.00 2.00 88. 00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target Ν amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments Effecti ve Wkst. A Line Approved Date Permanent No. Adjustment Amount Per Di scharge 3. 00 2.00 1.00 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0 00 0 89 00 on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per di scharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90.00 Ν Υ yes or "N" for no in the applicable column. 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. 91.00 Ν 91.00 Ν Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 96.00 Ν Ν 96.00 applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97.00 0.00 0.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Drovi don C	CN: 14-1318	Period:	u of Form CMS Worksheet S	
NOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	1	From 10/01/2022 From 09/30/2023	Part I Date/Time P	repared
			V	2/20/2024 3 XI X	:03 pm
			1.00	2.00	\dashv
98.00 Does title V or XIX follow Medicare (title XVIII) for the i	nterns and res	sidents post	N N	N N	98.0
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.	for yes or "N'	'for no in			
P8. 01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.				Y	98.0
Does title V or XIX follow Medicare (title XVIII) for the combed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes			N	Y	98.0
for title V, and in column 2 for title XIX. 18.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y			N	N	98.0
for title V, and in column 2 for title XIX. 18.04 Does title V or XIX follow Medicare (title XVIII) for a CAP- outpatient services cost? Enter "Y" for yes or "N" for no i			N	N	98.0
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in	ack the RCE di	sallowance on	N	Υ	98.0
column 2 for title XIX. 08.06 Does title V or XIX follow Medicare (title XVIII) when cost	reimbursed fo	or Wkst. D,	N	N	98.0
Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX. Rural Providers	nn 1 for title	V, and in			
105.00 Does this hospital qualify as a CAH?			Y		105.0
106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		. ,	t N		106.0
07.00 Column 1: If line 105 is Y, is this facility eligible for a training programs? Enter "Y" for yes or "N" for no in colum Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded I	nn 1. (see ins you train I&F PF and/or IRF	structions) Rs in an			107. (
Enter "Y" for yes or "N" for no in column 2. (see instruct 108.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		edul e? See 42	N		108. (
	Physi cal	Occupati onal	Speech	Respi rator	у
	1. 00	2. 00	3. 00	4. 00	
09.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	Y	N	N	N	109. (
for yes or "N" for no for each therapy.					
				1.00	
	"Y" for yes or	"N" for no.	lf yes,	1. 00 N	110.
10.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo	"Y" for yes or	"N" for no.	lf yes,		110.
10.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Woapplicable.	"Y" for yes or orksheet E-2, I the Frontier (cost reporting column 1 is Y, articipating in	Community period? Enter enter the column 2.	If yes, ugh 215, as 1.00	N	
 10.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for a 	"Y" for yes or orksheet E-2, I the Frontier (cost reporting column 1 is Y, articipating in	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ugh 215, as	N 2. 00	
10.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.	"Y" for yes or brksheet E-2, I the Frontier (cost reporting column 1 is Y, articipating in additional beds	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ugh 215, as 1.00	N	111.
 10.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for a for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost in period? Enter "Y" for yes or "N" for no in column 1. If contact the community of the current cost in period? Enter "Y" for yes or "N" for no in column 1. 	"Y" for yes or prksheet E-2, I the Frontier (cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ugh 215, as	N 2. 00	111.
 10.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for a for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital ceparticipation in the demonstration, if applicable. 	"Y" for yes on prksheet E-2, I the Frontier (cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is pating in the	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ugh 215, as	N 2. 00	111.
10.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is participate in the Pennsyl vania Rural Health apply: "A" for Ambulance services; "B" for a for tele-health services. 12.00 Did this hospital participate in the Pennsyl vania Rural Health (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began participate in the date the hospital comparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes condumn 1. If column 1 is yes, enter the method used (A, in column 2. If column 1 is yes, enter in column 3 either "for short term hospital or "98" percent for long term care	"Y" for yes on orksheet E-2, I the Frontier (cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is pating in the beased or "N" for no B, or E only) 93" percent (includes	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ugh 215, as	N 2. 00	111.
 10.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demoin which this CAH is participate all that apply: "A" for Ambulance services; "B" for a for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Head (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If of "Y", enter in column 2, the date the hospital began particity demonstration. In column 3, enter the date the hospital context participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub.15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" 	"Y" for yes on orksheet E-2, I the Frontier (cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is pating in the eased or "N" for no B, or E only) '93" percent (includes ers) based on	Community period? Enter enter the column 2. s; and/or "C"	If yes, ugh 215, as	N 2. 00	111.0
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to continuous integration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for a for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If column 2, the date the hospital began participation. In column 3, enter the date the hospital coparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes continuous in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provides.	"Y" for yes on orksheet E-2, In the Frontier (cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is pating in the eased or "N" for no B, or E only) '93" percent (includes ers) based on the for yes or	Community period? Enter enter the column 2. s; and/or "C"	If yes, ugh 215, as	N 2. 00	0115.0

Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 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. 121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	pm
Premiums Losses Insurance	18. 01 18. 02 19. 00 20. 00 21. 00 22. 00
118. 01 List amounts of malpractice premiums and paid losses: 7, 091 1.00 2.00 118. 02 Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 19. 00 DO NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA S3121 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 S3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121. 00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	18. 02 19. 00 20. 00 21. 00 22. 00
118. 01 List amounts of malpractice premiums and paid losses: 7, 091 1.00 2.00 118. 02 Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 19. 00 DO NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA S3121 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 S3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121. 00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	18. 02 19. 00 20. 00 21. 00 22. 00
118. 01 List amounts of mal practice premiums and paid losses: 7, 091 1.00 2.00 118. 02 Are mal practice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 19. 00 DO NOT USE THIS LINE 120. 00 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. 121. 00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	18. 02 19. 00 20. 00 21. 00 22. 00
118.02 Are mal practice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 DNOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA S3121 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. 121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	18. 02 19. 00 20. 00 21. 00 22. 00
118.02 Are mal practice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 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. 121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	19. 00 20. 00 21. 00 22. 00
Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 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. 121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	19. 00 20. 00 21. 00 22. 00
120.00 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. 121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	20. 00 21. 00 22. 00
121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	22. 00
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2	23. 00
the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase professional Services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y"	
for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	
Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes N 1	25. 00
and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	24 00
126.00 If this is a Medicare-certified kidney transplant program, enter the certification date 1 1 1 1 1 1 1 1 1	26. 00
127.00 If this is a Medicare-certified heart transplant program, enter the certification date 1 1 1 1 1 1 1 1 1	27. 00
128.00 If this is a Medicare-certified liver transplant program, enter the certification date 1 1 1 1 1 1 1 1 1	28. 00
129.00 If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.	29. 00
130.00 If this is a Medicare-certified pancreas transplant program, enter the certification 1	30.00
	31. 00
	32.00
in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 1	33. 00
134.00 If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. All Providers	34.00
140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, Y HB1728 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)	40. 00
1.00 2.00 3.00 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.	
141.00 Name: OSF HEALTHCARE SYSTEM Contractor's Name: WPS Contractor's Number: 05901 1	41.00
	42. 00 43. 00
1.00 1.44.00 Are provider based physicians' costs included in Worksheet A? Y 1	44. 00
1.00 2.00	
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting	45. 00
period? Enter "Y" for yes or "N" for no in column 2. 146.00Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	46. 00

Health Financial Systems	OSF HOLY							u of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENIIFICATION DATA		Provider CC	N: 14-1318	F	Peri od: From 10/01/2022 To 09/30/2023		Worksheet S- Part I Date/Time Pro 2/20/2024 3:	epared
								1.00	-
47.00Was there a change in the statist	ical basis? Enter "Y"	for ve	s or "N" for	no				N 1.00	147.0
148.00Was there a change in the order o								N N	148. 0
149.00 Was there a change to the simplif					for	no.		N	149.0
			Part A	Part	В	Ti	tle V	Title XIX	
			1. 00	2. 00			3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or									
55. 00 Hospi tal			N	N			N	N	155. C
56.00 Subprovi der - IPF			N	N			N	N	156. C
57.00 Subprovi der - I RF			N	N			N	N	157. 0
58. 00 SUBPROVI DER									158.0
59. 00 SNF			N	N			N	N	159.0
60.00 HOME HEALTH AGENCY 61.00 CMHC			N	N N			N N	N	160.0
61. ООЈСМИС				IN			IN	N	161.0
								1.00	
Multicampus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs?									165. C
Enter "Y" for yes or "N" for no.	N		0	CLIL	7.	0.1.	ODCA	ETE (O	
	Name O		County 1.00	State 2.00		Code 00	4. 00	FTE/Campus 5.00	+
66.00 If line 165 is yes, for each	0		1.00	2.00	J.	00	4.00		0166.0
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)									
								1.00	-
Health Information Technology (HI	T) incentive in the Am	neri can	Recovery an	d Rei nves	tment	t Act		1.00	
167.00 s this provider a meaningful use								Y	ີ∣167. 0
68.00 If this provider is a CAH (line 1				e 167 is	"Y"),	enter	the		168. 0
reasonable cost incurred for the					6.				140.0
68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)						a nard	sni p		168.0
69.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y")					N"), e	nter the	0.0	0169. 0
transition factor. (see firstructi	JIIS)					Rea	i nni ng	Endi ng	
							1.00	2.00	1
70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and end	li ng da	te for the r	eporti ng					170. C
H							1.00	2.00	
171.00 fline 167 is "Y", does this pro	vider have any days fo	r indi	vi dual s opro	lladin			N . 00	2. 00	0171.0
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, umn 1. If column 1 is j	Pt. I,	, line 2, co	I. 6? Ent		1	IN		0171.0

Health Financial Systems OSF HOLY FAMILY MED CTR In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-1318 Peri od: Worksheet S-2 From 10/01/2022 Part II Date/Time Prepared: 09/30/2023 2/20/2024 3:03 pm Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column $\hat{\textbf{3}},$ "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management 3.00 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) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 12.00 Υ If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting 13.00 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? N N 16.00 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) Was the cost report prepared using the PS&R Report for 17.00 Υ 12/13/2023 Υ 12/13/2023 17.00 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) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 Ν 18.00 N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

HUSPI I	n Financial Systems OSF HOLY FAMI TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 14-1318	Peri od: From 10/01/2022	wof Form CMS Worksheet S Part II	
				To 09/30/2023		
		Descr	i pti on	Y/N	Y/N	
		1	0	1.00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1. 00	2. 00	3.00	4. 00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS	HOSPI TALS)			
22 00	Capital Related Cost				V	
22.00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense			cina the cost	Y N	22. 00 23. 00
23.00	reporting period? If yes, see instructions.	due to apprai	Sai S illaue uui	Trig the cost	IN	23.00
24. 00	. 9.	ed into during	this cost re	eporting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during	the cost repo	rting period	? If yes, see	N	25.00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	ne cost report	ina period?	lf ves. see	N	26.00
	instructions.	·	3 1			
27. 00	сору.	N	27. 00			
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	N	28.00			
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	N	29.00			
	treated as a funded depreciation account? If yes, see instr	,				
30. 00	Has existing debt been replaced prior to its scheduled matuinstructions.	s, see	N	30.00		
31. 00	Has debt been recalled before scheduled maturity without is instructions.	s, see	N	31.00		
32 00	Purchased Services Have changes or new agreements occurred in patient care ser	rvi cas furni sh	ed through co	ontractual	Υ	32.00
	arrangements with suppliers of services? If yes, see instru	uctions.	-			
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 applino, see instructions.	olied pertaini	ng to competi	itive bidding? If	f N	33.00
	Provi der-Based Physi ci ans					
34. 00	Were services furnished at the provider facility under an a	arrangement wi	th provider-l	pased physicians?	Y	34.00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	sting agreeme	nts with the	provi der-based	Υ	35.00
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Data	
				1.00	2. 00	
	Home Office Costs			00	2.00	
	Were home office costs claimed on the cost report?			Υ		36.00
37. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office	? Y		37.00
38. 00				f N		38. 00
	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other			s, N		39.00
39. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40.00
	It fille so is yes, and the provider reliaer services to the					
	instructions.					
		1.	00	2.	00	
40. 00	instructions. Cost Report Preparer Contact Information		00		00	
40. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	1. PATRI CI A	00	RACHELL	00	41.00
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		00		00	41.00
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	PATRI CI A	00			

Heal th F	Financial Systems	OSF HOLY	FAMI LY	MED CTR		In Lieu	u of Form CMS-	2552-10
HOSPI TAI	L AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provi der	CCN: 14-1318	09/30/2023	Worksheet S-2 Part II Date/Time Pre 2/20/2024 3:0	pared:
					3. 00			
C	Cost Report Preparer Contact Information							
41. 00 E	Enter the first name, last name and the t	itle/position	MAN	NAGING DIR	RECTOR			41.00
	neld by the cost report preparer in colum	ns 1, 2, and	3,					
r	respecti vel y.							
42. 00 E	Enter the employer/company name of the co	st report						42.00
Jr.	oreparer.							
43. 00 E	Enter the telephone number and email addr	ess of the co	st					43.00
r	report preparer in columns 1 and 2, respe	cti vel y.						

Health Financial Systems OSF HOL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 10/01/2022 | Part I | Date/Time | Prepared: | Date/Time | Prepared: | Part | Prepared: | Part | Prepared: | Part | Provider CCN: 14-1318

					1	To 09/30/2023	Date/Time Pre 2/20/2024 3:0	
							1/P Days /	3 piii
							0/P Visits /	
							Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		15	5, 475	18, 720. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
2 00	for the portion of LDP room available beds)							2.00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider							2.00 3.00
4. 00	HMO IRF Subprovider							4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7. 00	Total Adults and Peds. (exclude observation			15	5, 475	18, 720. 00	0	7.00
7.00	beds) (see instructions)			10	0, 170	10,720.00	O	7.00
8.00	INTENSIVE CARE UNIT		İ					8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT		İ					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14.00	Total (see instructions)			15	5, 475	18, 720. 00	0	14.00
15.00	CAH visits						0	15.00
15. 10	REH hours and visits							15. 10
16. 00	SUBPROVIDER - IPF							16. 00
17. 00	SUBPROVIDER - IRF							17.00
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19. 00 20. 00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE							20.00
22. 00	HOME HEALTH AGENCY							22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24. 00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30.00						24. 10
25. 00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC	88. 00	İ				0	26. 00
26. 01	RURAL HEALTH CLINIC II	88. 01	İ				0	26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00	ĺ				0	26. 25
27.00	Total (sum of lines 14-26)		ĺ	15				27.00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			0	(O		32.00
32. 01	Total ancillary labor & delivery room							32. 01
22.00	outpatient days (see instructions)							22.00
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges							33. 00 33. 01
	Temporary Expansion COVID-19 PHE Acute Care	30.00		0	(0	
54.00	Trainportary Expansion Covid-17 THE Acute Care	30.00	1	Ч		1	O	J J 7. 00

Provider CCN: 14-1318

					-	2/20/2024 3:0	3 pm
		I/P Days	s / O/P Visits	/ Tri ps	Full Time I	Equi val ents	
		T	T				
	Component	Title XVIII	Title XIX	Total All	Total Interns		
		6. 00	7. 00	Patients 8.00	& Residents 9.00	Payrol I 10.00	
	PART I - STATISTICAL DATA	6.00	7.00	8.00	9.00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	385	18	703		I	1.00
1.00	8 exclude Swing Bed, Observation Bed and	300	10	703			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	192	76				2.00
3.00	HMO IPF Subprovider	0	0	•			3.00
4. 00	HMO IRF Subprovider	0	0	1			4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	496	0				5.00
6.00	Hospital Adults & Peds. Swing Bed NF		5	125			6.00
7. 00	Total Adults and Peds. (exclude observation	881	23	•			7.00
	beds) (see instructions)			,			
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	881	23	1, 668	0.00	104. 79	14.00
15.00	CAH vi si ts	0	0	0			15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC	5 004	0 (50	00.404	0.00	40.40	25.00
26.00	RURAL HEALTH CLINIC	5, 924	8, 659				1
26. 01	RURAL HEALTH CLINIC II	587	523				
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00	Total (sum of lines 14-26)		71	204	0.00	151. 13	
28. 00	Observation Bed Days		71	384			28. 00 29. 00
29. 00 30. 00	Ambulance Trips	0		0			30.00
31.00	Employee discount days (see instruction) Employee discount days - LRF						31.00
32.00	Labor & delivery days (see instructions)	0	0				32.00
32. 00	Total ancillary labor & delivery room		0				32.00
3Z. UI	outpatient days (see instructions)			١			32.01
33. 00	LTCH non-covered days	٨					33.00
33. 01	LTCH site neutral days and discharges						33.00
	Temporary Expansion COVID-19 PHE Acute Care	l o	0	0			34.00
31.00	1. Simpo. a. J. Expansion oovid 17 The Moute out	١	O		I .	I	, 51. 55

Health Financial Systems OSF HOL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-1318

				10	0 09/ 30/ 2023	2/20/2024 3: 0	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	DADT I CTATICTICAL DATA	11. 00	12. 00	13. 00	14. 00	15. 00	
1 00	PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and		0	130	6	231	1. 00
1. 00	8 exclude Swing Bed, Observation Bed and		U	130	٥	231	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			51	o		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
8. 00	I NTENSI VE CARE UNI T						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						11. 00 12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	0	130	6	231	14. 00
15. 00	CAH visits	0.00	O	130	J	231	15. 00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23. 00	` '						23. 00
24. 00 24. 10	HOSPICE						24. 00 24. 10
25. 00	HOSPICE (non-distinct part) CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0.00					26.00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00		0.00					27. 00
28.00							28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00							32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33.00	1			0			33.00
33. 01	LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care						33. 01 34. 00
54.00	Transportatly Expansion Covid-19 File Acute Cale	ı I		ı	I	ı	34.00

Heal th	Financial Systems	OSF HOLY FAM	IIY MED CTR		In lie	u of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 14-1318	Peri od:	Worksheet S-	
			Component	CCN: 14-3461	From 10/01/2022 To 09/30/2023	Date/Time Pro 2/20/2024 3:	
					RHC I	Cost	JS PIII
					1.	00	
	Clinic Address and Identification						
1. 00	Street) c:	+.,	1000 W. HARLEM		1.00
				00	State 2.00	ZIP Code 3. 00	
2. 00	City, State, ZIP Code, County		MONMOUTH 1.	00		61462	2.00
2.00	jointy, otato, zii oodo, oodinty		photonoo III			01102	2.00
						1. 00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for				3.00
					nt Award	Date	
	Source of Federal Funds				1. 00	2. 00	
4. 00	Community Health Center (Section 330(d), PHS	Act)					4.00
5. 00	Migrant Health Center (Section 329(d), PHS A						5.00
6. 00	Health Services for the Homeless (Section 34						6.00
7.00	Appalachian Regional Commission						7. 00
8.00	Look-Al i kes						8. 00
9. 00	OTHER (SPECIFY)						9. 00
					1. 00	2. 00	
10. 00	Does this facility operate as other than a h	osni tal -hased	RHC or FOHC2 F	nter "Y" for			10.00
10.00	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of	other operatio	ns in column			10.00
		Sun	nday	N	londay	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3. 00	4. 00	5. 00	
11 00	Facility hours of operations (1)			07.00	10.00	07. 00	11 00
11.00	CLINIC			07: 00	18: 00	07: 00	11.00
					1.00	2. 00	
12. 00	Have you received an approval for an excepti	on to the prod	uctivity stand	ard?	N		12.00
13. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	umn 1. If yes,	enter in colu	mn 2 the	N	(13.00
	number of providers included in this report. numbers below.	LIST the name	s of all provi	uers anu			
	Trumber 3 berow.			Prov	ider name	CCN	
					1. 00	2. 00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N	V 2.00	XVIII	XIX	Total Visits	
15. 00	Have you provided all or substantially all	1. 00	2.00	3. 00	4. 00	5. 00	15.00
15.00	GME cost? Enter "Y" for yes or "N" for no in						15.00
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)		Col	l inty			
				00			
2. 00	City, State, ZIP Code, County		WARREN				2.00
		Tuesday	Wedn	esday	Thur	sday	
		to	from	to	from	to	
		6. 00	7. 00	8. 00	9. 00	10. 00	
11 00	Facility hours of operations (1)	10.00	07.00	10.00	07.00	10.00	11 00
11.00	CLINIC	18: 00	07: 00	18: 00	07: 00	18: 00	11.00

Health Financial Systems	OSF HOLY FAM	LY MED CTR		In Lieu	of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1318	Peri od:	Worksheet S-8	
		Component	CCN: 14-3461	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/20/2024 3:0	
				RHC I	Cost	
	Fri	day	Sa ⁻	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 00	18: 00	08: 00	17: 00		11.00

Health Financial Systems	OSF HOLY FAMI	LY MED CTR		In lie	u of Form CMS	-2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	001 11021 171111		CN: 14-1318	Peri od:	Worksheet S-	
		C	CON 14 0/01	From 10/01/2022	D-+- /T: D-	
		Component	CCN: 14-8621	To 09/30/2023	Date/Time Pr 2/20/2024 3:	
				RHC II	Cost	
				1.	00	
Clinic Address and Identification				235 E. PENN AV	ENITE	1 00
1.00 Street		Ci	ty	State	ZIP Code	1.00
			00	2.00	3. 00	
2.00 City, State, ZIP Code, County		ROSEVI LLE			61473	2.00
2 00 HOSPITAL DASED FOLICE ONLY: Decimpeting Ent	on "D" for run	al an "II" fan	unhan		1. 00	0 2 00
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er k for rura	al or U for		nt Award	Date	0 3.00
				1. 00	2. 00	
Source of Federal Funds						
4.00 Community Health Center (Section 330(d), PHS						4.00
5.00 Migrant Health Center (Section 329(d), PHS A						5. 00
6.00 Health Services for the Homeless (Section 34	O(d), PHS Act)					6.00
7.00 Appalachian Regional Commission 8.00 Look-Alikes						7. 00 8. 00
9. 00 OTHER (SPECIFY)						9.00
THE COLEGIA (OF ESTATE)						71.00
				1.00	2. 00	
10.00 Does this facility operate as other than a h						0 10.00
yes or "N" for no in column 1. If yes, indic						
(Enter in subscripts of line 11 the type o hours.)	r otner operati	ion(s) and the	operating			
Tiour 3.)	Sun	dav	I N	londay	Tuesday	
	from	to	from	to	from	
	1. 00	2. 00	3. 00	4. 00	5. 00	
Facility hours of operations (1)			07.00	17.00	07.45	
11. 00 CLINIC			07: 00	17: 00	07: 15	11. 00
				1. 00	2. 00	
12.00 Have you received an approval for an excepti	on to the produ	uctivity stand	ard?	N	2.00	12.00
13.00 Is this a consolidated cost report as define	d in CMS Pub. '	100-04, chapte	r 9, section	N		0 13.00
30.8? Enter "Y" for yes or "N" for no in col						
number of providers included in this report.	List the names	s of all provi	ders and			
numbers below.			Prov	ider name	CCN	
			1100	1. 00	2. 00	
14.00 RHC/FQHC name, CCN						14.00
	Y/N	V	XVIII	XIX	Total Visits	
15 00 llava vau provi dad alla ar avitatanti alla	1. 00	2.00	3. 00	4. 00	5. 00	15.00
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15. 00
column 1. If yes, enter in columns 2, 3 and						
4 the number of program visits performed by						
Intern & Residents for titles V, XVIII, and						
XIX, as applicable. Enter in column 5 the						
number of total visits for this provider. (see instructions)						
Lace Histituctions)		Cou	I Inty			
			00			
2.00 City, State, ZIP Code, County		WARREN				2. 00
	Tuesday		esday		sday	
	to	from	to	from	to	
Facility hours of operations (1)	6. 00	7. 00	8.00	9. 00	10.00	
racifity nours of operations (1)						
		07: 00	17: 00		17: 00	11.00

Health Financial Systems	OSF HOLY FAM	LY MED CTR		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 14-1318	Peri od:	Worksheet S-8	3
				From 10/01/2022		
		Component	CCN: 14-8621	To 09/30/2023		
					2/20/2024 3:0	13 pm
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 00	17: 00				11.00

Heal th	Financial Systems	OSF HOLY FAMILY	MED CTR		In Lie	eu of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CO	CN: 14-1318	Peri od: From 10/01/2022 To 09/30/2023	Worksheet S-1 Parts I & II	0 pared:
						1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA					1.00	
	Uncompensated and Indigent Care Cost-to-Char	ge Ratio					
1.00	Cost to charge ratio (see instructions)					0. 267091	1.00
	Medicaid (see instructions for each line)						
2. 00	Net revenue from Medicaid					6, 910, 771	2.00
3.00	Did you receive DSH or supplemental payments				0	Y	3.00
4. 00 5. 00	If line 3 is yes, does line 2 include all DS				cai d?	Y	4. 00 5. 00
6. 00	If line 4 is no, then enter DSH and/or suppl Medicaid charges	emeritai paymerits	ironi medicai	u		20, 282, 360	1
7. 00	Medicald charges Medicald cost (line 1 times line 6)		5, 417, 236				
8. 00	Difference between net revenue and costs for	Medicaid program	(see instru	ictions)		0	
0.00	Children's Health Insurance Program (CHIP) (0.00
9.00	Net revenue from stand-alone CHIP			,		0	9.00
10.00	Stand-alone CHIP charges					0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)					0	11.00
12.00	Difference between net revenue and costs for					0	12.00
40.00	Other state or local government indigent car					1	40.00
13. 00 14. 00	Net revenue from state or local indigent car					0	
14.00	Charges for patients covered under state or 10)	rocai indigent ca	e program ((NOT THE Tude	i ili ilines o oi	0	14.00
15. 00	State or Local indigent care program cost (ine 1 times line	14)			0	15.00
16. 00	Difference between net revenue and costs for			e program (se	ee instructions)	0	
	Grants, donations and total unreimbursed cos instructions for each line)	t for Medicaid, C	IP and stat	te/local indi	gent care progra	ams (see	
17. 00	Private grants, donations, or endowment inco	me restricted to	fundi ng char	rity care		0	17.00
18. 00	Government grants, appropriations or transfe					Ö	
					ns (sum of lines	0	1
	8, 12 and 16)						
				Uni nsured	Insured	Total (col. 1	
				pati ents	pati ents	+ col . 2)	
	Uncomponented care cost (see instructions fo	r oach Line)		1. 00	2. 00	3. 00	
20. 00	Uncompensated care cost (see instructions fo Charity care charges and uninsured discounts		2)	1, 215, 8	71 436, 943	1, 652, 814	20.00
21. 00	Cost of patients approved for charity care a			324, 7			
21.00	instructions)	na annisarea arse	Junta (300	021,7	100, 710	701,071	21.00
22. 00	Payments received from patients for amounts	previously writte	n off as		0 0	0	22. 00
22.00	charity care			224 7	40 424 042	7/1 /01	22.00
23. 00	Cost of charity care (see instructions)			324, 7	436, 943	761, 691	23.00
						1.00	
24. 00	Does the amount on line 20 col. 2, include of	harges for patien	t days bevor	nd a length o	of stay limit	N N	24.00
	imposed on patients covered by Medicaid or o			3 3 3 4 4	3		
25. 00	If line 24 is yes, enter the charges for pat	ient days beyond	the indigent	t care progra	am's length of	0	25. 00
	lstav limit					1	

26.00

27.00

27.01

28.00

29.00

30.00

1, 585, 282

1, 476, 576

1, 194, 119

70, 658

108, 706

432, 428

1, 194, 119 31.00

stay limit

26.00 Bad debt amount (see instructions)

Charges for insured patients' liability (see instructions)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

27.00 Medicare reimbursable bad debts (see instructions)

27.01 Medicare allowable bad debts (see instructions)

	Financial Systems OSF HOLY FAMILY MED CT AL UNCOMPENSATED AND INDIGENT CARE DATA Provid	der CCN: 14-1318	Period:	eu of Form CMS-: Worksheet S-1	
5PI I.	AL UNCOMPENSATED AND INDIGENT CARE DATA PROVID	der CCN: 14-1318	From 10/01/2022		epare
				1. 00	
	PART II - HOSPITAL DATA				$\overline{}$
	Uncompensated and Indigent Care Cost-to-Charge Ratio				
00	Cost to charge ratio (see instructions)				1.
	Medicaid (see instructions for each line)				
00	Net revenue from Medicaid				2
00	Did you receive DSH or supplemental payments from Medicaid?				3
00	If line 3 is yes, does line 2 include all DSH and/or supplemental pa		cai d?		4
00	If line 4 is no, then enter DSH and/or supplemental payments from Me	edi cai d			5
00	Medi cai d charges				6
00	Medicaid cost (line 1 times line 6)				7
0	Difference between net revenue and costs for Medicaid program (see				8
0	Children's Health Insurance Program (CHIP) (see instructions for each Net revenue from stand-alone CHIP	cn rrne)			9
	Stand-alone CHIP charges				10
	Stand-alone CHIP cost (line 1 times line 10)				11
	Difference between net revenue and costs for stand-alone CHIP (see	instructions)			12
00	Other state or local government indigent care program (see instructi		<i>5</i>)	1	- ' '
00	Net revenue from state or local indigent care program (Not included				1 13
	Charges for patients covered under state or local indigent care produced in the control of the c				14
	10)	5 . (
00	State or local indigent care program cost (line 1 times line 14)				15
00	Difference between net revenue and costs for state or local indigen	t care program (s	ee instructions)		16
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)	d state/local ind	igent care progr	ams (see	
00	Private grants, donations, or endowment income restricted to funding	g charity care			7 17
00	Government grants, appropriations or transfers for support of hospi	tal operations			18
00	Total unreimbursed cost for Medicaid , CHIP and state and local indi	igent care progra	ms (sum of lines	;	19
	8, 12 and 16)				
		Uni nsured		Total (col. 1	
		patients	pati ents	+ col . 2)	+
	Uncompensated care cost (see instructions for each line)	1.00	2. 00	3. 00	+
00	Charity care charges and uninsured discounts (see instructions)				1 20
00	Cost of patients approved for charity care and uninsured discounts	(see			21
,,	instructions)				-
00	Payments received from patients for amounts previously written off	as			22
	chari ty care				
00	Cost of charity care (see instructions)				23

25.00

25.01

26.00

27. 00 27. 01

28. 00 29. 00

30.00

31.00

25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

27.00 Medicare reimbursable bad debts (see instructions)

27.01 Medicare allowable bad debts (see instructions)

stay limit

26.00 Bad debt amount (see instructions)

Health Financial Systems	OSF HOLY FAMIL	Y MED CTR		In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C	CN: 14-1318 P	eri od:	Worksheet A	
				rom 10/01/2022 o 09/30/2023	Date/Time Pre	narod:
				0 09/30/2023	2/20/2024 3: 0	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
· ·			+ col . 2)	i ons (See	Trial Balance	
			·	A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FIXT		1, 160, 504			1, 201, 175	1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P		323, 395	1	1	728, 970	2.00
3. 00 00300 OTHER CAP REL COSTS	07.054	00 500	177 7/0		0	3.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT 5.00 O0500 ADMINISTRATIVE & GENERAL	97, 254	80, 508			3, 508, 929	4. 00 5. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS	1, 108, 464 0	6, 966, 688 673, 643			7, 059, 710 248, 926	6.00
7. 00 00700 0PERATION OF PLANT	315, 595	1, 010, 385			1, 254, 916	7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	313, 373	1,010,303	1, 323, 700	1	4, 216	8.00
9. 00 00900 HOUSEKEEPI NG	460, 422	363, 092	· ·		668, 322	9. 00
10. 00 01000 DI ETARY	359, 957	302, 070	1		565, 271	•
11. 00 01100 CAFETERI A	0	0	0		0	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	o	0	d	o	0	12.00
13.00 01300 NURSING ADMINISTRATION	141, 438	37, 384	178, 822	-34, 376	144, 446	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	o c	0	0	14.00
15. 00 01500 PHARMACY	0	0	o c	0	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	2, 790	2, 790		48, 130	16. 00
17. 00 01700 SOCIAL SERVICE	0	0	0	291, 281	291, 281	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	1, 381, 133	542, 102	1, 923, 235	-390, 142	1, 533, 093	30.00
ANCILLARY SERVICE COST CENTERS	504.454	000 705	4 407 070	445 000	0/0 704	
50. 00 05000 OPERATING ROOM	524, 154	883, 725			962, 781	50.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	138, 688	-134, 901			-15, 823	53.00
56. 00 05600 RADI OLOGY - DI AGNOSTI C	702, 159 35, 236	306, 425 44, 589			1, 105, 763 72, 813	1
57. 00 05700 CT SCAN	33, 230	68, 191			45, 917	57.00
58. 00 05800 MRI	0	299, 237			297, 494	•
60. 00 06000 LABORATORY	703, 156	913, 665	1		1, 512, 392	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	703, 130	713, 009	1,010,021	0	1, 312, 372	62. 30
64. 00 06400 I NTRAVENOUS THERAPY	o	0		23, 068	23, 068	64.00
65. 00 06500 RESPIRATORY THERAPY	151, 055	73, 796	224, 851		173, 764	1
66. 00 06600 PHYSI CAL THERAPY	325, 281	111, 490			342, 918	1
67. 00 06700 OCCUPATI ONAL THERAPY	99, 206	21, 691	120, 897	10, 246	131, 143	67.00
68.00 06800 SPEECH PATHOLOGY	1, 179	306	1, 485	954	2, 439	68. 00
69. 00 06900 ELECTROCARDI OLOGY	366, 815	143, 963	510, 778	-117, 727	393, 051	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	-33, 789	-33, 789		5, 700	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			246, 056	•
73. 00 07300 DRUGS CHARGED TO PATIENTS	243, 291	1, 488, 324			2, 036, 470	1
76. 00 03950 DI ABETI C SERVI CES	20, 907	8, 774	1		21, 717	76.00
76. 01 03020 WOUND CLINIC	72, 948	784, 243	857, 191	-348, 062	509, 129	76. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0			0	76. 98
76. 99 07699 LI THOTRI PSY 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0		o	0	76. 99 77. 00
78. 00 07/00 ALLOGENETC H3CT ACQUISITION 78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	1	1	0	78.00
OUTPATIENT SERVICE COST CENTERS	U _I	0	1	ı U	U	76.00
88. 00 08800 RURAL HEALTH CLINIC	3, 816, 370	2, 234, 279	6, 050, 649	-1, 032, 389	5, 018, 260	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	288, 356	203, 346			428, 465	
91. 00 09100 EMERGENCY	1, 384, 464	2, 091, 145			3, 137, 710	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	., 00 ., 10 .	2/07///	0, 1,0,00,	001,077	0, 107, 710	92.00
OTHER REIMBURSABLE COST CENTERS				'		
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	C	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	12, 737, 528	20, 971, 060	33, 708, 588	24	33, 708, 612	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	-		190. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0	-	1		192.00
194.00 07950 NONREI MBURSABLE COST CENTER	201	25	1	1		194. 00
194. 01 07951 RESEARCH	0	0	0	-		194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	12, 737, 729	20, 971, 085	33, 708, 814	- 0	33, 708, 814	200.00

Provider CCN: 14-1318

Peri od: Worksheet A From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/20/2024 3:03 pm

				2/20/2024 3: 03	pm
	Cost Center Description	Adjustments	Net Expenses		
	•	(See A-8)	For		
		(, , , , , , , , , , , , , , , , , , ,	Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1. 00	00100 CAP REL COSTS-BLDG & FLXT	169, 020	1, 370, 195		1.00
		,		· · · · · · · · · · · · · · · · · · ·	
2.00	00200 CAP REL COSTS-MVBLE EQUIP	512, 552			2.00
3. 00	00300 OTHER CAP REL COSTS	0	·		3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	39		· · · · · · · · · · · · · · · · · · ·	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	-1, 314, 138	5, 745, 572		5.00
6.00	00600 MAINTENANCE & REPAIRS	-11, 465	237, 461		6.00
7.00	00700 OPERATION OF PLANT	0	1, 254, 916		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	4, 216		8.00
9.00	00900 HOUSEKEEPI NG	0	668, 322		9.00
10.00	01000 DI ETARY	0	565, 271		10.00
11. 00	01100 CAFETERI A	-74, 262		l l	11.00
	01200 MAINTENANCE OF PERSONNEL	7 1, 202	0		12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	202 701			13. 00
	1 1	302, 791	447, 237		
	01400 CENTRAL SERVICES & SUPPLY	0		l	14.00
	01500 PHARMACY	0	0		15.00
	01600 MEDICAL RECORDS & LIBRARY	-40		l l	16. 00
17. 00	01700 SOCIAL SERVICE	-10, 665	280, 616		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-38, 648	1, 494, 445		30.00
	ANCILLARY SERVICE COST CENTERS		,		
50.00		0	962, 781		50.00
53. 00	05300 ANESTHESI OLOGY	54, 341	l	l .	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-16, 529			54.00
56. 00	05600 RADI OLOGI - DI AGNOSTI C	-10, 327		l l	
		0	72, 813	· · · · · · · · · · · · · · · · · · ·	56.00
57.00	05700 CT SCAN	0	45, 917	i i	57.00
58. 00	05800 MRI	0	297, 494	I	58.00
60.00	06000 LABORATORY	-3, 165			60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400 I NTRAVENOUS THERAPY	0	23, 068		64.00
65.00	06500 RESPI RATORY THERAPY	0	173, 764		65.00
66.00	06600 PHYSI CAL THERAPY	1, 842	344, 760		66.00
67.00	06700 OCCUPATI ONAL THERAPY	510	131, 653		67.00
68.00	06800 SPEECH PATHOLOGY	6	2, 445		68.00
69.00	06900 ELECTROCARDI OLOGY	0	393, 051		69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	5, 700	l	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	246, 056	l l	72.00
	1 1	420 702			73.00
	07300 DRUGS CHARGED TO PATIENTS	-420, 783		l l	
	03950 DI ABETI C SERVI CES	-250		l	76.00
76. 01	03020 WOUND CLINIC	68, 633	577, 762		76. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		76. 98
76. 99	07699 LI THOTRI PSY	0	0		76. 99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	l ol		78.00
	OUTPATIENT SERVICE COST CENTERS				
88 00	08800 RURAL HEALTH CLINIC	-330, 719	4, 687, 541		88. 00
	08801 RURAL HEALTH CLINIC II	-42, 363			88. 01
	09100 EMERGENCY	-1, 309, 527			91.00
		-1,307,327	1,020,103		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
	OTHER REIMBURSABLE COST CENTERS	_			
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	1	02.00
	SPECIAL PURPOSE COST CENTERS	ı			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-2, 462, 820	31, 245, 792		18.00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	1	90.00
192.00	19200 PHYSICIANS PRIVATE OFFICES	0	l .	I	92.00
	07950 NONREI MBURSABLE COST CENTER	l n	202		94.00
	07951 RESEARCH		0		94. 01
200.00	1 1	-2, 462, 820	-		200.00
200.00	1 TOTAL (SOM OF LINES THE CHILDUGH 199)	2,402,020	1 31, 243, 774		50.00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/20/2024 3: 03 pm Provider CCN: 14-1318

Cost Order Tree Services Salary Other						10 09/30/2023	2/20/2024 3: 03 pm
A. WARDIEWEL COSTS S. 100 C. 100		01		6.1	011		
A							
1.00			3.00	4.00	5.00		
0 0 0 0 24,777 0 8 - DRUSS RECLASS 73,00 0 24,664 0 0 0 0 0 0 0 0 0	1. 00		54. 00	0	356, 118		1.00
B			I		6 <u>8, 5</u> 99		
1.00		0		0	424, 717		
2 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 00		70.00		24.774		1.00
3.00		DRUGS CHARGED TO PATTENTS		- 1			•
1.00				-	_		4
1.00				o	-		
C - OTHER THERAPEUT E SERVICES 0				o	-		•
1.00		0			24, 664		
O							
- PREMIER CONTRACT ADMIN FEES RECLASS 1.00 26,863 1.00	1. 00	I NTRAVENOUS_THERAPY	<u> </u>		0		1.00
1.00		F - PREMIER CONTRACT ADMIN FE	ES RECLASS	23, 068	U		
PATI ENT	1. 00			0	26, 863		1.00
F - PROPERTY INSURANCE					.,		
1.00				0	26, 863		
1.00	4 00		2 20		0004		1.00
G - EMPLOYEE BENEFIT RECLASS 2.00 2.00 3.00 4.00 0.00 0.00 0.00 0.00 0.00 0	1.00	OTHER CAP REL COSTS					1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 9.00 9.00 9.00 9.00 9.00 9		G - EMPLOYEE BENEFIT RECLASS		<u> </u>	20, 024		
2.00 3.00 4.00 0.00 0.00 0.00 0.00 0.00 0	1. 00		4. 00	0	3, 285, 670		1.00
4.00	2.00			- 1	0		2. 00
5.00 6.00 7.00 7.00 7.00 7.00 7.00 7.00 7			l l				
6. 00 7. 00 8. 00 9. 00 9. 00 10. 00				-	_		•
7.00				0			1
8. 00				0			
9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 11.00 12.00 13.00 14.00 15.00 16.00 16.00 17.00 18.00 17.00 18.00 18.00 19.00 1		1	I	-			•
10.00 0.00 0.00 0.00 0.00 11.00 12.00 12.00 13.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 15.00 16.00 16.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 18.00 17.00 18.00 18.00 17.00 18.00 18.00 19.00 18.00 19.00			I .	ı,			
11.00 12.00 13.00 13.00 14.00 15.00 16.00 15.00 16.00 17.00 18.00 17.00 18.00 19.00				-			1
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15.00	13.00		0.00	O	0		13.00
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17. 00 0. 00 0				ı,			4
18.00 0.00 0 0 0 0 0 0 0							
1.00 0.00 0.00 0 0.00 0 0.00				0			
20.00 0.00 0.00 0 0 0 0 0				O O			
21.00				0	-		
22.00			l l	0			
23.00				-			
1. 00 DRUG CHARGED TO PATIENTS 73.00 0 321, 589					0		•
1.00 DRUGS CHARGED TO PATLENTS 73.00 0 321,589 1 DEPRECIATION RECLASS		0		0	3, 285, 670		
TOTALS	1 00			٥١	321 590		1 00
- DEPRECIATION RECLASS	1.00						1.00
2. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 398,601 2. 00 3. 00 4. 00 5. 00 6.					. ,		
3.00 4.00 5.00 6.00 6.00 7.00 8.00 9.00 9.00 9.00 9.00 9.00 9.00 9				- 1			
4.00 5.00 6.00 7.00 0.00 0.00 0.00 0.00 0.00 0		CAP REL COSTS-MVBLE EQUIP		- 1			
5. 00 0. 00 0. 00 0. 00 5. 00 6. 00 0. 00 0. 00 0. 00 0. 00 6. 00 7. 00 0. 00 0. 00 0. 00 0. 00 7. 00 8. 00 8. 00 0. 00 0. 00 0. 00 0. 00 9. 00 9. 00 10. 00 0. 00 0. 00 0. 00 0. 00 11. 00 11. 00 12. 00 0. 00 0. 00 0. 00 0. 00 12. 00 12. 00 13. 00 0. 00 0. 00 0. 00 0. 00 0. 00 13. 00 14. 00 0. 00 0. 00 0. 00 0. 00 15. 00 15. 00 15. 00 0. 00 0. 00 0. 00 0. 00 17. 00 18. 00 17. 00 18. 00 19. 00				- 1			
6. 00 7. 00 8. 00 9. 00 10. 00 10. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 10. 00				- 1			
7. 00 8. 00 9. 00 10. 00 10. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 17. 00 18. 00 19. 00 11. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 17. 00 18. 00 19. 0		1		- 1			
8. 00 9. 00 10. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 2. 00 10. 0				- 1			
9. 00 10. 00 11. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 00 17. 00 18. 00 19. 00 2. 00 10. 00 2. 00 2. 00				-			
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13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 10 10 10 10 11 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 19. 00 19. 00 10 10 10 10 11 10 10				-			
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 19. 00 19. 00 10 10 10 11. 00 11. 00 12. 00 13. 00 1420, 222 1. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 2. 00 10 2. 00				-			4
15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 10. 00 10. 00 10. 00 10. 00 11. 00 11. 00 12. 00 13. 00 1420, 222 1. 00 14. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 19. 00 19. 00 19. 00 10. 00							
16. 00 17. 00 18. 00 19. 00 10				-			
17. 00 18. 00 19. 00 0 0 0 0 0 0 0 0 0 17. 00 18. 00 19. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				٧,			
18. 00 19. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					-		
19. 00				-			
0				Ö			
J - LAUNDRY RECLASS 1. 00 LAUNDRY & LI NEN SERVI CE 8. 00 0 4, 216 1. 00 2. 00 0 0 0 0 2. 00							
2.000 2.00							
		LAUNDRY & LINEN SERVICE					
<u> U </u>	2. 00						2.00
		<u> </u> U		O	4, 216		

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/20/2024 3: 03 pm Provider CCN: 14-1318

					2/20/2	2024 3: 03 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3. 00	4. 00	5. 00		
1 00	K - MED SUPPLIES & IMPLANTABLE			44.407		1.00
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	14, 187		1.00
2. 00	IMPL. DEV. CHARGED TO	72. 00	o	246, 056		2.00
2.00	PATI ENTS	72.00	J	240, 030		2.00
	0	+		260, 243		
	M - MINISTRY ALLOCATION RECLAS	SS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	166, 609		1.00
2.00	OPERATION OF PLANT	7. 00	0	88, 187		2.00
3.00	SOCI AL SERVI CE	17. 00	O	291, 281		3.00
4.00	PHYSI CAL THERAPY	66. 00	0	18, 415		4. 00
5.00	OCCUPATI ONAL THERAPY	67. 00	0	5, 097		5. 00
6. 00	SPEECH PATHOLOGY	68. 00	0	63		6. 00
7. 00	DRUGS CHARGED TO PATIENTS		0	38, 487		7.00
	0		0	608, 139		
1 00	P - REHAB ADMINISTRATION	(7.00	20 557	2 025		1.00
1.00	OCCUPATI ONAL THERAPY	67.00	20, 557	3, 925		1.00
2. 00	SPEECH PATHOLOGY		<u>998</u> 21, 555			2.00
	R - VACATION, PTO, REWARDS		21, 555	4, 115		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	3, 102	0		1.00
2. 00	OPERATION OF PLANT	7. 00	701	O		2.00
3. 00	HOUSEKEEPI NG	9. 00	1, 011	0		3.00
4.00	DI ETARY	10.00	679	0		4.00
5.00	NURSING ADMINISTRATION	13. 00	267	0		5. 00
6.00	ADULTS & PEDIATRICS	30. 00	2, 647	0		6.00
7.00	OPERATING ROOM	50.00	1, 754	0		7.00
8.00	ANESTHESI OLOGY	53. 00	262	0		8. 00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00	1, 325	0		9. 00
10. 00	RADI OI SOTOPE	56. 00	67	0		10.00
11. 00	LABORATORY	60.00	1, 327	0		11.00
12.00	RESPIRATORY THERAPY	65. 00	285	0		12.00
13.00	PHYSI CAL THERAPY	66.00	614	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00	187	0		14.00
15. 00 16. 00	SPEECH PATHOLOGY ELECTROCARDI OLOGY	68. 00 69. 00	2 692	0		15. 00 16. 00
17. 00	DRUGS CHARGED TO PATIENTS	73. 00	459	0		17.00
18. 00	DI ABETI C SERVI CES	76. 00	39	0		18.00
19. 00	WOUND CLINIC	76. 01	138	0		19.00
20.00	RURAL HEALTH CLINIC	88. 00	7, 203	Ö		20.00
21. 00	RURAL HEALTH CLINIC II	88. 01	544	0		21.00
22. 00	EMERGENCY	91.00	2, 645	0		22.00
		_ _	25, 950			
	S - SHORT TERM DISABILITY					
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	881		1.00
2. 00	HOUSEKEEPI NG	9. 00	0	700		2. 00
3. 00	ADULTS & PEDI ATRI CS	3000	•	<u>2, 217</u>		3.00
	T DUC DROW DED DECLASS		0	3, 798		
1. 00	T - RHC PROVIDER RECLASS RURAL HEALTH CLINIC II	88. 01	18, 229	0		1.00
1.00	TOTALS		18, 229	0		1.00
	V - RETENTION BONUS		10, 227	0		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	6, 445	0		1.00
2. 00	OPERATION OF PLANT	7. 00	1, 835	Ö		2.00
3.00	HOUSEKEEPI NG	9. 00	2, 678	0		3.00
4.00	DI ETARY	10.00	2, 093	0		4.00
5.00	NURSING ADMINISTRATION	13. 00	823	0		5. 00
6.00	ADULTS & PEDIATRICS	30. 00	13, 078	0		6.00
7.00	OPERATING ROOM	50. 00	5, 719	0		7. 00
8.00	ANESTHESI OLOGY	53. 00	807	0		8. 00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00	4, 083	0		9. 00
10. 00	RADI OI SOTOPE	56. 00	205	0		10.00
11.00	LABORATORY THERAPY	60.00	4, 089	0		11.00
12.00	RESPIRATORY THERAPY	65. 00	3, 550	0		12.00
13.00	PHYSI CAL THERAPY	66. 00 67. 00	1, 892 577	0		13.00
14.00	OCCUPATIONAL THERAPY	67. 00 68. 00	577 7	0		14.00
15. 00 16. 00	SPEECH PATHOLOGY ELECTROCARDI OLOGY	69. 00	3, 320	0		15. 00 16. 00
17. 00	DRUGS CHARGED TO PATIENTS	73. 00	1, 415	0		17.00
18. 00	DI ABETI C SERVI CES	76. 00	1, 413	0		18.00
19. 00	WOUND CLINIC	76. 01	424	0		19.00
20. 00	RURAL HEALTH CLINIC	88. 00	22, 194	Ö		20.00
21. 00	RURAL HEALTH CLINIC II	88. 01	1, 677	Ö		21.00
22. 00	EMERGENCY	91.00	20, 220	0		22.00
	· '	•	'	•		· · · · · · · · · · · · · · · · · · ·

Heal th	Financial Systems		OSF HOLY FAM	LLY MED CTR		In Lieu	u of Form CMS	-2552-10
RECLAS:	SI FI CATI ONS			Provi der C	CCN: 14-1318	Peri od:	Worksheet A-	6
						From 10/01/2022 To 09/30/2023	Date/Time Pr 2/20/2024 3:	epared: 03 pm
		Increases						
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3. 00	4. 00	5. 00				
23.00	NONREIMBURSABLE COST CENTER	194. 00	1	0				23. 00
	0		97, 254	0				
	X - MINISTRY MEDICAL RECORDS							
1.00	MEDICAL RECORDS & LIBRARY	<u>16.</u> 00	0	45, 340				1.00
	0		0	45, 340				
	Z - REGIONAL ADMIN COSTS							
1.00	RURAL HEALTH CLINIC	88. 00	0	14, 208				1.00
2.00	RURAL HEALTH CLINIC II	88. 01	0	1, 155				2.00
	TOTALS		0	15, 363				
500.00	Grand Total: Increases		186, 056	5, 470, 963				500.00

Provider CCN: 14-1318

Peri od: Worksheet A-0 From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/20/2024 3:03 pm

						2/20/2024 3	: U3 piii
	Cook Cooker	Decreases	Calara	O+l WI			
	Cost Center 6.00	Li ne # 7. 00	Sal ary 8. 00	0ther Wk	10.00		
	A - MAINTENANCE COSTS	7.00	8.00	7.00	10.00		
1. 00	MAINTENANCE & REPAIRS	6.00	0	424, 717	0		1.00
2. 00		0. 00	o	0	Ö		2.00
				424, 717	1		
	B - DRUGS RECLASS		-1	.=.,			
1.00	OPERATING ROOM	50.00	0	12, 015	0		1.00
2.00	CT SCAN	57.00	O	6, 752	0		2.00
3.00	MRI	58. 00	O	1, 743	О		3.00
4.00	LABORATORY	60.00	0	84	0		4.00
5.00	WOUND CLINIC	<u>76.</u> 01	0	4, 070	0		5.00
	0		0	24, 664			
	C - OTHER THERAPEUTIC SERVICE		<u>, </u>				
1.00	ADULTS & PEDIATRICS	30. 00	2 <u>3, 0</u> 68	0	0		1.00
	0		23, 068	0			_
	E - PREMIER CONTRACT ADMIN FE						
1. 00	ADMI NI STRATI VE & GENERAL		•_	<u>26, 863</u>	0		1.00
	TOTALS		0	26, 863			_
	F - PROPERTY INSURANCE						
1. 00	ADMI NI STRATI VE & GENERAL		0	26, 024	12		1.00
	0		0	26, 024			_
1 00	G - EMPLOYEE BENEFIT RECLASS	E 00		2/7 407	2		1
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	267, 187	0		1.00
2.00	OPERATION OF PLANT	7.00	0	88, 705	0		2.00
3. 00 4. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	0	158, 124 93, 286	0		3. 00 4. 00
5. 00	NURSING ADMINISTRATION	13. 00	0		0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	35, 466 349, 082	0		6.00
7. 00	OPERATING ROOM	50.00	0	129, 395	0		7.00
8. 00	ANESTHESI OLOGY	53.00	0	17, 752	0		8.00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	181, 673	0		9.00
10. 00	RADI OI SOTOPE	56.00	o	2, 746	o		10.00
11. 00	LABORATORY	60.00	o	163, 959	o		11.00
12. 00	RESPIRATORY THERAPY	65. 00	Ö	49, 124	O		12.00
13. 00	PHYSI CAL THERAPY	66. 00	ol	84, 934	o		13.00
14. 00	OCCUPATI ONAL THERAPY	67. 00	o	20, 097	o		14.00
15.00	SPEECH PATHOLOGY	68. 00	o	306	0		15.00
16.00	ELECTROCARDI OLOGY	69.00	O	114, 985	0		16.00
17.00	DRUGS CHARGED TO PATIENTS	73. 00	O	59, 470	О		17.00
18.00	DI ABETI C SERVI CES	76.00	O	8, 125	0		18.00
19.00	WOUND CLINIC	76. 01	0	22, 965	0		19.00
20.00	RURAL HEALTH CLINIC	88. 00	0	1, 044, 027	0		20.00
21.00	RURAL HEALTH CLINIC II	88. 01	0	82, 100	0		21.00
22.00	EMERGENCY	91. 00	0	312, 137	0		22.00
23.00	NONREIMBURSABLE COST CENTER	194. 00	0	25	0		23.00
	0		0	3, 285, 670			
	H - WOUND CLINIC IMPLANTS REC						
1. 00	WOUND CLINIC	<u>76.</u> 01	•	32 <u>1, 5</u> 89	0		1.00
	TOTALS		0	321, 589			
	I - DEPRECIATION RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	35, 065	9		1.00
2.00	OPERATION OF PLANT	7. 00	0	72, 977	9		2.00
3.00	HOUSEKEEPI NG	9.00	0	615	0		3.00
4.00	DI ETARY	10.00	0	6, 242	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	33, 677	0		5.00
6.00	OPERATING ROOM ANESTHESIOLOGY	50. 00 53. 00	-	50, 153	0		6.00
7.00		53. 00 54. 00	0	2, 927	0		7.00
8.00	RADI OLOGY-DI AGNOSTI C	54. 00 56. 00	0	82,674	0		8.00
9. 00 10. 00	RADI OI SOTOPE CT SCAN	56. 00 57. 00	0	4, 538 15, 522	0		9.00
11. 00	LABORATORY	60.00	0	11, 758	0		11.00
12.00	RESPI RATORY THERAPY	65. 00	0	5, 798	0		12.00
13. 00	PHYSICAL THERAPY	66. 00	o	4, 170	0		13.00
14. 00	ELECTROCARDI OLOGY	69. 00	o	5, 181	0		14.00
15. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 561	0		15. 00
	PATI ENT	, 1. 55	Ĭ	1, 301	9		13.00
16. 00	DRUGS CHARGED TO PATIENTS	73. 00	o	22, 289	o		16.00
17. 00	RURAL HEALTH CLINIC	88.00	o	13, 738	o		17. 00
18. 00	RURAL HEALTH CLINIC II	88. 01	ő	2, 742	o		18.00
19. 00	EMERGENCY	91. 00	ő	48, 595	o		19.00
	0	— — — " †	 	420, 222	- — — ĭ		
	J - LAUNDRY RECLASS		<u> </u>	,			
1 00	LABORATORY	60.00	0	2, 643	0		1.00
1. 00			•	1, 573	o		2.00
2. 00	ELECTROCARDI OLOGY	69. 00	0	4, 216	Ol		2.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 14-1318

						2/20/2024 3	03 pm
	01.01	Decreases	6.1	0.11	w		
	Cost Center 6.00	Li ne #	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	K - MED SUPPLIES & IMPLANTABLI		0.00	7. 00	10.00		
1.00	OPERATI NG ROOM	50.00	0	260, 243	0		1.00
2.00		000	o	0	0		2. 00
	0		0	260, 243			
1. 00	M - MINISTRY ALLOCATION RECLASSIBLE ADMINISTRATIVE & GENERAL	5. 00	O	608, 139	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	0.00	0	008, 139	0		2.00
3. 00		0. 00	o	O	O		3.00
4.00		0. 00	o	0	0		4.00
5. 00		0. 00	0	0	0		5. 00
6.00		0.00	0	0	0		6.00
7. 00		000		0 608, 139			7. 00
	P - REHAB ADMINISTRATION		<u> </u>	000, 137			
1.00	PHYSI CAL THERAPY	66. 00	21, 555	4, 115	0		1.00
2.00		000	•	0	0		2. 00
	O D WACATION DTO DEWARDS		21, 555	4, 115			
1. 00	R - VACATION, PTO, REWARDS EMPLOYEE BENEFITS DEPARTMENT	4. 00	O	23, 858	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	Ö	1, 008	Ö		2.00
3.00	OPERATION OF PLANT	7. 00	О	105	0		3. 00
4.00	HOUSEKEEPI NG	9. 00	0	142	0		4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	40	0		5.00
6. 00 7. 00	OPERATING ROOM EMERGENCY	50. 00 91. 00	0	765 32	0		6. 00 7. 00
8. 00	EWERGENCT	0.00	o	0	0		8.00
9. 00		0. 00	Ö	Ö	Ö		9. 00
10.00		0. 00	O	0	0		10.00
11. 00		0. 00	0	0	0		11.00
12. 00 13. 00		0. 00 0. 00	0	0	0		12. 00 13. 00
14. 00		0.00	O O	0	0		14.00
15. 00		0. 00	Ö	Ö	o		15. 00
16.00		0.00	o	0	0		16.00
17.00		0. 00	0	0	0		17. 00
18.00		0.00	0	0	0		18.00
19. 00 20. 00	1	0. 00 0. 00	U O	0	0		19. 00 20. 00
21. 00		0.00	Ö	0	0		21.00
22. 00		0. 00	o	0	0		22. 00
	0		0	25, 950			╛
1 00	S - SHORT TERM DI SABILITY	F 00	001		٥		1 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL HOUSEKEEPING	5. 00 9. 00	881 700	0	0		1.00 2.00
3. 00	ADULTS & PEDIATRICS	30.00	2, 217	0	0		3.00
0.00	0	=	3, 798	- — — ö			0.00
	T - RHC PROVIDER RECLASS						
1. 00	RURAL HEALTH CLINIC	8800	18, 229	0			1. 00
	TOTALS V - RETENTION BONUS		18, 229	0			
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	97, 254	0	0		1.00
2. 00		0.00	0	O			2.00
3.00		0. 00	O	0	0		3.00
4. 00		0.00	0	0	0		4.00
5. 00 6. 00		0. 00 0. 00	0	0	0		5. 00 6. 00
7. 00		0.00	o	0	0		7.00
8. 00		0. 00	o	O	O		8.00
9. 00		0. 00	o	0	0		9. 00
10.00		0.00	0	0	0		10.00
11.00		0. 00 0. 00	0	0	0		11.00
12. 00 13. 00		0.00	0	0	0		12. 00 13. 00
14. 00		0.00	0	0	0		14.00
15. 00		0. 00	o	Ö	0		15. 00
16.00		0. 00	o	0	О		16.00
17.00		0.00	0	0	0		17.00
18.00		0. 00 0. 00	0	0	0		18.00
19. 00 20. 00		0.00	0	0	0		19. 00 20. 00
21. 00		0.00	o	o	0		21.00
22.00		0. 00	О	0	0		22. 00
23. 00		000		0	0		23. 00
	0		97, 254	0			

Heal th	Financial Systems		OSF HOLY FAM	LY MED CTR		In Lie	u of Form CMS-	2552-10
RECLASS	SI FI CATI ONS			Provi der (CCN: 14-1318	Peri od: From 10/01/2022	Worksheet A-	6
							Date/Time Pr 2/20/2024 3:	epared: 03 pm
		Decreases						
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref	· .		
	6. 00	7. 00	8. 00	9. 00	10.00			
	X - MINISTRY MEDICAL RECORDS							
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	45, 340		0		1.00
	0		0	45, 340				
	Z - REGIONAL ADMIN COSTS							
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	15, 363		0		1.00
2.00		0.00	o	0		o		2.00
	TOTALS		0	15, 363		1		
500.00	Grand Total: Decreases		163, 904	5, 493, 115				500.00

					To 09/30/2023	Date/Time Pre	
				Acqui si ti ons		2/20/2024 3:0	3 pm
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances	i di chases	Donation	Total	Retirements	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	325, 000	0	(0 0	0	1.00
2.00	Land Improvements	369, 733	115, 192	(0 115, 192	0	2.00
3.00	Buildings and Fixtures	20, 716, 827	6, 370, 589	(0 6, 370, 589	0	3.00
4.00	Building Improvements	0	0	(0 0	0	4.00
5.00	Fixed Equipment	0	0	(0	0	5. 00
6.00	Movable Equipment	15, 762, 640	0	(0	5, 549, 449	6.00
7.00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	37, 174, 200	6, 485, 781	(0 6, 485, 781	5, 549, 449	8. 00
9.00	Reconciling Items	6, 340, 660		(0 -5, 974, 388	0	9. 00
10.00	Total (line 8 minus line 9)	30, 833, 540	12, 460, 169	(0 12, 460, 169	5, 549, 449	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		_1				
1. 00	Land	325, 000	0				1.00
2.00	Land Improvements	484, 925	0				2.00
3. 00	Buildings and Fixtures	27, 087, 416	0				3. 00
4.00	Building Improvements	0	0				4.00
5. 00	Fi xed Equi pment	0	0				5.00
6. 00	Movable Equipment	10, 213, 191	0				6.00
7. 00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	38, 110, 532	0				8.00
9.00	Reconciling Items	366, 272	0				9.00
10. 00	Total (line 8 minus line 9)	37, 744, 260	0				10.00

Heal th	Financial Systems	OSF HOLY FAMI	LY MED CTR		In lie	eu of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS	001 11021 174	Provi der CO	CN: 14-1318	Peri od: From 10/01/2022 To 09/30/2023	Worksheet A-7 Part II Date/Time Pre	pared:
			SI	IMMARY OF CAP	DI TAI	2/20/2024 3:0	3 pm
			30	INIMAKT OF CAP	TIAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9. 00	10. 00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	1, 160, 504	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	323, 395	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 483, 899	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 160, 504				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	323, 395			l	2.00
3 00	Total (sum of lines 1-2)	1	1 /03 000				3 00

0 0 0

1, 160, 504 323, 395 1, 483, 899

2.00

3.00 Total (sum of lines 1-2)

Heal th Fi	nancial Systems	OSF HOLY FAM	LY MED CTR		In Lie	u of Form CMS-2	2552-10
RECONCI LI	ATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 10/01/2022 To 09/30/2023		pared:
		COMI	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
		1, 00	2.00	col . 2) 3.00	4. 00	5. 00	
PAI	RT III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00	
	P REL COSTS-BLDG & FLXT	27, 897, 341	0	27, 897, 34	1 0. 732011	19, 050	1.00
	P REL COSTS-MVBLE EQUIP	10, 213, 191	0				2.00
3. 00 To	tal (sum of lines 1-2)	38, 110, 532	0	38, 110, 53	2 1. 000000	26, 024	3.00
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)	0.00	10.00	
DAI	RT III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8. 00	9. 00	10.00	
	P REL COSTS-BLDG & FLXT	ENTERS 0		19, 05	0 1, 351, 145	0	1. 00
	P REL COSTS-BEDG & TTXT	0	ľ	6, 97			2.00
	ital (sum of lines 1-2)	0	ľ	26, 02			3. 00
			SL	JMMARY OF CAPI		-	7.75
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
	, , , , , , , , , , , , , , , , , , ,		(see	instructions)	Capi tal -Rel at		
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
1=	:	11. 00	12. 00	13. 00	14. 00	15. 00	
	RT III - RECONCILIATION OF CAPITAL COSTS C P REL COSTS-BLDG & FIXT		10.050		0 0	1 270 105	1 00
	P REL COSTS-BLDG & FIXT P REL COSTS-MVBLE EQUIP	0			0 0	1, 370, 195 1, 241, 522	1. 00 2. 00
	ital (sum of lines 1-2)	0	i .				
3. 00 10	(Sum 01 111103 1 2)	1	1 20,024	l '	0	2,011,717	5. 00

ADJUST	WENTS TO EXPENSES			Provider CCN. 14-1316	From 10/01/2022	WOI KSHEET A-0	
					To 09/30/2023	Date/Time Pre 2/20/2024 3:0	
			To	Expense Classification of From Which the Amount is			
				777 OII WITT CIT THE AMOUNT TO	s to be hajusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2.00	3. 00	4.00	Ref. 5.00	
1. 00	Investment income - CAP REL	1, 55		P REL COSTS-BLDG & FIXT	1.00	0	1.00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		OCA	AP REL COSTS-MVBLE EQUIP	2. 00	0	2.00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	В	Olar	MINISTRATIVE & GENERAL	5. 00	0	3.00
	(chapter 2)	Ь		WITH STRATIVE & GENERAL		_	
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6. 00	Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		o		0. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service	Α	-11, 229 AD	MINISTRATIVE & GENERAL	5. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9.00
10.00	Provi der-based physician adjustment	A-8-2	-1, 178, 420			0	10.00
11. 00	Sale of scrap, waste, etc.		О		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	-135, 613			0	12.00
13. 00	transactions (chapter 10) Laundry and linen service				0.00	0	13.00
14. 00	Cafeteria-employees and guests	В	-74, 262 CA	FETERI A	11. 00	0	ı
15. 00	Rental of quarters to employee and others		0		0. 00	0	15.00
16. 00	Sale of medical and surgical	В	0		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and	В	-40 ME	DICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20.00	Vending machines		o		0. 00	0	20.00
21. 00	Income from imposition of interest, finance or penalty	В	-5, 790 AD	MINISTRATIVE & GENERAL	5. 00	0	21.00
22.00	charges (chapter 21)				0.00		22.00
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	OIRE	SPI RATORY THERAPY	65. 00		23. 00
20.00	therapy costs in excess of	7. 0 0		STITUTION I	00.00		20.00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0 PF	IYSI CAL THERAPY	66. 00		24.00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0 * *	* Cost Center Deleted **	* 114.00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL	Α	343, 026 CA	P REL COSTS-BLDG & FIXT	1. 00	9	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL	А	164, 292 CA	P REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0 **	* Cost Center Deleted ***	* 19.00		28. 00
29. 00	Physicians' assistant		0	3331 John Dorotou	0. 00	0	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	000	CUPATI ONAL THERAPY	67. 00		30.00
20.00	limitation (chapter 14)			NULTO 0 DEDLATRICO	20.00		20.00
30. 99	Hospice (non-distinct) (see instructions)		OAL	OULTS & PEDIATRICS	30. 00		30. 99
	,				,		

Не	al th	Financial Systems		OSF HOLY FAMI	LLY MED CTR	In Lie	u of Form CMS-2	2552-10
		MENTS TO EXPENSES				Peri od:	Worksheet A-8	
						rom 10/01/2022	D. I. (T' D	
						To 09/30/2023	Date/Time Pre 2/20/2024 3:0	parea: 3 nm
					Expense Classification on	Worksheet A	27 207 202 1 0. 0	D PIII
					To/From Which the Amount is	to be Adjusted		
		Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		3001 3011101 20001 Pt. 311	(2)	71111041110		2	Ref.	
			1. 00	2. 00	3.00	4. 00	5. 00	
31	1. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
		pathology costs in excess of						
		limitation (chapter 14)						
32	2. 00			0		0. 00	0	32.00
0.0		Depreciation and Interest		200	ADMINI CEDATINE A CENEDAL	F 00		00.00
	3. 00	ADVERTI SI NG EXPENSE LOBBYI NG	A		ADMINISTRATIVE & GENERAL	5. 00		33. 00 33. 01
	3. 01		A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33.01
	3. 02	A Company of the Comp	B		DIABETIC SERVICES	76. 00	0	33.02
	3. 04	340B EXPENSE	A		DRUGS CHARGED TO PATIENTS	73.00		33. 04
	3. 05		A		EMPLOYEE BENEFITS DEPARTMENT			33. 05
	3. 06	DEFINED BENEFIT PENSION	A		EMPLOYEE BENEFITS DEPARTMENT			33.06
	3. 07	MEDICAL DIRECTOR FEE	В		RURAL HEALTH CLINIC	88. 00		33. 07
33	3. 08	RHC MISC INCOME	В	-12, 000	RURAL HEALTH CLINIC II	88. 01	0	33. 08
33	3. 09	GUILD ADJUSTMENT	А	3, 077	EMERGENCY	91.00	0	33. 09
33	3. 10	MALPRACTICE EXPENSE	A	-6, 512	ADMINISTRATIVE & GENERAL	5. 00	0	33. 10
50	0. 00	TOTAL (sum of lines 1 thru 49)		-2, 462, 820				50.00
		(Transfer to Worksheet A,						
		1						

column 6, line 200.)

B. Amount Received - if cost cannot be determined.

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

⁽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.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Provider CCN: 14-1318

Worksheet A-8-1

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Peri od: From 10/01/2022 OFFICE COSTS 09/30/2023 Date/Time Prepared: 2/20/2024 3:03 pm

Line No. Cost Center Expense I tems Amount of All owable Cost Amount of Included in Nks. A, column S
1.00 2.00 3.00 4.00 5.00
1.00
1.00
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00
1.00 CAP REL COSTS-BLDG & FIXT CAPITAL BLDG HO BLDG CAPITAL 140, 436 298, 031 2.00 2.00 CAP REL COSTS-MVBLE EQUIP CAPITAL MME HO MME CAPITAL 348, 260 0 0.00 2.00 3.00 3.00 5.00 ADMINISTRATIVE & GENERAL HO POOLED - ADMIN & GENERAL 2, 329, 075 3, 268, 972 3.00 3.01 4.00 EMPLOYEE BENEFITS DEPARTMENT MINISTRY ALLOCATION 166, 609 166, 609 3.01 3.02 6.00 MAINTENANCE & REPAIRS MINISTRY ALLOCATION 177 177 3.02 3.03 3.04 3.00 ADULTS & PEDIATRICS MINISTRY ALLOCATION 88, 187 88, 187 3.03 3.04 30.00 ADULTS & PEDIATRICS MINISTRY ALLOCATION 26, 712 0 3.04 3.05 66.00 PHYSICAL THERAPY MINISTRY ALLOCATION 20, 257 18, 415 3.05 67.00 OCCUPATIONAL THERAPY MINISTRY ALLOCATION 20, 257 18, 415 3.05 3.07 68.00 SPEECH PATHOLOGY MINISTRY ALLOCATION 5, 607 5, 097 3.06 68.00 SPEECH PATHOLOGY MINISTRY ALLOCATION 69 63 3.07 3.00 ROUGED SCHARGED TO PATIENTS MINISTRY ALLOCATION 38, 487 38, 487 38, 487 3.08 3.00 ROUGED SCHARGED TO PATIENTS MINISTRY ALLOCATION 69 63 3.07 3.00 ROUGED SCHARGED TO PATIENTS MINISTRY ALLOCATION 253 253 3.09 3.00 ADMINISTRY ALLOCATION 49 49 3.10 4.00
1.00
2.00 CAP REL COSTS-MVBLE EQUIP CAPITAL MME HO MME CAPITAL 348, 260 0 2.00 3.00 5.00 ADMINISTRATIVE & GENERAL HO POOLED - ADMIN & GENERAL 2, 329, 075 3, 268, 972 3.00 4.00 EMPLOYEE BENEFITS DEPARTMENT MINISTRY ALLOCATION 166, 609 166, 609 3.01 3.02 6.00 MAINTENANCE & REPAIRS MINISTRY ALLOCATION 177 177 3.02 7.00 OPERATION OF PLANT MINISTRY ALLOCATION 88, 187 88, 187 3.03 3.04 30.00 ADULTS & PEDIATRICS MINISTRY ALLOCATION 26, 712 0 3.04 3.05 6.00 OPHYSICAL THERAPY MINISTRY ALLOCATION 20, 257 18, 415 3.05 3.06 67.00 OCCUPATIONAL THERAPY MINISTRY ALLOCATION 5, 607 5, 097 3.06 67.00 OCCUPATIONAL THERAPY MINISTRY ALLOCATION 5, 607 6.00 OCCUPATIONAL THERAPY MINISTRY ALLOCATION 5, 607 6.00 OCCUPATIONAL THERAPY MINISTRY ALLOCATION 5, 607 6.00 ORADIOLOGY-DIAGNOSTIC MINISTRY ALLOCATION 69 63 3.07 3.00 DRUGS CHARGED TO PATIENTS MINISTRY ALLOCATION 253 253 3.09 3.10 6.00 OLABORATORY MINISTRY ALLOCATION 253 253 3.09 3.10 6.00 OLABORATORY MINISTRY ALLOCATION 49 49 3.10 4.00 13.00 NURSING ADMINISTRATION HO FUNCTIONAL - NURSING ADMI 103, 736 103, 736 4.01 73.00 DRUGS CHARGED TO PATIENTS MINISTRY ALLOCATION 49 49 3.10 4.00 13.00 NURSING ADMINISTRATION HO FUNCTIONAL - NURSING ADMI 103, 736 103, 736 4.01 73.00 DRUGS CHARGED TO PATIENTS HO FUNCTIONAL - NURSING ADMI 103, 736 103, 736 4.01 73.00 DRUGS CHARGED TO PATIENTS HO FUNCTIONAL - NURSING ADMI 103, 736 103, 736 4.01 73.00 DRUGS CHARGED TO PATIENTS HO FUNCTIONAL - ADMIN & GEN 1, 909, 248 1, 147, 100 4.03 4.04 73.00 DRUGS CHARGED TO PATIENTS HO FUNCTIONAL - ADMIN & GEN 1, 742 4.04 4.05 5.00 ADMINISTRATIVE & GENERAL HO FUNCTIONAL - ADMIN & GEN 1, 742 5.00 ADMINISTRATIVE & GENERAL SFI CVO 25, 199 25, 144 4.06
3. 00 5. 00 ADMI NI STRATI VE & GENERAL HO POOLED - ADMI N & GENERAL 2, 329, 075 3, 268, 972 3. 00 3. 01 4. 00 EMPLOYEE BENEFI TS DEPARTMENT MI NI STRY ALLOCATI ON 166, 609 166, 609 3. 01 3. 02 6. 00 MAI NTENANCE & REPAI RS MI NI STRY ALLOCATI ON 177 177 3. 03 3. 00 ADULTS & PEDI ATRI CS MI NI STRY ALLOCATI ON 26, 712 0 3. 04 30. 00 ADULTS & PEDI ATRI CS MI NI STRY ALLOCATI ON 26, 712 0 3. 04 30. 05 66. 00 PHYSI CAL THERAPY MI NI STRY ALLOCATI ON 20, 257 18, 415 3. 05 3. 06 67. 00 OCCUPATI ONAL THERAPY MI NI STRY ALLOCATI ON 5, 607 5, 097 3. 06 68. 00 SPEECH PATHOLOGY MI NI STRY ALLOCATI ON 69 63 3. 07 3. 00 DRUGS CHARGED TO PATI ENTS MI NI STRY ALLOCATI ON 38, 487 38, 487 3. 08 3. 09 354. 00 RADI OLOGY-DI AGNOSTI C MI NI STRY ALLOCATI ON 253 253 3. 09 3. 10 60. 00 LABORATORY MI NI STRY ALLOCATI ON 253 253 3. 09 3. 10 60. 00 LABORATORY MI NI STRY ALLOCATI ON 302, 791 0 49 49 3. 10 400 401 401 401 402 401 402 401 402 402 402 403 404 405 405 405 406 40
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3. 03
3. 04 30. 00 ADULTS & PEDIATRICS MINISTRY ALLOCATION 26, 712 0 3. 04 3. 05 66. 00 PHYSICAL THERAPY MINISTRY ALLOCATION 20, 257 18, 415 3. 05 3. 06 67. 00 OCCUPATIONAL THERAPY MINISTRY ALLOCATION 5, 607 5, 097 3. 06 68. 00 SPEECH PATHOLOGY MINISTRY ALLOCATION 69 63 3. 07 3. 08 73. 00 DRUGS CHARGED TO PATIENTS MINISTRY ALLOCATION 38, 487 38, 487 3. 08 3. 09 54. 00 RADIOLOGY-DIAGNOSTIC MINISTRY ALLOCATION 253 253 2.05 3. 09 3. 10 60. 00 LABORATORY MINISTRY ALLOCATION 253 253 3. 08 3. 10 4. 00 4. 01 73. 00 DRUGS CHARGED TO PATIENTS HO FUNCTIONAL - NURSING ADMI 302, 791 0 4. 00 4. 01 73. 00 DRUGS CHARGED TO PATIENTS HO FUNCTIONAL - NURSING ADMI 103, 736 103, 736 4. 01 4. 02 4. 03 4. 04 73. 00 DRUGS CHARGED TO PATIENTS HO FUNCTIONAL - SOCIAL SERVI 280, 616 291, 281 4. 02 4. 04 73. 00 DRUGS CHARGED TO PATIENTS HO FUNCTIONAL - ADMIN & GEN 1, 909, 248 1, 147, 100 4. 03 4. 05 54. 00 RADIOLOGY-DIAGNOSTIC SFI EQUIPMENT RENTAL 5, 759 5, 856 4. 05 4. 06 55. 00 ADMINISTRATIVE & GENERAL SFI CVO 25, 199 25, 144 4. 06
3. 05
3. 06 67. 00 OCCUPATI ONAL THERAPY MI NI STRY ALLOCATI ON 5, 607 5, 097 3. 06 3. 07 68. 00 SPEECH PATHOLOGY MI NI STRY ALLOCATI ON 69 63 3. 07 3. 08 73. 00 DRUGS CHARGED TO PATI ENTS MI NI STRY ALLOCATI ON 38, 487 38, 487 3. 08 3. 09 54. 00 RADI OLOGY-DI AGNOSTI C MI NI STRY ALLOCATI ON 253 253 3. 09 3. 10 60. 00 LABORATORY MI NI STRY ALLOCATI ON 49 49 3. 10 4. 00 13. 00 NURSI NG ADMI NI STRATI ON HO FUNCTI ONAL - NURSI NG ADMI 302, 791 0 4. 00 4. 01 73. 00 DRUGS CHARGED TO PATI ENTS HO FUNCTI ONAL - NURSI NG ADMI 103, 736 103, 736 4. 01 4. 02 17. 00 SOCI AL SERVI CE HO FUNCTI ONAL - NURSI NG ADMI 103, 736 103, 736 4. 01 4. 02 4. 03 5. 00 ADMI NI STRATI VE & GENERAL HO FUNCTI ONAL - ADMI N & GEN 1, 909, 248 1, 147, 100 4. 03 4. 04 73. 00 DRUGS CHARGED TO PATI ENTS HO FUNCTI ONAL - ADMI N & GEN 1, 742 0 4. 04 4. 05 54. 00 RADI OLOGY-DI AGNOSTI C SFI EQUI PMENT RENTAL 5, 759 5, 856 4. 05 4. 06 5. 00 ADMI NI STRATI VE & GENERAL SFI CVO 25, 199 25, 144 4. 06
3. 07 3. 08 3. 07 3. 08 3. 09 3. 09 3. 10 4. 00 4. 00 4. 01 4. 02 4. 03 4. 02 4. 03 4. 03 4. 04 4. 05 4. 00 4. 04 4. 05 4. 06 4. 06 4. 06 4. 08 4. 00
3. 08 73. 00 DRUGS CHARGED TO PATIENTS MINISTRY ALLOCATION 38, 487 38, 487 3. 08 3. 09 54. 00 RADI OLOGY-DI AGNOSTI C MINISTRY ALLOCATION 253 253 3. 09 3. 10 60. 00 LABORATORY MINISTRY ALLOCATION 49 49 3. 10 4. 00 13. 00 NURSI NG ADMI NISTRATION HO FUNCTI ONAL - NURSI NG ADMI 302, 791 0 4. 00 4. 01 73. 00 DRUGS CHARGED TO PATIENTS HO FUNCTI ONAL - NURSI NG ADMI 103, 736 103, 736 4. 01 4. 02 17. 00 SOCI AL SERVI CE HO FUNCTI ONAL - SOCI AL SERVI 280, 616 291, 281 4. 02 4. 03 5. 00 ADMI NI STRATI VE & GENERAL HO FUNCTI ONAL - ADMI N & GEN 1, 909, 248 1, 147, 100 4. 03 4. 04 73. 00 DRUGS CHARGED TO PATIENTS HO FUNCTI ONAL - ADMI N & GEN 1, 742 0 4. 04 4. 05 54. 00 RADI OLOGY-DI AGNOSTI C SFI EQUI PMENT RENTAL 5, 759 5, 856 4. 05 4. 06 5. 00 ADMI NI STRATI VE & GENERAL SFI CVO 25, 199 25, 144 4. 06
3. 09 3. 10 4. 00 3. 10 60. 00 LABORATORY MINISTRY ALLOCATION 4. 00 4. 01 4. 01 73. 00 DRUGS CHARGED TO PATIENTS 4. 02 4. 03 4. 03 5. 00 ADMINISTRATIVE & GENERAL 4. 05 5. 00 ADMINISTRATIVE & GENERAL 5. 00 ADMINISTRATIVE & GENERAL 4. 05 5. 00 ADMINISTRATIVE & GENERAL 5. 00 ADMINI
3. 10 60. 00 LABORATORY MINISTRY ALLOCATION 49 49 3. 10 4. 00 13. 00 NURSING ADMINISTRATION HO FUNCTIONAL - NURSING ADMI 302, 791 0 4. 00 4. 01 73. 00 DRUGS CHARGED TO PATIENTS HO FUNCTIONAL - NURSING ADMI 103, 736 103, 736 4. 01 4. 02 17. 00 SOCIAL SERVICE HO FUNCTIONAL - SOCIAL SERVI 280, 616 291, 281 4. 02 4. 03 5. 00 ADMINISTRATIVE & GENERAL HO FUNCTIONAL - ADMIN & GEN 1, 909, 248 1, 147, 100 4. 03 4. 04 73. 00 DRUGS CHARGED TO PATIENTS HO FUNCTIONAL - ADMIN & GEN 1, 742 0 4. 04 4. 05 54. 00 RADIOLOGY-DIAGNOSTIC SFI EQUIPMENT RENTAL 5, 759 5, 856 4. 05 4. 06 55. 00 ADMINISTRATIVE & GENERAL SFI CVO 25, 199 25, 144 4. 06
4.00 4.01 4.01 4.02 4.03 4.03 4.04 4.04 4.05 5.00 ADMI NI STRATI VE & GENERAL 4.05 4.06 4.06 4.00 13.00 NURSI NG ADMI NI STRATI ON HO FUNCTI ONAL - NURSI NG ADMI 103, 736 103, 736 4.01 103, 736 4.01 103, 736 4.01 103, 736 103, 736 4.01 103, 736 103, 736 4.01 103, 736 103, 736 103, 736 4.01 103, 736
4. 01
4. 02
4. 03 5. 00 ADMI NI STRATI VE & GENERAL HO FUNCTI ONAL - ADMI N & GEN 1, 909, 248 1, 147, 100 4. 03 4. 04 73. 00 DRUGS CHARGED TO PATI ENTS HO FUNCTI ONAL - ADMI N & GEN 1, 742 0 4. 04 05 54. 00 RADI OLOGY-DI AGNOSTI C SFI EQUI PMENT RENTAL 5, 759 5, 856 4. 05 4. 06 5. 00 ADMI NI STRATI VE & GENERAL SFI CVO 25, 199 25, 144 4. 06
4.04 73.00 DRUGS CHARGED TO PATIENTS HO FUNCTIONAL - ADMIN & GEN 1,742 0 4.04 4.05 54.00 RADIOLOGY-DIAGNOSTIC SFI EQUIPMENT RENTAL 5,759 5,856 4.05 4.06 5.00 ADMINISTRATIVE & GENERAL SFI CVO 25,199 25,144 4.06
4. 05 54. 00 RADI OLOGY-DI AGNOSTI C SFI EQUI PMENT RENTAL 5, 759 5, 856 4. 05 4. 06 5. 00 ADMI NI STRATI VE & GENERAL SFI CVO 25, 199 25, 144 4. 06
4. 06 5. 00 ADMINISTRATIVE & GENERAL SFI CVO 25, 199 25, 144 4. 06
4 07 CONTAINTENANCE & DEDALDO CEL HEALTHOADE TECHNIQUON CVI COZ COST
4.07 6.00 MAINTENANCE & REPAIRS SFI HEALTHCARE TECHNOLOGY SV 237,005 248,470 4.07
4. 08 54. 00 RADI OLOGY-DI AGNOSTI C SFI HEALTHCARE TECHNOLOGY SV 339, 679 356, 111 4. 08
4. 09 60. 00 LABORATORY SFI HEALTHCARE TECHNOLOGY SV 65, 432 68, 597 4. 09
4. 10 30. 00 ADULTS & PEDIATRICS PURCH SVCS-ST GABRIEL 225, 423 225, 954 4. 10
4.11 1.00 CAP REL COSTS-BLDG & FIXT OSFMG MINISTRY ALLOCATION 694 17,105 4.11
4. 12 30. 00 ADULTS & PEDIATRICS OSFMG MINISTRY ALLOCATION 4, 159 15, 911 4. 12
4. 13 53. OO ANESTHESI OLOGY OSFMG MINI STRY ALLOCATION 447 7, 019 4. 13
4.14 88.00 RURAL HEALTH CLINIC OSFMG MINISTRY ALLOCATION 406, 428 723, 447 4.14
4.15 88.01 RURAL HEALTH CLINIC II OSFMG MINISTRY ALLOCATION 40,003 70,366 4.15
4.16 91.00 EMERGENCY OSFMG MINISTRY ALLOCATION 17,185 74,900 4.16
5.00 TOTALS (sum of lines 1-4). 7,129,724 7,265,337 5.00
Transfer column 6, line 5 to
Worksheet A-8, column 2,
line 12.

The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and/	or Home Office	
					ł
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1.00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HO	ME 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII

i ei ilibui	Selliett under title Aviii.				
6.00	В	OSF HEALTHCARE SYSTEM	100.00	0.00	6.00
7. 00			0.00	0.00	7. 00
8. 00			0.00	0.00	8.00
9. 00			0.00	0.00	9. 00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:			1	

- (1) Use the following symbols to indicate 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.
- 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 organi zati on.
- 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 provi der

			To 09/30/2023	Date/Time Pre 2/20/2024 3:0	pared:
	Net	Wkst. A-7 Ref.		2/20/2024 3.0	о ріп
	Adjustments				
	(col. 4 minus				
	col. 5)*				
	6. 00	7. 00			
	A. COSTS INCUR	RED AND ADJUSTME	NTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR	CLAIMED HOME	
	OFFICE COSTS:				
1.00	-157, 595	9			1.00
2.00	348, 260	9			2.00
3.00	-939, 897	0			3.00
3. 01	0	0			3. 01
3.02	0	0			3. 02
3.03	0	0			3.03
3.04	26, 712	0			3.04
3.05	1, 842	0			3.05
3.06	510	0			3.06
3.07	6	0]	3.07
3.08	0	0			3.08
3.09	0	0			3.09
3. 10	0	0			3. 10
4.00	302, 791	0			4.00
4.01	o	0			4.01
4.02	-10, 665	0			4.02
4.03	762, 148	0			4.03
4.04	1, 742	0			4.04
4.05	-97	0			4.05
4.06	55	0			4.06
4.07	-11, 465	0			4.07
4.08	-16, 432	0			4.08
4.09	-3, 165	0			4. 09
4. 10	-531	0			4. 10
4. 11	-16, 411	9			4. 11
4. 12	-11, 752	0			4. 12
4. 13	-6, 572	0			4. 13
4. 14	-317, 019	0			4. 14
4. 15	-30, 363	0			4. 15
4. 16	-57, 715	0			4. 16
5.00	-135, 613		and the second state of th		5. 00

* The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s) and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELA	TED 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00 7. 00 8. 00		6. 00
7. 00		7.00
8. 00		8.00
9. 00		9.00
10. 00		10.00
9. 00 10. 00 100. 00		100.00

- $\hbox{(1) Use the following symbols to indicate interrelationship to related organizations:}\\$
- 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.

| Period: | Worksheet A-8-2 | From 10/01/2022 | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 14-1318

					-	To 09/30/2023	Date/Time Pre 2/20/2024 3:0	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				'			Hours	
	1.00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	30.00	ADULTS & PEDIATRICS	53, 077	53, 077	0	0	0	1.00
2.00	53.00	ANESTHESI OLOGY	-60, 913	-60, 913	0	0	o	2.00
3.00	53.00	DR. K	25, 000	0	25, 000	0	o	3.00
4.00	60.00	LABORATORY	14, 400	0	14, 400	0	o	4.00
5.00	76. 01	WOUND CLINIC	-68, 633	-68, 633	0	0	o	5.00
6.00	91.00	EMERGENCY	1, 513, 373	1, 254, 889	258, 484	0	o	6.00
7.00	0.00		0	0	0	0	o	7. 00
8.00	0.00		0	0	0	0	o	8.00
9.00	0.00		0	0	0	0	O	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1, 476, 304	1, 178, 420	297, 884		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12.00	13. 00	14. 00	
1.00		ADULTS & PEDIATRICS	0	0	_	_	0	1. 00
2.00		ANESTHESI OLOGY	0	0			0	2. 00
3. 00		DR. K	0	0	-	_	0	3.00
4. 00		LABORATORY	0	0	0	0	0	4. 00
5.00		WOUND CLINIC	0	0	0	0	0	5.00
6. 00		EMERGENCY	0	0	0	0	0	6. 00
7. 00	0.00		0	0	0	0	0	7. 00
8. 00	0.00		0	0	0	0	0	8. 00
9. 00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	· ·	10100
200.00			0	0	0	0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	15.00					1. 00
2. 00		ANESTHESI OLOGY		0				2. 00
3. 00		DR. K		0	-			3. 00
4. 00	•	LABORATORY		0	-			4. 00
5. 00	•	WOUND CLINIC		0	-	-68, 633		5. 00
6. 00		EMERGENCY		0		1, 254, 889		6. 00
7. 00	0.00			0	-	1, 234, 669		7. 00
8. 00	0.00			0				8. 00
9. 00	0.00			0	-			9. 00
10.00	0.00							10.00
200.00	0.00				0	1, 178, 420		200.00
200.00	I	I	1	ı U	ı U	1, 170, 420		200.00

	Financial Systems	OSF HOLY FAMI				u of Form CMS-2		
	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der C	CN: 14-1318	Peri od: From 10/01/2022 To 09/30/2023		pared:	
					Physical Therapy		<u>5 piii </u>	
						1 00		
	PART I - GENERAL INFORMATION					1. 00		
1. 00	Total number of weeks worked (excluding aide	s) (see instruc	tions)			7	1.00	
2.00	Line 1 multiplied by 15 hours per week		.	:: +-	- !+	105	2.00	
3. 00 4. 00	Number of unduplicated days in which supervi Number of unduplicated days in which therapy	0	3. 00 4. 00					
	nor therapist was on provider site (see inst	ructions)	•			_		
5. 00	Number of unduplicated offsite visits - supe				by thereny	0	5.00	
6. 00	Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the					0	6.00	
	instructions)	•			,, ,			
7. 00 8. 00	Standard travel expense rate Optional travel expense rate per mile					5. 62 0. 00	7. 00 8. 00	
0.00	poper orial traver expense rate per inite	Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	0.00	
0.00	Transfer and the second second	1. 00	2.00	3.00	4. 00	5. 00	0.00	
9. 00 10. 00	Total hours worked AHSEA (see instructions)	0. 00 0. 00	175. 50 95. 15	1		0. 00 0. 00		
	Standard travel allowance (columns 1 and 2,	47. 58	47. 58	•		0.00	11.00	
	one-half of column 2, line 10; column 3,							
12. 00	one-half of column 3, line 10) Number of travel hours (provider site)	0	0		0		12.00	
12. 01	Number of travel hours (offsite)	o	Ö	•	Ö		12. 01	
13.00	Number of miles driven (provider site)	0	0	•	0		13.00	
13. 01	Number of miles driven (offsite)	0	0)	0		13. 01	
						1. 00		
14 00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1	line 10)				0	14.00	
	0 Supervisors (cordinari, fine 9 times cordinari, fine 10) 0 Therapists (column 2, line 9 times column 2, line 10)						15.00	
16. 00	Assistants (column 3, line 9 times column 3,					0	16.00	
17. 00	Subtotal allowance amount (sum of lines 14 a others)	nd 15 for respi	ratory therap	y or lines 14	-16 for all	16, 699	17. 00	
18.00	Aides (column 4, line 9 times column 4, line	10)				0	18. 00	
	Trainees (column 5, line 9 times column 5, l		thorony on Liv	noo 17 and 10	for all athera	1/ /00		
20. 00	Total allowance amount (sum of lines 17–19 f If the sum of columns 1 and 2 for respirator	v therapy or co	lumns 1-3 for	physical the	rapv. speech pat	16, 699 thol oay or	20.00	
	occupational therapy, line 9, is greater tha	n line 2, make		1 2	13. 1	55		
21 00	amount from line 20. Otherwise complete lin Weighted average rate excluding aides and tr		divided by s	um of columns	1 and 2 line (0.00	21.00	
21.00	for respiratory therapy or columns 1 thru 3,			uiii or coruiiiris	and 2, Time s	0.00	21.00	
	Weighted allowance excluding aides and train	ees (line 2 tim	es line 21)			0		
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO	WANCE AND TRAVE	I EXPENSE COM	PUTATION - PR	OVIDER SITE	16, 699	23.00	
	Standard Travel Allowance		2 2711 21102 001111		OTTE			
	Therapists (line 3 times column 2, line 11)					0		
25. 00 26. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 2	4 and 25 for	all others)		0	25. 00 26. 00	
27. 00	Standard travel expense (line 7 times line 3			,	3 and 4 for all	0	27. 00	
28. 00	others) Total standard travel allowance and standard	traval avnonce	at the provi	dor si to (sum	of lines 26 and	0	28. 00	
20.00	27)	traver expense	at the provi	del si te (sui	r or rrines 20 and	0	20.00	
00.00	Optional Travel Allowance and Optional Trave		10 11 10	`			00.00	
29. 00 30. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3		d 2, Tine 12)		0		
31.00	Subtotal (line 29 for respiratory therapy or		9 and 30 for	all others)		0		
32. 00	Optional travel expense (line 8 times column	s 1 and 2, line	13 for respi	ratory therap	y or sum of	0	32.00	
33. 00	columns 1-3, line 13 for all others) Standard travel allowance and standard trave	l expense (line	28)			0	33.00	
34. 00	Optional travel allowance and standard trave			nd 31)		0	34.00	
35. 00	Optional travel allowance and optional trave				MICEC OUTCLDE DE	0	35.00	
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense	ANCE AND TRAVEL	EXPENSE COMPI	UTATIUN - SER	VICES UUISIDE PH	TOVIDER SITE		
36.00	Therapists (line 5 times column 2, line 11)					0		
37. 00 38. 00	Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)					0	37. 00 38. 00	
55.00	00 Subtotal (sum of lines 36 and 37) 0 38							

31.00	Subtotal (Title 29 for respiratory therapy or sum of filles 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of	0	32.00
	columns 1-3, line 13 for all others)		1
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PR	ROVI DER SITE	1
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		1
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lin	nes 44, 45, or	
	46, as appropriate.		1
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00
		·	
MCRIF3	2 - 21. 3. 178. 2		

Heal th	Financial Systems	OSF HOLY FAMIL	Y MED CTR		In Lie	u of Form CMS-2	2552-10
REASON	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der CO	CN: 14-1318	Peri od: From 10/01/2022 To 09/30/2023		pared:
					Physical Therapy	Cost	
						1. 00	
46. 00	Optional travel allowance and optional trave				nstructions) Trainees	0 Total	46. 00
		Therapi sts 1.00	Assi stants 2.00	Ai des 3.00	4. 00	5. 00	
	PART V - OVERTIME COMPUTATION						
47. 00	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)	0.00	0.00	0. (0.00	0.00	47.00
	Overtime rate (see instructions)	0.00	0.00	0. (0.00		48.00
49. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0. 00	0. (0. 00		49.00
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0. (0. 00	0.00	50.00
	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0. 00	0. (0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE	95. 15	0.00	0.0	0.00		52.00
53. 00	Adjusted hourly salary equivalency amount (see instructions) Overtime cost limitation (line 51 times line		0.00		0 0.00		53.00
54. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
55. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0		0 0		55.00
56. 00	line 47 times line 52) 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.)	0	0		0 0	0	56.00
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	AND EXCESS COST	ADJUSTMENT				
57.00 Salary equivalency amount (from line 23) 58.00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 59.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46) 60.00 Overtime allowance (from column 5, line 56) 61.00 Equipment cost (see instructions) 62.00 Supplies (see instructions) 63.00 Total allowance (sum of lines 57-62) 64.00 Total cost of outside supplier services (from your records) 65.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero)						14, 965	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
100. 01	LINE 33 CALCULATION 100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 100.02 Line 33 = line 28 = sum of lines 26 and 27						
101. 01	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respirator; Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	0	101. 00 101. 01 101. 02
	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				umns 1-3, line		102. 00 102. 01
102. 02	13 for all others Line 35 = sum of lines 31 and 32					0	102. 02

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS OSF HOLY FAMILY MED CTR In Lieu of Form CMS-2552-10 Peri od: Worksheet B
From 10/01/2022 Part I
To 09/30/2023 Date/Time Prepared: 2/20/2024 3:03 pm Provider CCN: 14-1318 CAPITAL RELATED COSTS

			CAPITAL REI	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	COST CENTER DESCRIPTION	for Cost	DEDU & TIXI	WVDLL LQOIT	BENEFI TS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A			DEI / III III EI II		
		col. 7)					
		0	1. 00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 370, 195	1, 370, 195				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 241, 522		1, 241, 522			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 508, 968			3, 508, 968		4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	5, 745, 572	227, 911		308, 681	6, 488, 670	5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	237, 461	0	0	0	237, 461	6. 00
7. 00	00700 OPERATION OF PLANT	1, 254, 916	169, 123		87, 906	1, 665, 186	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	4, 216	45.00/	0	100.040	4, 216	
9.00	00900 HOUSEKEEPI NG	668, 322	15, 396		128, 049	825, 717	9.00
10.00	01000 DI ETARY	565, 271	86, 677		100, 229	830, 714	1
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL	-74, 262	0	1	0	-74, 262 0	11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	447, 237	0	0	39, 383	486, 620	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	447, 237	0	0	37, 303	480, 020	14.00
15. 00	01500 PHARMACY	0	0	0	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	48, 090	3, 941	-	0	55, 602	16.00
17. 00	01700 SOCI AL SERVI CE	280, 616	0,711		0	280, 616	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00		1, 494, 445	134, 166	121, 567	378, 992	2, 129, 170	30.00
	ANCILLARY SERVICE COST CENTERS	<u> </u>	·		· · · · · · · · · · · · · · · · · · ·		
50.00	05000 OPERATING ROOM	962, 781	95, 058	86, 131	146, 899	1, 290, 869	50.00
53.00	05300 ANESTHESI OLOGY	38, 518	3, 035	2, 750	21, 786	66, 089	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 089, 234	58, 301	52, 826	195, 514	1, 395, 875	54.00
56.00	05600 RADI OI SOTOPE	72, 813	0	0	9, 812	82, 625	56.00
57.00	05700 CT SCAN	45, 917	0	0	0	45, 917	57.00
58. 00	05800 MRI	297, 494	0	0	0	297, 494	58. 00
60.00	06000 LABORATORY	1, 509, 227	24, 960		195, 792	1, 752, 595	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1	0	0	62. 30
64.00	06400 I NTRAVENOUS THERAPY	23, 068		0	6, 374	29, 442	64.00
65.00	06500 RESPI RATORY THERAPY	173, 764	3, 941		42, 799	224, 075	65.00
66.00	06600 PHYSI CAL THERAPY	344, 760			84, 618	540, 581	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	131, 653			33, 304 604	171, 993 3, 926	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 445 393, 051	460 31, 410		102, 467	555, 388	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 700		35, 067	102, 407	79, 468	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	246, 056			0	246, 056	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 615, 687		-	67, 744	1, 716, 609	1
76. 00	03950 DI ABETI C SERVI CES	21, 467	13, 846		5, 821	53, 680	76. 00
76. 01	03020 WOUND CLINIC	577, 762	7, 291		20, 312	611, 971	76. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	4, 687, 541					
88. 01	08801 RURAL HEALTH CLINIC II	386, 102			85, 329		1
91.00	09100 EMERGENCY	1, 828, 183	78, 689	71, 300	388, 872	2, 367, 044	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
100.00	OTHER REIMBURSABLE COST CENTERS		0		0	0	100.00
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
118.00		31, 245, 792	1, 313, 457	1, 190, 112	3, 508, 912	31, 137, 588	110 00
110.00	NONREI MBURSABLE COST CENTERS	31, 240, 192	1, 313, 437	1, 170, 112	3, 300, 712	31, 137, 300	11 10.00
190 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSI CI ANS PRI VATE OFFI CES	0			0	108, 148	1
	07950 NONREI MBURSABLE COST CENTER	202	0.00	01, 110	56		194.00
	07951 RESEARCH	0	Ö	o o	0		194. 01
200.00		1]			200.00
201.00			0	0	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	31, 245, 994	1, 370, 195	1, 241, 522	3, 508, 968	31, 245, 994	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1318

Peri od: Worksheet B From 10/01/2022 Part I To 09/30/2023 Date/Time Prepared:

2/20/2024 3:03 pm Cost Center Description ADMINISTRATIV MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG E & GENERAL **REPAIRS PLANT** LINEN SERVICE 5.00 7.00 8.00 9.00 6.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 00500 ADMINISTRATIVE & GENERAL 5.00 6, 488, 670 5.00 6.00 00600 MAINTENANCE & REPAIRS 62,050 299, 511 6.00 7.00 00700 OPERATION OF PLANT 435, 125 44, 345 2, 144, 656 7.00 00800 LAUNDRY & LINEN SERVICE 1, 102 5, 318 8 00 8 00 9.00 00900 HOUSEKEEPI NG 215, 766 4,037 33, 930 0 1,079,450 9.00 01000 DI ETARY 217, 071 97, 689 10.00 10.00 22, 727 191, 018 0 11.00 01100 CAFETERI A C 0 0 0 11.00 0 01200 MAINTENANCE OF PERSONNEL 12 00 0 C 0 0 12 00 13.00 01300 NURSING ADMINISTRATION 127, 157 0 0 0 13.00 C 14.00 01400 CENTRAL SERVICES & SUPPLY 0 C 0 0 0 14.00 01500 PHARMACY 0 15.00 15.00 0 0 0 01600 MEDICAL RECORDS & LIBRARY 16.00 14, 529 1.033 8.685 0 4.442 16.00 17.00 01700 SOCIAL SERVICE 73, 327 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 556, 367 35, 179 30.00 1, 539 30.00 295, 676 151, 212 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 337, 313 209, 489 107, 135 24, 925 636 50.00 05300 ANESTHESI OLOGY 53.00 17, 270 796 6, 688 3, 420 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 364, 752 54.00 15, 287 128, 484 1, 234 65, 708 54.00 56.00 05600 RADI OI SOTOPE 21, 590 0 0 Λ 56.00 57.00 05700 CT SCAN 11, 998 0 0 0 57.00 05800 MRI 77. 737 0 9 58.00 0 0 58.00 60.00 06000 LABORATORY 457, 965 6,545 55,007 28, 131 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 0 62.30 64.00 06400 INTRAVENOUS THERAPY 7,693 0 64.00 O 0 65.00 06500 RESPIRATORY THERAPY 58, 552 1, 033 8,685 0 4, 442 65.00 66.00 06600 PHYSI CAL THERAPY 141, 258 15, 297 128, 571 146 65, 753 66.00 67.00 06700 OCCUPATI ONAL THERAPY 44, 943 968 8, 135 56 4, 160 67.00 06800 SPEECH PATHOLOGY 1,026 121 1,013 3 518 68.00 68.00 06900 FLECTROCARDI OLOGY 69, 222 94 35, 401 69 00 145. 127 8. 236 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 20, 766 10, 148 85, 289 0 43,618 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 64, 296 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 448, 562 4.564 38, 360 0 19, 618 73.00 03950 DIABETIC SERVICES 14, 027 0 76.00 3, 631 30, 514 15, 605 76.00 16,068 76.01 03020 WOUND CLINIC 159, 912 1, 912 0 8, 217 76.01 07697 CARDIAC REHABILITATION 0 76.97 0 C 0 0 76.97 76 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 76.98 Ω 0 07699 LI THOTRI PSY 0 76.99 0 C 0 0 76.99 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 77.00 77.00 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 1, 603, 754 53, 955 453, 518 52 231, 935 88.00 88.01 08801 RURAL HEALTH CLINIC II 140, 783 9, 262 77, 849 39, 813 88.01 09100 EMERGENCY 173, 416 91.00 91.00 618, 525 1.493 88.687 20, 633 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 92.00 92.00 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 460, 343 284, 634 2, 019, 617 5, 262 1, 015, 504 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190. 00 C 192.00 19200 PHYSICIANS PRIVATE OFFICES 63, 946 192. 00 28, 260 14.877 125, 039 56 194. 00 07950 NONREI MBURSABLE COST CENTER 0 194.00 67 C 0 0 194. 01 194. 01 07951 RESEARCH 0 0 0 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201 00 202.00 TOTAL (sum lines 118 through 201) 6, 488, 670 299, 511 2, 144, 656 5, 318 1, 079, 450 202. 00

Provider CCN: 14-1318

						2/20/2024 3: 03	3 pm
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	
				OF PERSONNEL	ADMI NI STRATI O	SERVICES &	
					N	SUPPLY	
		10. 00	11. 00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7. 00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00		1, 359, 219					10.00
11. 00		918, 011	843, 749				11. 00
12. 00		710, 011	043, 747	0			12. 00
			9, 958				13. 00
14. 00		0	7, 730 N		023, 733	0	14. 00
15. 00			0		-		15. 00
			0				
16.00			0			0	16.00
17. 00		l 0	0	0	0	0	17. 00
00.00	INPATIENT ROUTINE SERVICE COST CENTERS	2/0 500	444 045		200 (00		00.00
30. 00		369, 530	111, 915	0	292, 699	0	30.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	54, 512	46, 371	0	0	0	50. 00
	1	34, 312	3, 641				53. 00
54. 00	1		66, 064			0	54. 00
56. 00	1		2, 824	1	0		56. 00
57. 00	1	0	2, 024		0	0	57.00
58. 00	1	0	0	0		0	58.00
60.00	1	0	76, 096	· ·	_	0	60.00
62. 30	1	0	70, 090			0	62. 30
64. 00		0	1, 932	· -	_	0	64. 00
65. 00	1	0	15, 308			0	65.00
66. 00	1						66.00
67. 00		0	18, 801 8, 769				67.00
68. 00		0	223		0		68. 00
69. 00		0	34, 853		0		69. 00
		0	0 0 0 0 0				71.00
71.00		0	0		-		71.00
73. 00			16, 349	·	-		73.00
		0	1, 784				76.00
76. 00		0	5, 425			0	76. 00 76. 01
			J, 42J		-		76. 97
76. 97 76. 98			0		_		76. 97 76. 98
			0		0	0	76. 9 8
77.00			0		0		76. 99 77. 00
78.00			0				77.00 78.00
76.00	OUTPATIENT SERVICE COST CENTERS	l o	0		U U	<u>_</u>	76.00
88 00	08800 RURAL HEALTH CLINIC	O	315, 088	0	0	0	88. 00
	1	0	0 0 0 0 0	1			88. 01
	09100 EMERGENCY	17, 166	108, 348				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	17, 100	100, 340	Ĭ	200, 470	i	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
102 00	0 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
102.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		· · · · · ·	<u> </u>		102.00
118.00		1, 359, 219	843, 749	0	623, 735	0	118. 00
110.00	NONREI MBURSABLE COST CENTERS	1,007,217	010, 717		020, 700		110.00
190 00	0 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	0 19200 PHYSI CI ANS PRI VATE OFFI CES	ا	0				192.00
194 00	0 07950 NONREIMBURSABLE COST CENTER	ا	0				194. 00
	1 07951 RESEARCH		0	·			194. 01
200.00			O	I	l ~		200.00
201.00		n	0	0	0		201.00
202.00		1, 359, 219	843, 749				202. 00
				'		- [

Health Financial Systems OSF HOLY FAMILY MED CTR In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1318 Peri od: Worksheet B From 10/01/2022 Part I Date/Time Prepared: 09/30/2023 2/20/2024 3:03 pm Cost Center Description **PHARMACY** MEDI CAL SOCI AL Subtotal Intern & SERVI CE RECORDS & Resi dents LI BRARY Cost & Post Stepdown Adjustments 15. 00 16.00 17.00 24.00 25. 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 84, 291 16.00 01700 SOCIAL SERVICE 0 353, 943 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 353, 943 30.00 30.00 2, 879 4, 300, 109 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 9, 078 50.00 0 2,080,328 0 50.00 53.00 05300 ANESTHESI OLOGY 0 1, 326 0 99, 230 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 2, 044, 174 54.00 0000000000000000000 6,770 0 0 54.00 56 00 05600 RADI OI SOTOPE 777 0 107, 816 Ω 56 00 05700 CT SCAN 0 57.00 11,026 68, 941 0 57.00 58.00 05800 MRI 2, 490 377, 721 0 58.00 06000 LABORATORY 60.00 15, 286 0 2, 391, 634 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62 30 0 62 30 06400 I NTRAVENOUS THERAPY 64.00 341 39, 408 0 64.00 1, 125 06500 RESPIRATORY THERAPY 313, 220 0 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 1.308 911, 715 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67 00 239, 526 0 67 00 502 0 68.00 06800 SPEECH PATHOLOGY 24 6,854 0 68.00 06900 ELECTROCARDI OLOGY 851, 543 69.00 69.00 3, 222 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 121 0 239, 410 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 312, 029 72 00 1.677 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 8,626 2, 295, 492 0 73.00 76 00 03950 DIABETIC SERVICES 0 124,004 0 76.00 03020 WOUND CLINIC 0 76.01 804, 642 0 76.01 1, 137 07697 CARDIAC REHABILITATION 0 76.97 r 0 0 76.97 76.98 07698 HYPERBARIC OXYGEN THERAPY 0 0 C 0 0 0 76.98 76. 99 07699 LI THOTRI PSY 0 76.99 0 0 0 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 C 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 6, 808 0 88.00 8, 802, 527 0 08801 RURAL HEALTH CLINIC II 0 0 88.01 605 807.076 0 88.01 09100 EMERGENCY 0 9, 157 0 3, 687, 944 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 84, 291 353, 943 30, 905, 343 0 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 190.00 0 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 192.00 0 0 340, 326 0 194. 00 07950 NONREI MBURSABLE COST CENTER 0 0 194.00 C 325

0

0

C

84 291

0

353, 943

0

0

31 245 994

0 194, 01

0 200.00 0 201.00

0 202.00

194. 01 07951 RESEARCH

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00

201.00

202 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS OSF HOLY FAMILY MED CTR In Lieu of Form CMS-2552-10 Provider CCN: 14-1318

Peri od: Worksheet B From 10/01/2022 Part I To 09/30/2023 Date/Ti me Prepared: 2/20/2024 3:03 pm

			4 3: 03 pm
	Cost Center Description	Total	
		26. 00	
	GENERAL SERVICE COST CENTERS		
1.00	00100 CAP REL COSTS-BLDG & FLXT		1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL		5.00
6. 00	00600 MAI NTENANCE & REPAI RS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPI NG		9.00
	01000 DI ETARY		10.00
11.00	01100 CAFETERI A		11.00
	01200 MAI NTENANCE OF PERSONNEL		12.00
	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY		13. 00 14. 00
	01500 PHARMACY		15. 00
	01600 MEDICAL RECORDS & LIBRARY		16.00
	01700 SOCI AL SERVI CE		17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS		17.00
30 00	03000 ADULTS & PEDIATRICS	4, 300, 109	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	4, 300, 107	30.00
50.00	05000 OPERATING ROOM	2, 080, 328	50.00
	05300 ANESTHESI OLOGY	99, 230	53.00
	05400 RADI OLOGY-DI AGNOSTI C	2, 044, 174	54.00
56. 00	05600 RADI OI SOTOPE	107, 816	56.00
	05700 CT SCAN	68, 941	57.00
58. 00	05800 MRI	377, 721	58.00
	06000 LABORATORY	2, 391, 634	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	62. 30
	06400 I NTRAVENOUS THERAPY	39, 408	64.00
65.00	06500 RESPI RATORY THERAPY	313, 220	65.00
66.00	06600 PHYSI CAL THERAPY	911, 715	66.00
67.00	06700 OCCUPATI ONAL THERAPY	239, 526	67.00
68.00	06800 SPEECH PATHOLOGY	6, 854	68. 00
69.00	06900 ELECTROCARDI OLOGY	851, 543	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	239, 410	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	312, 029	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 295, 492	73.00
	03950 DI ABETI C SERVI CES	124, 004	76.00
	03020 WOUND CLINIC	804, 642	76. 01
	O7697 CARDI AC REHABI LI TATI ON	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	76. 98
	07699 LI THOTRI PSY	0	76. 99
	07700 ALLOGENEIC HSCT ACQUISITION	0	77.00
78. 00	07800 CAR T-CELL I MMUNOTHERAPY	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	0.000.507	
	08800 RURAL HEALTH CLINIC	8, 802, 527	88.00
88. 01	08801 RURAL HEALTH CLINIC II	807, 076	88. 01
	09100 EMERGENCY	3, 687, 944	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
100.00	OTHER REIMBURSABLE COST CENTERS	٥	102.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	102.00
110 00	SPECIAL PURPOSE COST CENTERS	20 005 242	110.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	30, 905, 343	118. 00
100 00			100.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICIANS PRIVATE OFFICES	340 334	190.00
		340, 326	192. 00 194. 00
	07950 NONREI MBURSABLE COST CENTER 07951 RESEARCH	325	194.00
200.00		0	200.00
200.00	, ,		201.00
201.00		31, 245, 994	202. 00
202.00	TOTAL (Sum TIMES TO UNIOUGH 201)	31,243,774	1202.00

| Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1318

					To	09/30/2023	Date/Time Pre 2/20/2024 3:0	
				CAPI TAL REI	LATED COSTS		2/20/2024 3.0	5 piii
		Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
			Assigned New				BENEFI TS	
			Capi tal Related Costs				DEPARTMENT	
			0	1. 00	2. 00	2A	4. 00	
	GENER	AL SERVICE COST CENTERS	<u> </u>	11.00	2.00			
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2. 00		CAP REL COSTS-MVBLE EQUIP						2.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	0	0		0	0	4.00
5.00		ADMINISTRATIVE & GENERAL	3, 600	227, 911	_	438, 017	0	5.00
6. 00 7. 00		MAINTENANCE & REPAIRS	7, 967	140 122	152 241	7, 967	0	6.00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	22, 538	169, 123	153, 241	344, 902	0	7. 00 8. 00
9. 00		HOUSEKEEPI NG	0	15, 396	13, 950	29, 346	0	9.00
10.00	1	DI ETARY	o	86, 677		165, 214	0	10.00
11.00	1	CAFETERI A	0	0	0	0	0	11.00
12.00		MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
		NURSING ADMINISTRATION	0	0	0	0	0	13.00
		CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
		PHARMACY MEDICAL RECORDS & LIBRARY	0	3, 941	3, 571	7, 512	0	15. 00 16. 00
		SOCIAL SERVICE	0	3, 941		7, 512	0	17.00
17.00		IENT ROUTINE SERVICE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		17.00
30.00		ADULTS & PEDIATRICS	0	134, 166	121, 567	255, 733	0	30. 00
		LARY SERVICE COST CENTERS						
		OPERATING ROOM	0	95, 058		181, 189	0	50.00
		ANESTHESI OLOGY	2, 102	3, 035		7, 887	0	53.00
54. 00 56. 00		RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	0	58, 301	52, 826	111, 127	0	54. 00 56. 00
57. 00		CT SCAN	0	0	0	0	0	57.00
58. 00	05800		o	0	0	0	0	58.00
60.00		LABORATORY	0	24, 960	22, 616	47, 576	0	60.00
62.30		BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
64.00		INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00		RESPI RATORY THERAPY	5, 327	3, 941		12, 839	0	65.00
66.00		PHYSI CAL THERAPY	0	58, 341		111, 203	0	66.00
67. 00 68. 00		OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	0	3, 691 460		7, 036 877	0	67. 00 68. 00
69. 00		ELECTROCARDI OLOGY	1, 941	31, 410	1	61, 811	0	69.00
		MEDICAL SUPPLIES CHARGED TO PATIENT	1, 741	38, 701		73, 768	0	71.00
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17, 406	15, 772	33, 178	0	73.00
		DIABETIC SERVICES	0	13, 846		26, 392	0	76. 00
76. 01	1	WOUND CLINIC	0	7, 291	6, 606	13, 897	0	76. 01
76. 97 76. 98		CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
		HYPERBARI C OXYGEN THERAPY LI THOTRI PSY	0	0	0	0	0	76. 98 76. 99
	1	ALLOGENEIC HSCT ACQUISITION	o	0	0	0	0	77.00
		CAR T-CELL IMMUNOTHERAPY	0	0	0	Ö	0	
	OUTPA	TIENT SERVICE COST CENTERS						
		RURAL HEALTH CLINIC	0	205, 788		392, 251	0	
		RURAL HEALTH CLINIC II	0	35, 325		67, 333	0	88. 01
		EMERGENCY	0	78, 689	71, 300	149, 989	0	91.00
		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS				0		92.00
		OPLOID TREATMENT PROGRAM	O	0	0	o	0	102. 00
102.00		AL PURPOSE COST CENTERS	<u> </u>	0	0	٥١		102.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43, 475	1, 313, 457	1, 190, 112	2, 547, 044	0	118.00
		IMBURSABLE COST CENTERS						
		GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0		190. 00
		PHYSICIANS PRIVATE OFFICES	0	56, 738	51, 410	108, 148		192.00
		NONREIMBURSABLE COST CENTER RESEARCH	0	0	0	O		194. 00 194. 01
200.00		RESEARCH Cross Foot Adjustments		0		0		200. 00
200.00		Negative Cost Centers		n	0	0		200.00
202.00	1	TOTAL (sum lines 118 through 201)	43, 475	1, 370, 195	1, 241, 522	2, 655, 192		202.00
		9 ,						•

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

Peri od: Worksheet B From 10/01/2022 Part II To 09/30/2023 Date/Time Prepared:

2/20/2024 3:03 pm Cost Center Description ADMINISTRATIV MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG E & GENERAL **REPAIRS PLANT** LINEN SERVICE 5.00 7.00 8.00 9.00 6.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 00500 ADMINISTRATIVE & GENERAL 5.00 438, 017 5.00 6.00 00600 MAINTENANCE & REPAIRS 4, 189 12, 156 6.00 7.00 00700 OPERATION OF PLANT 29, 374 1,800 376,076 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 74 74 9.00 00900 HOUSEKEEPI NG 14,566 164 5,950 0 50,026 9.00 01000 DI ETARY 0 4, 527 10.00 10.00 14,654 922 33, 496 0 11.00 01100 CAFETERI A 0 C 0 0 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 0 C 0 13.00 01300 NURSING ADMINISTRATION 8,584 C 0 0 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 14.00 01500 PHARMACY 0 15.00 0 15.00 0 0 0 01600 MEDICAL RECORDS & LIBRARY 981 0 16.00 42 1.523 206 16.00 17.00 01700 SOCIAL SERVICE 4, 950 0 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 21 30.00 37, 559 1, 428 51, 848 7, 008 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 012 9 22, 771 36, 735 4,965 50.00 05300 ANESTHESI OLOGY 0 53.00 1, 166 32 1, 173 159 53.00 05400 RADI OLOGY-DI AGNOSTI C 24, 623 54.00 620 22,530 17 3,045 54.00 56.00 05600 RADI OI SOTOPE 1, 458 C 0 0 Λ 56.00 57.00 05700 CT SCAN 810 0 0 0 0 57.00 0 05800 MRI 58.00 5.248 C 0 0 58.00 60.00 06000 LABORATORY 30, 916 266 9,646 1, 304 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 62.30 C 0 0 06400 I NTRAVENOUS THERAPY 519 0 64.00 64.00 C 0 0 0 2 1 65.00 06500 RESPIRATORY THERAPY 3.953 42 1.523 206 65.00 06600 PHYSI CAL THERAPY 66.00 9,536 621 22, 546 3,047 66.00 67.00 06700 OCCUPATI ONAL THERAPY 3,034 39 1, 427 193 67.00 0 68.00 06800 SPEECH PATHOLOGY 68.00 69 178 24 06900 ELECTROCARDI OLOGY 9 797 12, 138 69 00 334 1.641 69 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 402 412 14, 956 2,021 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 4, 340 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 30. 281 185 6.727 909 73.00 03950 DIABETIC SERVICES 5, 351 947 76.00 147 723 76.00 0 76.01 03020 WOUND CLINIC 10, 795 78 2,818 381 76.01 07697 CARDIAC REHABILITATION o 76.97 0 0 C 0 76.97 0 76 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 76.98 0 07699 LI THOTRI PSY 76.99 0 C 0 0 76.99 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 77.00 C 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 ol 0 78.00 0 OUTPATIENT SERVICE COST CENTERS 2, 190 88.00 08800 RURAL HEALTH CLINIC 108, 249 79, 525 1 10, 748 88.00 88.01 08801 RURAL HEALTH CLINIC II 9,504 376 13,651 0 1, 845 88.01 09100 EMERGENCY 21 91.00 91.00 41.755 837 30, 409 4, 110 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 92.00 92.00 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 436, 104 11, 552 354, 150 73 47, 062 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190. 00 C 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 1, 908 2, 964 192. 00 604 21, 926 194.00 07950 NONREI MBURSABLE COST CENTER 0 0 194.00 0 194. 01 07951 RESEARCH 0 194. 01 0 C 0 0 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 438, 017 12, 156 376, 076 74 50, 026 202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

Peri od: Worksheet B From 10/01/2022 Part II To 09/30/2023 Date/Time Prepared:

2/20/2024 3:03 pm Cost Center Description DI ETARY CAFETERI A MAI NTENANCE NURSI NG CENTRAL ADMI NI STRATI O SERVICES & OF PERSONNEL Ν **SUPPLY** 10.00 11. 00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 218, 813 10.00 01100 CAFETERI A 147, 786 11.00 135, 831 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 0 1,603 10, 187 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 14.00 01500 PHARMACY 0 15 00 0 0 15.00 C 0 0 16.00 01600 MEDICAL RECORDS & LIBRARY 0 C 0 0 16.00 01700 SOCIAL SERVICE 0 17.00 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 59, 488 0 30.00 30.00 18, 017 4, 780 0 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 8, 776 7, 465 0 0 0 50.00 0 05300 ANESTHESI OLOGY 0 53.00 0 586 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 10,635 0 54.00 56, 00 05600 RADI OI SOTOPE 0 455 0 0 56.00 0 0 0 0 0 0 0 0 0 57.00 05700 CT SCAN 57.00 0 0 0 05800 MRI 58 00 0 58 00 06000 LABORATORY 0 60.00 12, 250 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 000000000000 0 62.30 0 64.00 06400 INTRAVENOUS THERAPY 0 64.00 311 06500 RESPIRATORY THERAPY 2, 464 0 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 3,027 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 1, 412 0 0 0 67.00 0 68 00 06800 SPEECH PATHOLOGY 0 68 00 36 0 06900 ELECTROCARDI OLOGY 69.00 5, 611 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 0 699 2.632 0 73 00 03950 DIABETIC SERVICES 0 76.00 287 78 0 76.00 03020 WOUND CLINIC 0 0 76.01 76.01 873 76. 97 07697 CARDIAC REHABILITATION 0 0 0 0 Ω 76.97 C 0 07698 HYPERBARIC OXYGEN THERAPY 0 76.98 C 0 76.98 0 76. 99 07699 LI THOTRI PSY 0 0 76.99 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 C 0 ol 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 78.00 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 50, 725 0 0 0 88.00 88. 01 08801 RURAL HEALTH CLINIC II 88.01 0 0 0 0 91.00 09100 EMERGENCY 0 4,630 2.763 91.00 17, 442 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 102. 00 0 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 218, 813 135, 831 0 10, 187 0 118.00 NONREI MBURSABLE COST CENTERS 0 190. 00 190, 00 19000 GLET FLOWER COFFEE SHOP & CANTEEN 0 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 C 0 0 192.00 194. 00 07950 NONREI MBURSABLE COST CENTER 0 0 0 0 194.00 0 0 194. 01 194. 01 07951 RESEARCH 0 C 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers Λ 11, 955 0 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 218, 813 147, 786 10, 187 0 202.00

Health Financial Systems OSF HOLY FAMILY MED CTR In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1318 Peri od: Worksheet B From 10/01/2022 Part II Date/Time Prepared: 09/30/2023 2/20/2024 3:03 pm Cost Center Description **PHARMACY** MEDI CAL SOCI AL Subtotal Intern & SERVI CE RECORDS & Resi dents LI BRARY Cost & Post Stepdown Adjustments 15. 00 16.00 17.00 24.00 25. 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 16.00 10, 264 01700 SOCIAL SERVICE 0 4, 950 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 4, 950 441, 184 30.00 30.00 352 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 1, 110 264, 032 0 50.00 53.00 05300 ANESTHESI OLOGY 0 162 0 11, 165 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0000000000000000000 828 0 173, 425 0 54.00 56 00 05600 RADI OI SOTOPE 95 0 2.008 Ω 56 00 05700 CT SCAN 0 57.00 1, 348 2, 158 0 57.00 58.00 05800 MRI 304 0 5, 552 0 58.00 06000 LABORATORY 60.00 1,826 0 103, 784 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62 30 0 62 30 0 06400 I NTRAVENOUS THERAPY 0 64.00 42 872 0 64.00 06500 RESPIRATORY THERAPY 0 21, 165 0 65.00 65.00 138 06600 PHYSI CAL THERAPY 66.00 160 0 150, 142 0 66.00 06700 OCCUPATI ONAL THERAPY 0 13, 203 67 00 0 67 00 61 06800 SPEECH PATHOLOGY 0 68.00 1, 192 0 68.00 06900 ELECTROCARDI OLOGY 394 91, 727 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 15 0 92, 574 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 4.545 72 00 205 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,055 75, 666 0 73.00 76 00 03950 DIABETIC SERVICES 0 33, 926 0 76.00 03020 WOUND CLINIC 0 76.01 28, 981 76.01 139 0 07697 CARDIAC REHABILITATION 0 76.97 r 0 0 76.97 76.98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 0 76.98 76. 99 07699 LI THOTRI PSY 0 76. 99 0 0 0 0 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 C 0 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 0 644. 521 0 88.00 832 0 08801 RURAL HEALTH CLINIC II 0 88.01 74 92, 783 0 88.01 09100 EMERGENCY 0 0 253, 076 91.00 91.00 1, 120 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 10, 264 4, 950 2, 507, 681 0 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 190.00 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 192.00 0 135, 551 0 194. 00 07950 NONREI MBURSABLE COST CENTER 0 0 194.00 C 5 0

C

10, 264

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0

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4.950

0

0

11, 955

2, 655, 192

0 194, 01

0 200.00 0 201.00

0 202.00

194. 01 07951 RESEARCH

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00

201.00

202 00

| Peri od: | Worksheet B | From 10/01/2022 | Part I I | To 09/30/2023 | Date/Time Prepared: Provider CCN: 14-1318

			2/20/2024 3:	
	Cost Center Description	Total		
	· ·	26. 00		
	GENERAL SERVICE COST CENTERS			
1. 00	00100 CAP REL COSTS-BLDG & FLXT			1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP			2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500 ADMINISTRATIVE & GENERAL			5.00
6. 00	00600 MAINTENANCE & REPAIRS			6.00
7. 00	00700 OPERATION OF PLANT			7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE			8.00
10.00	00900 HOUSEKEEPI NG 01000 DI ETARY			9. 00 10. 00
11. 00	01100 CAFETERI A			11.00
12. 00	01200 MAINTENANCE OF PERSONNEL			12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON			13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY			14.00
15. 00	01500 PHARMACY			15. 00
16. 00	1 1			16. 00
17. 00	01700 SOCIAL SERVICE			17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDI ATRI CS	441, 184		30.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	264, 032		50.00
53.00	05300 ANESTHESI OLOGY	11, 165		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	173, 425		54.00
56.00	05600 RADI 0I SOTOPE	2, 008		56. 00
57.00	05700 CT SCAN	2, 158		57. 00
58. 00	05800 MRI	5, 552		58. 00
60. 00	06000 LABORATORY	103, 784		60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
64.00	06400 I NTRAVENOUS THERAPY	872		64.00
65.00	06500 RESPI RATORY THERAPY	21, 165		65.00
66.00	06600 PHYSI CAL THERAPY	150, 142		66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	13, 203 1, 192		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	91, 727		69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	92, 574		71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4, 545		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	75, 666		73. 00
76. 00	03950 DI ABETI C SERVI CES	33, 926		76. 00
76. 01	03020 WOUND CLINIC	28, 981		76. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	O		76. 98
76. 99	07699 LI THOTRI PSY	o		76. 99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	o		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		78. 00
	OUTPATIENT SERVICE COST CENTERS			
	08800 RURAL HEALTH CLINIC	644, 521		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	92, 783		88. 01
	09100 EMERGENCY	253, 076		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
	OTHER REIMBURSABLE COST CENTERS			
102.00	10200 OPI OI D TREATMENT PROGRAM	0		102. 00
110 01	SPECIAL PURPOSE COST CENTERS	0 507 (01		110.00
118. 00		2, 507, 681		118.00
100.00	NONREI MBURSABLE COST CENTERS			100.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	125 551		190.00
	19200 PHYSI CLANS PRI VATE OFFI CES	135, 551		192.00
	07950 NONREI MBURSABLE COST CENTER 07951 RESEARCH	5		194. 00 194. 01
200.00		0		200.00
200.00		11, 955		200.00
201.00		2, 655, 192		202.00
202.00	1.01/12 (3diii 11/103 110 tili 0dgii 201)	2,000,172		1202.00

Heal th	Financial Systems ALLOCATION - STATISTICAL BASIS	OSF HOLY FAM	ILY MED CTR Provider C	CN: 14_1318 [In Lie Period:	w of Form CMS- Worksheet B-1	
C031 F	ALLOCATION - STATISTICAL BASIS		Provider C	F	From 10/01/2022 To 09/30/2023		pared:
		CAPI TAL REI	LATED COSTS			2, 20, 202 ; 0.0	, o p
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
		1.00	0.00	SALARI ES)		5.00	
	GENERAL SERVICE COST CENTERS	1. 00	2. 00	4. 00	5A	5. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT	104, 302					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		104, 302				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	_	,,			4.00
5. 00 6. 00	OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS	17, 349	17, 349	1, 117, 119	-6, 488, 670	24, 831, 586 237, 461	1
7. 00	00700 OPERATION OF PLANT	12, 874	12, 874	318, 13	i o		
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	(0	4, 216	8.00
9.00	00900 HOUSEKEEPI NG	1, 172		1		825, 717	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	6, 598 0		362, 729		830, 714 0	1
12. 00	01200 MAINTENANCE OF PERSONNEL	0	_	Ò	0 0		1
13.00	01300 NURSING ADMINISTRATION	0	0	142, 528	0	1	
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	0			0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	300	300				
17. 00	01700 SOCI AL SERVI CE	0	0	(0	280, 616	17. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	10 212	10 212	1, 371, 573		2, 129, 170	20.00
30. 00	ANCILLARY SERVICE COST CENTERS	10, 213	10, 213	1, 3/1, 5/3	3 0	2, 129, 170	30.00
50.00	05000 OPERATING ROOM	7, 236	7, 236			1, 290, 869	50.00
53.00	05300 ANESTHESI OLOGY	231					1
54. 00 56. 00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	4, 438	4, 438	707, 567 35, 508		,	1
57. 00	05700 CT SCAN	0	Ö	33, 300	o o		1
58. 00	05800 MRI	0	0	(0		1
60. 00 62. 30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	1, 900		708, 572	0 0	.,,	1
64.00	06400 I NTRAVENOUS THERAPY		_	23, 068		1	1
65.00	06500 RESPI RATORY THERAPY	300	300	154, 890	0		1
66.00	06600 PHYSI CAL THERAPY	4, 441					1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	281 35	l .			,	1
69. 00	06900 ELECTROCARDI OLOGY	2, 391	l .	1			1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 946		i	-		1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 1, 325	_	1	0 5 0		1
76.00	03950 DI ABETI C SERVICES	1, 054				53, 680	
	03020 WOUND CLINIC	555					
	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 97 76. 98
76. 98 76. 99	07699 LI THOTRI PSY	0	0				1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0	0	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0	0	78.00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	15, 665	15, 665	3, 827, 538	3 0	6, 137, 417	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	2, 689	· ·				
91.00		5, 990	5, 990	1, 407, 329	9 0	2, 367, 044	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0		0	0	102.00
	SPECIAL PURPOSE COST CENTERS						
118.00	. 9 /	99, 983	99, 983	12, 698, 755	-6, 414, 408	24, 723, 180	118.00
190.00	NONREIMBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0	0	190. 00
192.00	19200 PHYSICIANS PRIVATE OFFICES	4, 319	4, 319	(0	108, 148	192.00
	07950 NONREI MBURSABLE COST CENTER	0	0	202	0		194.00
200.00	07951 RESEARCH Cross Foot Adjustments	0	0) U	0	194. 01 200. 00
201.00				•			201.00
202.00		1, 370, 195	1, 241, 522	3, 508, 968	3	6, 488, 670	202. 00
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	13. 136805	11. 903147	0. 276319		0. 261307	303 00
203.00		13. 130005	11. 703147	0.270319	ó	438, 017	
	Part II)	1					
205. 00	·			0. 000000		0. 017640	205.00
206. 00							206.00
	(per Wkst. B-2)	1					

Health Financial Systems	OSF HOLY FAMI	LY MED CTR		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
				From 10/01/2022 To 09/30/2023		
	CAPI TAL REL	ATED COSTS				
Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
	1. 00	2.00	4. 00	5A	5. 00	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems OSF HOLY FAMILY MED CTR In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1318 Peri od: Worksheet B-1 From 10/01/2022 09/30/2023 Date/Time Prepared: 2/20/2024 3:03 pm Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE **REPAIRS** PLANT (SQUARE FEET) (MEALS (SQUARE FEET) (SQUARE FEET) (POUNDS OF SERVED) LAUNDRY) 6. 00 7. 00 9. 00 10.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 6.00 00600 MAINTENANCE & REPAIRS 86, 953 6.00 00700 OPERATION OF PLANT 74, 079 7.00 12.874 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 101, 987 8.00 9 00 00900 HOUSEKEEPI NG 1, 172 1, 172 0 72, 907 9 00 01000 DI ETARY 47, 350 10.00 6,598 6, 598 0 6, 598 10.00 01100 CAFETERI A 0 31, 980 11.00 0 r 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 0 C 0 0 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 0 0 13.00 C 0 01400 CENTRAL SERVICES & SUPPLY 0 14.00 0 0 14.00 C 0 0 15.00 01500 PHARMACY 0 r 0 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 300 300 300 0 01700 SOCIAL SERVICE 17.00 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 10, 213 10, 213 29, 491 10, 213 12, 873 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 899 50.00 7.236 7.236 12, 203 7.236 05300 ANESTHESI OLOGY 53.00 231 231 231 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 438 4, 438 23,673 4, 438 0 54.00 56.00 05600 RADI OI SOTOPE 56.00 0 C 0 0 57 00 05700 CT SCAN 0 57 00 0 C 0 0 05800 MRI 58.00 \cap 0 0 0 58.00 60.00 06000 LABORATORY 1, 900 1, 900 1, 900 0 60.00 174 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 C 0 0 0 62.30 06400 I NTRAVENOUS THERAPY 64.00 0 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 300 300 300 0 65.00 06600 PHYSI CAL THERAPY 66.00 4, 441 4, 441 2,794 4, 441 0 66.00 67 00 06700 OCCUPATIONAL THERAPY 281 281 1, 073 281 0 67 00 06800 SPEECH PATHOLOGY 68.00 35 35 52 35 0 68.00 06900 ELECTROCARDI OLOGY 2, 391 2, 391 1, 806 2, 391 0 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2,946 2, 946 2,946 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS O 72 00 0 72 00 C 0 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 325 1, 325 0 1, 325 0 73.00 03950 DIABETIC SERVICES 0 76.00 76.00 1.054 1,054 1,054 76.01 03020 WOUND CLINIC 555 555 0 555 0 76.01 07697 CARDIAC REHABILITATION 76.97 0 0 C 0 0 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 C 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 C 0 0 0 76.99 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 0 0 77.00 C 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 15, 665 15, 665 1, 006 15, 665 0 88.00 08801 RURAL HEALTH CLINIC II 2, 689 2,689 2, 689 88.01 88.01 0 91.00 09100 EMERGENCY 5.990 5, 990 28, 639 5.990 598 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 82, 634 69, 760 100, 911 68, 588 47, 350 118. 00 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 4, 319 1,076 4, 319 0 192.00 4, 319 194. 00 07950 NONREI MBURSABLE COST CENTER 0 194.00 0 194. 01 07951 RESEARCH 0 C 0 0 0 194, 01 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 299, 511 1, 079, 450 1, 359, 219 202. 00 Cost to be allocated (per Wkst. B, 2, 144, 656 5.318 Part I) 14.805849 28. 705787 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 3.444516 28. 950931 0.052144 204.00 Cost to be allocated (per Wkst. B, 50, 026 218, 813 204. 00 12, 156 376,076 Part II)

0.139800

5.076688

0.000726

0.686162

4. 621183 205. 00

206.00

207.00

Unit cost multiplier (Wkst. B, Part

NAHE adjustment amount to be allocated

205.00

206.00

II)

(per Wkst. B-2)

Health Financial Systems	OSF HOLY FAMI	LY MED CTR		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		eri od:	Worksheet B-1	
			To	rom 10/01/2022 0 09/30/2023	Date/Time Pre	pared:
					2/20/2024 3:0)3 pm
Cost Center Description	CAFETERI A (FTES)	MAI NTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI O	CENTRAL SERVI CES &	PHARMACY (COSTED	
	(TTLS)	(NUMBER	N N	SUPPLY	REQUIS.)	
		HOUSED)	(DI RECT	(COSTED	,	
			NRSING HRS)	REQUIS.)		
GENERAL SERVICE COST CENTERS	11. 00	12. 00	13.00	14. 00	15. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT						6. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	11, 354	_				11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	0	// 740			12.00
13. 00 O1300 NURSI NG ADMI NI STRATI ON 14. 00 O1400 CENTRAL SERVI CES & SUPPLY	134	0	66, 740	0		13.00
15. 00 01500 PHARMACY	0	0		0	0	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	o	0	1
17. 00 01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	4 50/		04 040	ما		00.00
30. 00 03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	1, 506	0	31, 319	0	0	30.00
50. 00 05000 OPERATING ROOM	624	0	0	ol	0	50.00
53. 00 05300 ANESTHESI OLOGY	49	0		ō	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	889	0	0	o	0	
56. 00 05600 RADI 01 SOTOPE	38	0	0	0	0	
57. 00 05700 CT SCAN 58. 00 05800 MRI	0	0		0	0	
58. 00 05800 MRI 60. 00 06000 LABORATORY	1, 024	0		0	0	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	1, 024	0	o o	Ö	0	
64. 00 06400 I NTRAVENOUS THERAPY	26	0	0	o	0	1
65. 00 06500 RESPI RATORY THERAPY	206	0	0	0	0	1
66. 00 06600 PHYSI CAL THERAPY	253	0	0	0	0	
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	118 3	0		0	0	
69. 00 06900 SPEECH PATHOLOGY	469	0		0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	Ö	Ö	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	О	0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS	220	0	4, 580	0	0	
76. 00 03950 DI ABETI C SERVI CES	24	0	509	0	0	
76. 01 03020 WOUND CLINIC 76. 97 07697 CARDIAC REHABILITATION	73	0		0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	o	0	o o	0	0	
76. 99 07699 LI THOTRI PSY	Ö	0	Ö	Ö	0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	-	0	0	
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS 88. OO 08800 RURAL HEALTH CLINIC	4, 240	0	0	ol	0	88.00
88. 01 08801 RURAL HEALTH CLINIC I	4, 240	0		o	0	
91. 00 09100 EMERGENCY	1, 458	0	30, 332	o	0	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS	al					
102. 00 10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	11, 354	0	66, 740	ol	0	118.00
NONREI MBURSABLE COST CENTERS	,			- 1		
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0		192.00
194. 00 07950 NONREI MBURSABLE COST CENTER 194. 01 07951 RESEARCH	0	0		0		194. 00 194. 01
200.00 Cross Foot Adjustments	U	O		o _l	U	200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	843, 749	0	623, 735	o	0	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	74. 312929	0. 000000		0. 000000	0.000000	
204.00 Cost to be allocated (per Wkst. B, Part II)	147, 786	U	10, 187	٩	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part	11. 963273	0. 000000	0. 152637	0. 000000	0. 000000	205.00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						
	<u>'</u>		•	<u> </u>		

Health Financial Systems OSF HOLY FAMILY MED CTR In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CON: 14-1318 | Period: | Worksheet R-1

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1318 Peri od: Worksheet B-1 From 10/01/2022 09/30/2023 Date/Time Prepared: 2/20/2024 3:03 pm Cost Center Description MEDI CAL SOCI AL SERVI CE RECORDS & LI BRARY (TOTAL PATI (GROSS REVE ENT DAYS) NUE) 16.00 17.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 115, 710, 825 16.00 01700 SOCIAL SERVICE 703 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 703 30.00 03000 ADULTS & PEDIATRICS 3, 955, 037 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 12, 469, 758 Ω 50.00 53.00 05300 ANESTHESI OLOGY 1,821,730 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 9, 299, 149 54.00 0 54.00 56 00 05600 RADI OI SOTOPE 1,067,343 0 56 00 05700 CT SCAN 57.00 15, 145, 352 0 57.00 58.00 05800 MRI 3, 420, 431 0 58.00 60.00 06000 LABORATORY 20, 921, 573 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62 30 0 62 30 06400 INTRAVENOUS THERAPY 64.00 469,064 0 64.00 06500 RESPIRATORY THERAPY 1, 545, 591 0 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 1, 796, 037 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 689, 455 0 67.00 68.00 06800 SPEECH PATHOLOGY 33, 480 0 68.00 06900 ELECTROCARDI OLOGY 4, 425, 172 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 166, 644 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 2, 303, 238 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 11, 848, 746 73.00 76 00 03950 DIABETIC SERVICES 8, 412 0 76.00 03020 WOUND CLINIC 0 76.01 1, 562, 477 76.01 07697 CARDIAC REHABILITATION 76.97 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 76.98 07699 LI THOTRI PSY 76. 99 76.99 0 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 9, 351, 682 0 88.01 08801 RURAL HEALTH CLINIC II 831.518 0 88.01 09100 EMERGENCY 12, 578, 936 91.00 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 115, 710, 825 703 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190.00 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 192.00 194. 00 07950 NONREI MBURSABLE COST CENTER 194.00 0 0 194. 01 07951 RESEARCH 194 ∩1 0 C 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202 00 Cost to be allocated (per Wkst. B, 84, 291 353, 943 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000728 503. 475107 203.00 204.00 Cost to be allocated (per Wkst. B, 10, 264 4,950 204.00 Part II) Unit cost multiplier (Wkst. B, Part 205. 00 205.00 0.000089 7.041252 II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00

Parts III and IV)

Health Financial Systems	OSF HOLY FAM	ILY MED CTR		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od: From 10/01/2022 To 09/30/2023	Worksheet C Part I Date/Time Pre 2/20/2024 3:0	pared:
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30 00 03000 ADULTS & PEDLATRICS	4 300 100		4 300 10	0 0	0	30 00

				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col. 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	4, 300, 109		4, 300, 109	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	2, 080, 328		2, 080, 328	0	0	50.00
53. 00 05300 ANESTHESI OLOGY	99, 230		99, 230	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 044, 174		2, 044, 174	0	0	54.00
56. 00 05600 RADI OI SOTOPE	107, 816		107, 816	0	0	56.00
57. 00 05700 CT SCAN	68, 941		68, 941	0	0	57.00
58. 00 05800 MRI	377, 721		377, 721	0	0	58.00
60. 00 06000 LABORATORY	2, 391, 634		2, 391, 634	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62. 30
64. 00 06400 I NTRAVENOUS THERAPY	39, 408		39, 408	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	313, 220	0	313, 220	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	911, 715			0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	239, 526	o	239, 526	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	6, 854		6, 854	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	851, 543		851, 543	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	239, 410		239, 410	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	312, 029		312, 029	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 295, 492		2, 295, 492	0	0	73.00
76. 00 03950 DI ABETI C SERVI CES	124, 004		124, 004	0	0	76.00
76. 01 03020 WOUND CLINIC	804, 642		804, 642	0	0	76. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0		0	0	0	76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0		0	0	0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0		0	0	0	1
OUTPATIENT SERVICE COST CENTERS		·				
88. 00 08800 RURAL HEALTH CLINIC	8, 802, 527		8, 802, 527	0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	807, 076		807, 076	0	0	88. 01
91. 00 09100 EMERGENCY	3, 687, 944		3, 687, 944	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	851, 877		851, 877		0	92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>					
102.00 10200 OPI OI D TREATMENT PROGRAM	0		0		0	102.00
200.00 Subtotal (see instructions)	31, 757, 220	О	31, 757, 220	0	0	200.00
201.00 Less Observation Beds	851, 877		851, 877			201.00
202.00 Total (see instructions)	30, 905, 343		· ·	0		202.00
				'		•

Health Financial Systems	OSF HOLY FAMILY MED CTR	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1318	Period: Worksheet C From 10/01/2022 Part I
		To 09/30/2023 Date/Time Prepared:

					To 09/30/2023	Date/Time Pre 2/20/2024 3:0	epared: 03 pm
			Title	XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6. 00	7.00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 939, 901		2, 939, 90°			30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	11, 594	12, 458, 164	12, 469, 758	0. 166830	0. 000000	50.00
53.00	05300 ANESTHESI OLOGY	1, 777	1, 819, 953	1, 821, 730	0. 054470	0. 000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	126, 194	9, 172, 955	9, 299, 149	0. 219824	0. 000000	54.00
56.00	05600 RADI 0I SOTOPE	0	1, 067, 343	1, 067, 343		0. 000000	
57.00	05700 CT SCAN	296, 504	14, 848, 848	15, 145, 352	0. 004552	0. 000000	
58.00	05800 MRI	35, 768	3, 384, 663	3, 420, 43		0. 000000	
60.00	06000 LABORATORY	904, 343	20, 017, 230	20, 921, 57		0. 000000	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0			0. 000000	
64.00	06400 I NTRAVENOUS THERAPY	0	469, 064	469, 064		0. 000000	1
65.00	06500 RESPI RATORY THERAPY	758, 081	787, 510	1, 545, 59°		0. 000000	
66.00	06600 PHYSI CAL THERAPY	348, 157	1, 447, 880	1, 796, 03	0. 507626	0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	175, 298	514, 157			0. 000000	
68.00	06800 SPEECH PATHOLOGY	23, 407	10, 073			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	114, 162	4, 311, 010			0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	166, 644			0. 000000	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	2, 303, 238			0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 807, 437	10, 041, 309			0. 000000	
	03950 DI ABETI C SERVI CES	0	8, 412			0. 000000	
76. 01	03020 WOUND CLINIC	0	1, 562, 477	1, 562, 47		0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(0. 000000	0. 000000	
	07698 HYPERBARI C OXYGEN THERAPY	0	0	(0. 000000	0. 000000	
	07699 LI THOTRI PSY	0	0	(0. 000000	0. 000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0. 000000	0. 000000	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0. 000000	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS				.T		
	08800 RURAL HEALTH CLINIC	0	9, 351, 682				88. 00
	08801 RURAL HEALTH CLINIC II	0	831, 518				88. 01
	09100 EMERGENCY	238, 354	12, 340, 582				
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	178, 628	836, 508	1, 015, 13	0. 839175	0. 000000	92. 00
400.00	OTHER REIMBURSABLE COST CENTERS			1	.1		
	10200 OPIOID TREATMENT PROGRAM	0	0				102.00
200.00		7, 959, 605	107, 751, 220	115, 710, 825			200.00
201.00		7 050 (05	107 751 000	115 710 00	.		201.00
202.00	Total (see instructions)	7, 959, 605	107, 751, 220	115, 710, 82			202. 00

Health Financial Systems	OSF HOLY FAMILY	MED CTR		In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 14-1318	From 10/01/2022 To 09/30/2023	Worksheet C Part I Date/Time Prepared: 2/20/2024 3:03 pm

				10 04/30/2023	2/20/2024 3:03 pm	
			Title XVIII	Hospi tal	Cost	
Cost	Center Description	PPS Inpatient	·			
		Ratio				
		11. 00				
INPATIENT R	OUTINE SERVICE COST CENTERS					
	S & PEDIATRICS				30.	00
	ERVICE COST CENTERS					
50. 00 05000 OPERA		0. 000000			50.	
53. 00 05300 ANESTI		0. 000000			53.	
	LOGY-DI AGNOSTI C	0. 000000			54.	
56. 00 05600 RADI 0		0. 000000			56.	
57. 00 05700 CT SC	AN	0. 000000			57.	
58.00 05800 MRI		0. 000000			58.	
60. 00 06000 LABORA		0. 000000			60.	
62. 30 06250 BL00D	CLOTTING FOR HEMOPHILIACS	0. 000000			62.	
	VENOUS THERAPY	0. 000000			64.	
65. 00 06500 RESPI I	RATORY THERAPY	0. 000000			65.	
66. 00 06600 PHYSI (0. 000000			66.	
	ATI ONAL THERAPY	0. 000000			67.	
68. 00 06800 SPEECI		0. 000000			68.	
	ROCARDI OLOGY	0. 000000			69.	
	AL SUPPLIES CHARGED TO PATIENT	0. 000000			71.	
	DEV. CHARGED TO PATIENTS	0. 000000			72.	
	CHARGED TO PATIENTS	0. 000000			73.	
76. 00 03950 DI ABE		0. 000000			76.	
76. 01 03020 WOUND		0. 000000			76.	
76. 97 07697 CARDI /		0. 000000			76.	
	BARIC OXYGEN THERAPY	0. 000000			76.	
76. 99 07699 LI THO	TRI PSY	0. 000000			76.	
	ENEIC HSCT ACQUISITION	0. 000000			77.	
	-CELL IMMUNOTHERAPY	0. 000000			78.	00
	SERVICE COST CENTERS					
	HEALTH CLINIC				88.	
	HEALTH CLINIC II				88.	01
91. 00 09100 EMERGI		0. 000000			91.	00
	VATION BEDS (NON-DISTINCT PART	0. 000000			92.	00
	URSABLE COST CENTERS					
	D TREATMENT PROGRAM				102.	
	tal (see instructions)				200.	
	Observation Beds				201.	
202. 00 Total	(see instructions)				202.	00

Health Financial Systems	OSF HOLY FAM	ILY MED CTR		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 10/01/2022 To 09/30/2023	Worksheet C Part I Date/Time Pre 2/20/2024 3:0	pared:
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	4, 300, 109		4, 300, 10	9 0	4, 300, 109	30.00

				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,	,				
	col . 26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		2.00	0.00	00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	4, 300, 109		4, 300, 109	0	4, 300, 109	30.00
ANCILLARY SERVICE COST CENTERS			.,		.,	
50. 00 05000 OPERATING ROOM	2, 080, 328		2, 080, 328	0	2, 080, 328	50.00
53. 00 05300 ANESTHESI OLOGY	99, 230		99, 230	0	99, 230	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 044, 174		2, 044, 174	0	2, 044, 174	54.00
56. 00 05600 RADI OI SOTOPE	107, 816	,	107, 816	0	107, 816	56.00
57. 00 05700 CT SCAN	68, 941		68, 941	0	68, 941	57.00
58. 00 05800 MRI	377, 721		377, 721	0	377, 721	58.00
60. 00 06000 LABORATORY	2, 391, 634		2, 391, 634	0	2, 391, 634	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62. 30
64. 00 06400 I NTRAVENOUS THERAPY	39, 408	1	39, 408	0	39, 408	64.00
65. 00 06500 RESPIRATORY THERAPY	313, 220	o	313, 220	0	313, 220	65.00
66. 00 06600 PHYSI CAL THERAPY	911, 715			0	911, 715	
67. 00 06700 OCCUPATI ONAL THERAPY	239, 526		239, 526	0	239, 526	67.00
68. 00 06800 SPEECH PATHOLOGY	6, 854		6, 854	0	6, 854	68.00
69. 00 06900 ELECTROCARDI OLOGY	851, 543		851, 543	0	851, 543	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	239, 410		239, 410	0	239, 410	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	312, 029		312, 029	0	312, 029	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 295, 492		2, 295, 492	0	2, 295, 492	73.00
76. 00 03950 DI ABETI C SERVI CES	124, 004		124, 004	0	124, 004	76.00
76. 01 03020 WOUND CLINIC	804, 642		804, 642	0	804, 642	76. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0		0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0)	0	0	0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	8, 802, 527		8, 802, 527	0	8, 802, 527	88. 00
88.01 08801 RURAL HEALTH CLINIC II	807, 076	,	807, 076	0	807, 076	88. 01
91. 00 09100 EMERGENCY	3, 687, 944		3, 687, 944	0	3, 687, 944	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	851, 877	'	851, 877		851, 877	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOLD TREATMENT PROGRAM	0		0		0	102.00
200.00 Subtotal (see instructions)	31, 757, 220	0	31, 757, 220	0	31, 757, 220	200.00
201.00 Less Observation Beds	851, 877	1	851, 877		851, 877	
202.00 Total (see instructions)	30, 905, 343	0	30, 905, 343	0	30, 905, 343	202.00
•	•		•			

Health Financial Systems	OSF HOLY FAMILY MED CTR	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1318	Period: Worksheet C From 10/01/2022 Part I
		To 09/30/2023 Date/Time Prepared

				-	To 09/30/2023	Date/Time Pre 2/20/2024 3:0	epared: 03 pm
			Ti tl	e XIX	Hospi tal	PPS	<u> </u>
	·		Charges	<u> </u>			
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 939, 901		2, 939, 90	1		30.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	11, 594	12, 458, 164			0. 000000	
	05300 ANESTHESI OLOGY	1, 777	1, 819, 953			0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	126, 194	9, 172, 955			0. 000000	
	05600 RADI OI SOTOPE	0	1, 067, 343			0. 000000	
	05700 CT SCAN	296, 504	14, 848, 848			0. 000000	
	05800 MRI	35, 768	3, 384, 663			0. 000000	
	06000 LABORATORY	904, 343	20, 017, 230			0. 000000	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0. 000000	0. 000000	
	06400 I NTRAVENOUS THERAPY	0	469, 064			0. 000000	1
	06500 RESPI RATORY THERAPY	758, 081	787, 510			0. 000000	
	06600 PHYSI CAL THERAPY	348, 157	1, 447, 880			0. 000000	
	06700 OCCUPATI ONAL THERAPY	175, 298	514, 157	689, 45		0. 000000	
	06800 SPEECH PATHOLOGY	23, 407	10, 073			0. 000000	
	06900 ELECTROCARDI OLOGY	114, 162	4, 311, 010			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	166, 644			0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 303, 238			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	1, 807, 437	10, 041, 309			0. 000000	
	03950 DI ABETI C SERVI CES	0	8, 412			0. 000000	
	03020 WOUND CLINIC	0	1, 562, 477			0. 000000	
	07697 CARDI AC REHABI LI TATI ON	0	0		0.000000	0. 000000	
	07698 HYPERBARIC OXYGEN THERAPY	0	0		0. 000000	0. 000000	
	07699 LI THOTRI PSY	0	0		0. 000000	0. 000000	
	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0. 000000	0. 000000	
	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0.000000	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS	1 _1					
	08800 RURAL HEALTH CLINIC	0	9, 351, 682			0. 000000	
	08801 RURAL HEALTH CLINIC II	0	831, 518			0. 000000	
	09100 EMERGENCY	238, 354	12, 340, 582			0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	178, 628	836, 508	1, 015, 13	0. 839175	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						100.00
	10200 OPI OI D TREATMENT PROGRAM	7 050 (05	0		2		102.00
200.00		7, 959, 605	107, 751, 220	115, 710, 82	9		200.00
201.00		7 050 (05	107 751 000	115 710 00	_		201.00
202. 00	Total (see instructions)	7, 959, 605	107, 751, 220	115, 710, 82	이		202.00

Health Financial Systems	OSF HOLY FAMILY MED CTR	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1318	Peri od: Worksheet C From 10/01/2022 Part I To 09/30/2023 Date/Time Prepared: 2/20/2024 3:03 pm

				2/20/2024 3:03 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 166830			50.00
53. 00 05300 ANESTHESI OLOGY	0. 054470			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 219824			54.00
56. 00 05600 RADI 0I SOTOPE	0. 101013			56.00
57.00 05700 CT SCAN	0. 004552			57.00
58. 00 05800 MRI	0. 110431			58.00
60. 00 06000 LABORATORY	0. 114314			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
64. 00 06400 I NTRAVENOUS THERAPY	0. 084014			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 202654			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 507626			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 347414			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 204719			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 192432			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 436655			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 135474			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 193733			73.00
76. 00 03950 DI ABETI C SERVI CES	14. 741322			76.00
76. 01 03020 WOUND CLINIC	0. 514978			76. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78.00
OUTPATIENT SERVICE COST CENTERS	0.00000			70.00
88. 00 08800 RURAL HEALTH CLINIC	0. 941277			88.00
88. 01 08801 RURAL HEALTH CLINIC II	0. 970606			88. 01
91. 00 09100 EMERGENCY	0. 293184			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 839175			92.00
OTHER REIMBURSABLE COST CENTERS	0.037173			72.00
102.00 10200 OPI OI D TREATMENT PROGRAM				102.00
200.00 Subtotal (see instructions)				200.00
201. 00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
202.00 10141 (300 111311 4011 0113)	1			1202.00

REDUCTIONS FOR MEDICALD ONLY				To 09/30/2023		
		Ti tl	e XIX	Hospi tal	PPS	о рііі
Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
	(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
	Part I, col.	Part II col.	Capital Cost		Reducti on	
	26)	26)	(col. 1 -		Amount	
			col . 2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 080, 328	264, 032	1, 816, 29	6 0	0	
53. 00 05300 ANESTHESI OLOGY	99, 230	11, 165	88, 06	5 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 044, 174	173, 425	1, 870, 74	9 0	0	
56. 00 05600 RADI 0I SOTOPE	107, 816	2, 008	105, 80	8 0	0	
57.00 05700 CT SCAN	68, 941	2, 158		3 0	0	
58. 00 05800 MRI	377, 721	5, 552	372, 16	9 0	0	58.00
60. 00 06000 LABORATORY	2, 391, 634	103, 784	2, 287, 85	0 0	0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	
64.00 06400 I NTRAVENOUS THERAPY	39, 408				0	
65. 00 06500 RESPI RATORY THERAPY	313, 220				0	
66. 00 06600 PHYSI CAL THERAPY	911, 715	150, 142	761, 57	3 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	239, 526				0	
68.00 06800 SPEECH PATHOLOGY	6, 854	1, 192			0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	851, 543	91, 727	759, 81	6 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	239, 410	92, 574	146, 83	6 0	0	1 / 00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	312, 029	4, 545	307, 48	4 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 295, 492				0	
76. 00 03950 DI ABETI C SERVI CES	124, 004	33, 926	90, 07	8 0	0	
76. 01 03020 WOUND CLINIC	804, 642	28, 981	775, 66	1 0	0	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0	0		0 0	0	1 , 0 , , 0
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	8, 802, 527				0	
88.01 08801 RURAL HEALTH CLINIC II	807, 076		•		0	
91. 00 09100 EMERGENCY	3, 687, 944				0	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	851, 877	87, 401	764, 47	6 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	1	0 0		102.00
200.00 Subtotal (sum of lines 50 thru 199)	27, 457, 111					200.00
201.00 Less Observation Beds	851, 877		•			201.00
202.00 Total (line 200 minus line 201)	26, 605, 234	2, 066, 497	24, 538, 73	7 0	0	202. 00

					10 09/30/	024 3:03 pm
			Ti tl	e XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges	Outpati ent		
		Capital and	(Worksheet C,	Cost to		
		Operati ng	Part I,	Charge Ratio)	
		Cost	column 8)	(col. 6 /		
		Reducti on		col. 7)		
		6. 00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS	1			_	
	05000 OPERATI NG ROOM	2, 080, 328				50.00
	05300 ANESTHESI OLOGY	99, 230				53.00
	05400 RADI OLOGY-DI AGNOSTI C	2, 044, 174				54.00
	05600 RADI OI SOTOPE	107, 816				56.00
57. 00	05700 CT SCAN	68, 941	15, 145, 352			57.00
	05800 MRI	377, 721	3, 420, 431	0. 11043		58.00
60.00	06000 LABORATORY	2, 391, 634	1			60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0.00000		62. 30
64.00	06400 I NTRAVENOUS THERAPY	39, 408		0. 08401		64.00
	06500 RESPIRATORY THERAPY	313, 220		0. 20265		65.00
	06600 PHYSI CAL THERAPY	911, 715				66.00
67.00	06700 OCCUPATI ONAL THERAPY	239, 526				67.00
	06800 SPEECH PATHOLOGY	6, 854				68.00
	06900 ELECTROCARDI OLOGY	851, 543				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	239, 410	1			71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	312, 029				72.00
	07300 DRUGS CHARGED TO PATIENTS	2, 295, 492				73.00
	03950 DI ABETI C SERVI CES	124, 004				76.00
	03020 WOUND CLINIC	804, 642	1, 562, 477			76. 01
	07697 CARDI AC REHABI LI TATI ON	0	0	0.00000		76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000		76. 98
	07699 LI THOTRI PSY	0	0	0.00000		76. 99
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000		77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 00000	Ю	78. 00
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0.000.507	0.051.700	0.04107	7	88.00
	08800 RURAL HEALTH CLINIC	8, 802, 527				88.00
88. 01 91. 00	09100 EMERGENCY	807, 076				91.00
		3, 687, 944				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	851, 877	1, 015, 136	0. 83917	اد	92.00
102 00	10200 OPLOLD TREATMENT PROGRAM	0	0	0. 00000	in	102.00
200.00		27, 457, 111				200.00
200.00		851, 877				200.00
201.00	1	26, 605, 234				202. 00
202.00	Trotal (Title 200 IIII lus Title 201)	20,000,234	112,770,924		T	1202.00

Health Financial Systems	OSF HOLY FAM	ILY MED CTR		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der C	CN: 14-1318	Peri od: From 10/01/2022	Worksheet D	
				To 09/30/2023		narod:
				10 07/30/2023	2/20/2024 3: 0	3 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col . 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		,				
50.00 05000 OPERATING ROOM	264, 032		1		0	50.00
53. 00 05300 ANESTHESI OLOGY	11, 165		1		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	173, 425				557	54.00
56. 00 05600 RADI 0I SOTOPE	2, 008				0	56.00
57. 00 05700 CT SCAN	2, 158				7	57.00
58. 00 05800 MRI	5, 552		1		38	58.00
60. 00 06000 LABORATORY	103, 784				1, 081	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	_	0.0000		0	62. 30
64. 00 06400 I NTRAVENOUS THERAPY	872		1		0	64.00
65. 00 06500 RESPI RATORY THERAPY	21, 165				2, 184	
66. 00 06600 PHYSI CAL THERAPY	150, 142				2, 978	
67. 00 06700 OCCUPATI ONAL THERAPY	13, 203				424	
68. 00 06800 SPEECH PATHOLOGY	1, 192		1	·	375	
69. 00 06900 ELECTROCARDI OLOGY	91, 727				649	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	92, 574				0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 545				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	75, 666		1		2, 591	73.00
76. 00 03950 DI ABETI C SERVI CES	33, 926		1		0	76.00
76. 01 03020 WOUND CLINIC	28, 981	1, 562, 477			0	76.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0		0.00000		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		0.00000		0	
76. 99 07699 LI THOTRI PSY	0		0.00000		0	76. 99 77. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	_			0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0	0	78.00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	444 FO1	0.251.602	0.04003	0 0	0	00 00
88. 00 08800 RURAL HEALTH CLINIC	644, 521		1		0	88. 00 88. 01
91. 00 09100 EMERGENCY	92, 783 253, 076				89	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	87, 401				0	91.00
200.00 Total (lines 50 through 199)	2, 153, 898		1	991, 105	_	200.00
200.00 [10tal (11163 30 till ough 177)	2, 133, 070	112,770,924	1	791, 103	10, 7/3	1200.00

THROUGH COSTS				To 09/30/2023		
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0	(0	0	
53. 00 05300 ANESTHESI OLOGY	0	0	(0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
56. 00 05600 RADI 01 SOTOPE	0	0	(0	0	56.00
57.00 05700 CT SCAN	0	0	(0	0	57.00
58. 00 05800 MRI	0	0	(0	0	58. 00
60. 00 06000 LABORATORY	0	0	(0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0	62. 30
64.00 06400 I NTRAVENOUS THERAPY	0	0	(0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	(0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71.00
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73.00
76. 00 03950 DI ABETI C SERVI CES	0	0	(0	0	76. 00
76. 01 03020 WOUND CLINIC	0	0	(0	0	76. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	(0	0	76. 97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	(0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	(0	0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	(0	0	00.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	(0	0	88. 01
91. 00 09100 EMERGENCY	0	0	(0	0	,
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	
200.00 Total (lines 50 through 199)	0	0		0	. 0	200. 00

Health Financial Systems	OSF HOLY FAMILY MEI	D CTR	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Pro		Worksheet D
THROUGH COSTS		From 10/0	1/2022 Part IV

THROUGH COSTS To 09/30/2023 Date/Time Prepared: 2/20/2024 3:03 pm Title XVIII Hospi tal Cost All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (sum of cols. Outpati ent (from Wkst. Educati on 1, 2, 3, and Cost (sum of C, Part I, (col. 5 ÷ 4) Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 4. 00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 12, 469, 758 0.000000 50.00 05300 ANESTHESI OLOGY 0 0 1, 821, 730 0.000000 53.00 0000000000000000000000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 9, 299, 149 0.000000 54.00 0 54.00 05600 RADI OI SOTOPE 0 56.00 1, 067, 343 0.000000 56.00 57.00 05700 CT SCAN 0 15, 145, 352 0.000000 57.00 58.00 05800 MRI 0 3, 420, 431 0.000000 58.00 0 60.00 06000 LABORATORY 0 20, 921, 573 0.000000 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 0.000000 62.30 64.00 06400 I NTRAVENOUS THERAPY 469, 064 0.000000 64.00 0 06500 RESPIRATORY THERAPY 0 1, 545, 591 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 0 0 1, 796, 037 0.000000 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 689, 455 0.000000 67.00 06800 SPEECH PATHOLOGY 0 0.000000 68.00 33, 480 68.00 4, 425, 172 06900 ELECTROCARDI OLOGY 0 0.000000 69 00 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 166, 644 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 2, 303, 238 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 11, 848, 746 0.000000 73.00 03950 DIABETIC SERVICES 0 0 0.000000 76 00 8, 412 76 00 0 76.01 03020 WOUND CLINIC 0 1, 562, 477 0.000000 76.01 76. 97 07697 CARDIAC REHABILITATION 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 0 0 0.000000 76.98 0 07699 LI THOTRI PSY 76.99 0 0.000000 76.99 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0.000000 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 88 00 9, 351, 682 0.000000 88 00 08800 RURAL HEALTH CLINIC 0 0 0 88. 01 08801 RURAL HEALTH CLINIC II 0 0 831, 518 0.000000 88.01 0 91. 00 09100 EMERGENCY 0 12, 578, 936 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0.000000 92.00 1, 015, 136 0 200.00 Total (lines 50 through 199) 0 0 112, 770, 924 200.00

Health Financial Systems	OSF HOLY FAMILY MED CTR	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1318	Peri od: Worksheet D
THROUGH COSTS		From 10/01/2022 Part IV

THROUGH COSTS				09/30/2023	Date/Time Pre 2/20/2024 3:0	
		Title	xVIII	Hospi tal	Cost	э рііі
Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷	ŭ	Costs (col. 8	Ü	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11.00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	0	0	0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	29, 855	0	0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0	0	0	0	56.00
57. 00 05700 CT SCAN	0. 000000	50, 569		0	0	57.00
58. 00 05800 MRI	0. 000000	23, 450		0	0	58.00
60. 00 06000 LABORATORY	0. 000000	217, 926	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62.30
64.00 06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	159, 497		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	35, 626		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	22, 149		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	10, 542	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	31, 289	0	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	405, 765	0	0	0	73.00
76. 00 03950 DI ABETI C SERVI CES	0. 000000	0	0	0	0	76.00
76. 01 03020 WOUND CLINIC	0. 000000	0	0	0	0	76. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	0	0	0	76. 97
76.98 O7698 HYPERBARIC OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0	0	0	0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS			,			
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0	0	0	0	88. 01
91. 00 09100 EMERGENCY	0. 000000	4, 437	0	0	0	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	0	0	92.00
200.00 Total (lines 50 through 199)		991, 105	0	0	0	200. 00

 Heal th Financial
 Systems
 OSF HOLY FAMI

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Provider CCN: 14-1318 Peri od: Worksheet D From 10/01/2022 Part V Part V Date/Time Prepared:

				'	0 077 007 2020	2/20/2024 3:0	
			Title	XVIII	Hospi tal	Cost	<u> </u>
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	·	Charge Ratio	Rei mbursed	Reimbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3.00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS						
50.00 05	5000 OPERATING ROOM	0. 166830	0	5, 177, 728	0	0	50.00
53.00 05	5300 ANESTHESI OLOGY	0. 054470	0	715, 382	0	0	53.00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	0. 219824	0	2, 182, 821	0	0	54.00
56.00 05	5600 RADI 0I SOTOPE	0. 101013	0	321, 761	0	0	56.00
57.00 05	5700 CT SCAN	0. 004552	0	3, 783, 899	0	0	57.00
58.00 05	5800 MRI	0. 110431	0	784, 218	o	0	58.00
60.00 06	6000 LABORATORY	0. 114314	0	5, 239, 860	o	0	60.00
62. 30 06	6250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	(o	0	62. 30
64.00 06	6400 INTRAVENOUS THERAPY	0. 084014	0	l	o	0	64.00
65.00 06	6500 RESPI RATORY THERAPY	0. 202654	0	278, 744	0	0	65.00
	6600 PHYSI CAL THERAPY	0. 507626	0	361, 083	o	0	66.00
67. 00 06	6700 OCCUPATI ONAL THERAPY	0. 347414	0	124, 778	ol ol	0	67.00
68.00 06	6800 SPEECH PATHOLOGY	0. 204719	0	3, 631	0	0	68.00
	6900 ELECTROCARDI OLOGY	0. 192432	0	1, 385, 799		0	69.00
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 436655	0	62, 710		0	71.00
72.00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 135474	0	1, 085, 109	o	0	72.00
73.00 07	7300 DRUGS CHARGED TO PATIENTS	0. 193733	0	4, 029, 143	5, 491	0	73.00
76. 00 03	3950 DI ABETI C SERVI CES	14. 741322	0	2,020		0	76.00
76. 01 03	3020 WOUND CLINIC	0. 514978	0	544, 540		0	76. 01
	7697 CARDI AC REHABI LI TATI ON	0. 000000	0	C	o	0	1
76. 98 07	7698 HYPERBARIC OXYGEN THERAPY	0. 000000	0	1 0	ol	0	76. 98
	7699 LI THOTRI PSY	0. 000000	0	ď	o	0	76. 99
	7700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	ď	o	0	1
	7800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	ď	ol	0	1
	JTPATIENT SERVICE COST CENTERS						
	8800 RURAL HEALTH CLINIC						88. 00
	8801 RURAL HEALTH CLINIC II						88. 01
	9100 EMERGENCY	0. 293184	0	2, 799, 828	778	0	
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 839175	0	255, 027		0	
200.00	Subtotal (see instructions)		0	29, 138, 081		_	200.00
201.00	Less PBP Clinic Lab. Services-Program			1 21, 122, 001	0		201.00
	Only Charges]			
202. 00	Net Charges (line 200 - line 201)		0	29, 138, 081	6, 269	0	202.00
	1 3.4 (1.4 1.4 1.4 1.4 1.4 1.4 1.4 1.4 1.4 1.4	!	_	,			

Health Financial Systems	OSF HOLY FAMILY	MED CTR	In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1318	From 10/01/2022	Worksheet D Part V Date/Time Prepared:

				To 09/30/2023		epared: 03 pm
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
·	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	863, 800	0				50.00
53. 00 05300 ANESTHESI OLOGY	38, 967	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	479, 836	0				54.00
56. 00 05600 RADI OI SOTOPE	32, 502	0				56.00
57. 00 05700 CT SCAN	17, 224	0				57.00
58.00 05800 MRI	86, 602	0				58.00
60. 00 06000 LABORATORY	598, 989	0				60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPIRATORY THERAPY	56, 489	0				65.00
66. 00 06600 PHYSI CAL THERAPY	183, 295	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	43, 350	0				67.00
68.00 06800 SPEECH PATHOLOGY	743	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	266, 672	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	90, 093	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	147, 004	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	780, 578	1, 064				73.00
76. 00 03950 DI ABETI C SERVI CES	29, 777	0	1			76.00
76. 01 03020 WOUND CLINIC	280, 426	0				76. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
76. 99 07699 LI THOTRI PSY	0	0				76. 99
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	1			77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	1			78.00
OUTPATIENT SERVICE COST CENTERS						1 70.00
88. 00 08800 RURAL HEALTH CLINIC						88. 00
88. 01 08801 RURAL HEALTH CLINIC II						88. 01
91. 00 09100 EMERGENCY	820, 865	228				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	214, 012	0				92.00
200.00 Subtotal (see instructions)	5, 031, 224	1, 292				200.00
201.00 Less PBP Clinic Lab. Services-Program	0,031,224	1, 2/2				201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	5, 031, 224	1, 292				202. 00

Health Financial Systems	OSF HOLY FAMI	LY MED CTR		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 10/01/2022 To 09/30/2023		epared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II,	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 -	Total Patient Days	Per Diem (col. 3 / col. 4)	
	col . 26)	0.00	col . 2)	4.00	F 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1. 00	2.00	3.00	4. 00	5. 00	
30.00 ADULTS & PEDIATRICS	441, 184	· ·				
200.00 Total (lines 30 through 199)	441, 184		248, 86	7 1, 087		200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	18 18		1			30. 00 200. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS P			Provi der CCN: 14-1318		Worksheet D Part II Date/Time Pre 2/20/2024 3:0	pared: 3 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	264, 032	12, 469, 758	0. 02117	74 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	11, 165	1, 821, 730	0. 00612	29 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	173, 425	9, 299, 149	0. 01865	1, 025	19	54.00
56. 00 05600 RADI 0I SOTOPE	2, 008	1, 067, 343	0. 00188	31 0	0	56.00
57.00 05700 CT SCAN	2, 158	15, 145, 352	0. 00014	6, 986	1	57.00
58. 00 05800 MRI	5, 552	3, 420, 431	0. 00162	23 0	0	58. 00
60. 00 06000 LABORATORY	103, 784			15, 178	75	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000	00	0	62.30
64.00 06400 INTRAVENOUS THERAPY	872	469, 064	0. 00185	59 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	21, 165				212	65.00
66. 00 06600 PHYSI CAL THERAPY	150, 142	1, 796, 037	0. 08359	96 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	13, 203			50 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	1, 192				0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	91, 727	4, 425, 172		3, 506	73	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	92, 574	166, 644			0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 545				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	75, 666		l .		138	73.00
76. 00 03950 DI ABETI C SERVI CES	33, 926				0	76.00
76. 01 03020 WOUND CLINIC	28, 981	1, 562, 477		18	0	76. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0. 00000		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 00000		0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0. 00000		0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000		0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 00000		0	78. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	644, 521	9, 351, 682	0. 06892	20 0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	92, 783		l .		_	88. 01
91. 00 09100 EMERGENCY	253, 076		l .		39	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	87, 401	1, 015, 136	l .			
200.00 Total (lines 50 through 199)	2, 153, 898		•	67, 163		200. 00

Health Financial Systems	OSF HOLY FAMI	LY MED CTR		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 10/01/2022 To 09/30/2023	Date/Time Pre 2/20/2024 3:0	epared: 03 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown	Nursi ng Program	Allied Healt Post-Stepdow Adjustments		All Other Medical Education	
	Adjustments	4 00	0.4	0.00	Cost	
INDATIONE DOUTING CODYLOG COCT CONTEDC	1A	1. 00	2A	2. 00	3. 00	
30.00 3000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0		0 0	0	30. 00 200. 00
Cost Center Description	Swi ng-Bed Adj ustment Amount (see i nstructi ons)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	200.00
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0	1, 08 1, 08			30. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0					30. 00 200. 00

THROUGH COSTS				To 09/30/2023	Date/Time Pre 2/20/2024 3:0	epared:
		Ti tl	e XIX	Hospi tal	PPS	о рііі
Cost Center Description	Non Physician		Nursi ng	Allied Health	Allied Health	
·	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	C	0)	0	0	00.00
53. 00 05300 ANESTHESI OLOGY	C	0)	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C	0)	0	0	54.00
56. 00 05600 RADI 0I SOTOPE	C	0)	0	0	56. 00
57. 00 05700 CT SCAN	C	0)	0	0	57.00
58. 00 05800 MRI	C	0)	0	0	58. 00
60. 00 06000 LABORATORY	C	0)	0	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	C	0)	0	0	62. 30
64.00 06400 INTRAVENOUS THERAPY	C	0)	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	C	0)	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	C	0)	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	C	0)	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	C	0)	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	C	0)	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0)	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	0)	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS	C	0)	0	0	73. 00
76. 00 03950 DI ABETI C SERVI CES	C	0)	0	0	76. 00
76. 01 03020 WOUND CLINIC	C	0)	0	0	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0)	0	0	76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY		0)	0	0	76. 98
76. 99 07699 LI THOTRI PSY		0)	0	0	76. 99
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0)	0	0	77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY) 0)	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	_			_	_	
88. 00 08800 RURAL HEALTH CLINIC	C	0)	0	0	00.00
88. 01 08801 RURAL HEALTH CLINIC II	0	0)	0	0	88. 01
91. 00 09100 EMERGENCY			7	0	0	, 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		U	0	, ,
200.00 Total (lines 50 through 199)	C	0	ין	0 0	0	200.00

Health Financial Systems	OSF HOLY FAMILY	MED CTR	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-1318		Worksheet D
THROUGH COSTS			From 10/01/2022	Part IV

THROUGH COSTS				o 09/30/2023		
		Ti tl	e XIX	Hospi tal	PPS	о рііі
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
'	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0) (,,	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0) (1, 821, 730	0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0) (., = ,	0. 000000	54.00
56. 00 05600 RADI 0I SOTOPE	0	0) (1, 067, 343	0.000000	56.00
57.00 05700 CT SCAN	0	0) (0. 000000	
58. 00 05800 MRI	0	0) (3, 420, 431	0.000000	58. 00
60. 00 06000 LABORATORY	0	0) (20, 921, 573	0.000000	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0) (0	0.000000	
64.00 06400 I NTRAVENOUS THERAPY	0	0) (469, 064	0.000000	
65. 00 06500 RESPI RATORY THERAPY	0	0) (1, 545, 591	0.000000	
66. 00 06600 PHYSI CAL THERAPY	0	0) (1, 796, 037	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0) (689, 455	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0) (33, 480	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0) (4, 425, 172	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0) (166, 644	0. 000000	1
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	0	0) (2, 303, 238	0. 000000	1
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0) (,	0.000000	
76. 00 03950 DI ABETI C SERVI CES	0	0) (-,	0. 000000	
76. 01 03020 WOUND CLINIC	0	0) (1, 562, 477	0. 000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0) (0	0. 000000	
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0) (0	0. 000000	
76. 99 07699 LI THOTRI PSY	0	0) (0	0.000000	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0) (0	0.000000	
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0) (0	0. 000000	78. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0)	.,,	0. 000000	1
88.01 08801 RURAL HEALTH CLINIC II	0	0) (831, 518	0. 000000	1
91. 00 09100 EMERGENCY	0	0) (12, 578, 936	0. 000000	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	0) (1, 015, 136	0. 000000	92.00
200.00 Total (lines 50 through 199)	0	0) c	112, 770, 924		200. 00

Health Financial Systems	OSF HOLY FAMILY !	MED CTR	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	NCILLARY SERVICE OTHER PASS	Provider CCN: 14-1318	Peri od:	Worksheet D
THROUGH COSTS			From 10/01/2022	Part IV

THROUGH COS	515			T-	09/30/2023	Date/Time Pre 2/20/2024 3:0	
			Ti tl	e XIX	Hospi tal	PPS	э рііі
	Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	F	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷	3	Costs (col. 8	J	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11.00	12.00	13.00	
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	0. 000000	0	0	0	0	50.00
	O ANESTHESI OLOGY	0. 000000	0		0	0	53.00
	O RADI OLOGY-DI AGNOSTI C	0. 000000	1, 025	0	0	0	54.00
	O RADI OI SOTOPE	0. 000000	0		0	0	56.00
	OCT SCAN	0. 000000	6, 986	0	0	0	57.00
	O MRI	0. 000000	0	0	0	0	58. 00
60.00 0600	O LABORATORY	0. 000000	15, 178	0	0	0	60.00
	O BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62.30
	O INTRAVENOUS THERAPY	0. 000000	0	0	0	0	64.00
	O RESPIRATORY THERAPY	0. 000000	15, 449	0	0	0	65.00
	O PHYSI CAL THERAPY	0. 000000	0	0	0	0	66.00
	O OCCUPATI ONAL THERAPY	0. 000000	0	0	0	0	67.00
68. 00 0680	O SPEECH PATHOLOGY	0. 000000	0	0	0	0	68. 00
69. 00 0690	O ELECTROCARDI OLOGY	0. 000000	3, 506	0	0	0	69. 00
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0	0	0	0	71. 00
	O IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	0	0	0	72.00
	O DRUGS CHARGED TO PATIENTS	0. 000000	21, 675	0	0	0	73.00
	O DI ABETI C SERVI CES	0. 000000	0	0	0	0	76. 00
76. 01 0302	O WOUND CLINIC	0. 000000	0	0	0	0	76. 01
	7 CARDIAC REHABILITATION	0. 000000	0	0	0	0	76. 97
	8 HYPERBARIC OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
	9 LI THOTRI PSY	0. 000000	0	0	0	0	76. 99
77. 00 0770	O ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	0	0	77. 00
78.00 0780	O CAR T-CELL IMMUNOTHERAPY	0. 000000	0	0	0	0	78. 00
	ATIENT SERVICE COST CENTERS						
	ORURAL HEALTH CLINIC	0. 000000	0	0	0	0	
	1 RURAL HEALTH CLINIC II	0. 000000	0	0	0	0	88. 01
-	O EMERGENCY	0. 000000	1, 953		0	0	91.00
	O OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	1, 391		0	0	92.00
200.00	Total (lines 50 through 199)		67, 163	0	0	0	200. 00

Health Financial Systems	OSF HOLY FAMILY N	MED CTR	In Lieu	ı of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST	F	Provider CCN: 14-1318	Peri od: From 10/01/2022		
			To 09/30/2023	Date/Time Prep 2/20/2024 3:03	
		Title XVIII	Hospi tal	Cost	
Cost Center Description					

PART I - ALL PROVIDER COMPONENTS INPATLENT DAYS I right tent days (including private room days and swing-bed days, excluding newborn) 2.052 Inpatient days (including private room days, excluding swing-bed and newborn days) 3.06 Private room days (excluding swing-bed and observation bed days) 5.07 Fried and room days (excluding swing-bed and observation bed days) 5.08 Fried and observation bed days) 6.09 Fried as wing-bed SNF type inpatient days (including private room days) through becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Fried as wing-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) 7.00 Fried as wing-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) 8.00 Fried as wing-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) 9.00 Fried inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Fried inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 1.00 Fried as wing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 1.00 Fried as wing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 1.00 Fried as wing-bed SNF type inpatient days applicable to services through December 31 of the cost reporting period (including private room days) 1.00 Fried as wing-bed SNF type inpatient days applicable to services through December 31 of th			Title XVIII	Hospi tal	2/20/2024 3:0 Cost	3 pm
PART I - ALL PROVIDER COMPONENTS IMPATIENT DAYS Inpatient days (including private room days, excluding swing-bed days, excluding newborn) 2,052 10 Inpatient days (including private room days, excluding swing-bed and newborn days) 1,067 10 Inpatient days (including private room days, excluding swing-bed and newborn days) 1,067 10 Order of the strip of the s		Cost Center Description		nespi tai		
IMPATIENT DAYS		PART I - ALL PROVIDER COMPONENTS			1. 00	
1.087 inpatient days (including private room days, excluding swing-bed and newborn days) of ont complete this line. 3.00 Private room days (excluding swing-bed and observation bed days). Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period of 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) 7.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 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) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 11.00 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) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Nedically inaccessary private room days applicable to titles V or XIX only (including private room days) 15.00 Interporting period (if calendar year, enter 0 on this line) 16.00 Interporting period (if calendar year, enter 0 on this line) 17.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 18.00 New Swing-bed NF type inpatient days applicable to						
on to complete this line. 5emi private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 5emi private room days (excluding swing-bed and observation bed days) through December 31 of the cost reporting period 6.00 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) 7.01 Total swing-bed Nf type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 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) 9.01 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.02 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 1.03 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see Instructions) 1.04 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) 8.04 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) 9.03 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 9.04 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 9.05 Swing-bed SNF type inpatient days applicable to services after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.06 Swing-bed Cost applicable to SNF type services applicable to services after December 31 of the cost r						•
do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 703 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) 7.00 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) 7.01 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.02 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) 7.03 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 7.04 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.05 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.06 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.07 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.08 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.09 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 7.09 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 7.00 Total nursery days (title V or XIX only) 7.01 SWING BED AUSTMENT 7.02 SWING BED AUSTMENT 7.03 Total nursery days (title V or XIX only) 7.04 SWING BED AUSTMENT 7.05 SWING BED AUSTMENT 7.06 Office and are for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line 6 X I line 18) 7.07 SWING BED AUSTMENT 7.08 SWING BED AUSTMENT 7.09 SWING BED AUSTMENT 7.09 SWING BED AUSTMENT				sivata room dave		2. 00 3. 00
Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) Total inpatient days applicable to title XVIII only (including private room days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) Obstract Type Inpatient days applicable to titles V or XIX only (including private room days) Obstract Type Inpatient days applicable to the Program (excluding swing-bed days) Obstract Type Inpatient (if cal endar year, enter 0 on this line) Obstract Type Inpatient (if cal endar year, enter 0 on this line) Obstract Type Inpatient (if cal endar year, enter 0 on this line) Obstract Type Inpatient (if cal endar year, enter 0 on this line) Obstract Type Inpatient (if cal endar year, enter 0 on this line) Obstract Type Inpatient (if cal endar year, enter 0 on this line) Obstract Type Inpatient (if ca	3.00		lys). If you have only pr	ivate room days,		3.00
reporting period 6.00 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) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 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) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 11.00 Swing-bed NF 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) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Wedically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Norsery days (title V or XIX only) 17.00 Wedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Wedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Wedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 8 x line 17) 20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x X line 19) 21.50 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x X line 19) 22.00 Swing-bed cost ap						4.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7.01 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 7.02 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 7.03 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 7.04 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7.05 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) on through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7.04 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) on after December 31 of the cost reporting period (including period (including private room days) on after December 31 of the cost reporting period (including period on the period of the period of the period of the December 31 of the cost reporting period (including period including private room days) on the period of the December 31 of the cost reporting period (including private room days) on the period of the period (including private room days) on the period (including private room days applicable to services after December 31 of the cost reporting period (including period (includin	5. 00		om days) through Decembe	er 31 of the cost	210	5.00
reporting period (if cal endar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 9.00 Total nursery days (citile V or XIX only) 10.00 Swing-bed NF type inpatient days applicable to services after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 11.00 Swing-bed NF type inpatient days including private room days) after December 31 of the cost reporting period (see instructions) 11.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 13.00 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 (see instructions) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Total nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17) 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x X line 19) 23.00 Swing-bed cost applicable to NF type services after December 31 of the cost repor	6. 00	1 9 1	om davs) after December	31 of the cost	630	6.00
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Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 201.56 reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) O.0000032.00	18. 00		es after December 31 of	the cost		18. 00
20.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 4, 300, 109 4, 300, 109 4, 300, 109 4, 300, 109 5 ving-bed cost reporting period (line 6 over reporting period (line 6 over reporting period (line 6 over reporting period (line 6 over reporting period (line 8 over	19. 00		s through December 31 of	f the cost	201. 56	19.00
reporting period Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 cost 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) PRIVATE room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) O General inpatient routine service cost/charge ratio (line 27 ÷ line 28) O composition of the cost reporting period (line 4 of the cost reporting period (line 5 of the cost reporting period (line 6 of the cost reporting period (line 6 of the cost reporting period (line 8 of the cost reporting period (line 8 of the cost reporting period (line 8 of the cost reporting period (line 8 of the cost reporting period (line 8 of the cost reporting period (line 8 of the cost reporting period (line 8 of the cost reporting period (line 8 of the cost reporting period (line 8 of the cost reporting period (line 8 of the cost reporting period (line 8 of the cost reporting period (line 2 of the cost reporting period (line 2 of the cost reporting period (line 2 of the cost reporting period (line 2 of the cost reporting period (line 2 of the cost reporting period (line 2 of the cost reporting period (line 2 of the cost reporting period (line 2 of the cost reporting period (line 2 of the cost reporting period (line						
21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3)	20.00		es after December 31 of 1	the cost] 201. 56 	20.00
5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6, 248 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 18, 947 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Occupancy of the cost reporting period (line 6 occupancy of the cost reporting period (line 8 occupancy occupancy oc	21. 00	Total general inpatient routine service cost (see instruction				21.00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6, 248 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 18, 947 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 32.00 Average private room per diem charge (line 29 ÷ line 3)	22. 00		er 31 of the cost report	ting period (line	0	22.00
x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6, 248 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 18, 947 x line 20) 26.00 Total swing-bed cost (see instructions) 1, 888, 676 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 2, 411, 433 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 32.00 Average private room per diem charge (line 29 ÷ line 3) 0.00	23. 00		31 of the cost reportin	na period (line 6	0	23.00
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Octobr/> 34.00 Average private room per diem charge (line 29 ÷ line 3) 35.00 Control of the cost reporting period (line 8 18,947 and 19,947	x line 18)	·				
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 38.00 October 18, 947 18, 947 18, 947 19, 947 10, 947	24. 00		r 31 of the cost reporti	ng period (line	6, 248	24.00
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-pri vate room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average pri vate room per diem charge (line 29 ÷ line 3) 1,888,676 2,411,433 2,411,433	25. 00		31 of the cost reporting	period (line 8	18, 947	25.00
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 2, 411, 433 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 32.00 Average private room per diem charge (line 29 ÷ line 3) 0.00		,				
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 0.000		,	(line 21 minus line 26)			
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 0.000000 0.0000000	27.00		(TITIE 21 IIIITIUS TITIE 20)		2,411,455	27.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 0.000000 0.000000			d and observation bed ch	narges)		•
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 0.000000 0.00						
32.00 Average private room per diem charge (line 29 ÷ line 3) 0.00			÷ line 28)			
22 00 Average comi private reem non diem aborge (line 20 . 1! == 4)		,	•			1
	33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00				ctions)		
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 0.00		, , ,	ne 31)			35. 00 36. 00
, , ,		,	and private room cost di	fferential (line		
27 minus line 36)		27 minus line 36)	, 3.12 . 25m 000t ui			
PART II - HOSPITAL AND SUBPROVIDERS ONLY			LICTMENTS			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2,218.43	38 00				2 218 43	38. 00
			•			40.00
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 854,096	41.00	Total Program general inpatient routine service cost (line 39	+ line 40)		854, 096	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	OSF HOLY FAM		CCN: 14-1318	Period:	worksheet D-1	
COMPUT	ATTON OF INPATTENT OPERATING COST		Provider	CN. 14-1316	From 10/01/2022 To 09/30/2023	Date/Time Pre	pared:
			Title	e XVIII	Hospi tal	2/20/2024 3: 0 Cost)3 pm
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	1	Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00	2.00	3. 00	4. 00	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT						43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					180, 488	
48. 01 49. 00	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines of the costs)), column 1)	0 1, 034, 584	
47.00	PASS THROUGH COST ADJUSTMENTS	41 till ough 46.	or) (see Tristic	ictions)		1, 034, 364	49.00
50.00	Pass through costs applicable to Program inpa	atient routine	services (fro	om Wkst. D, su	ım of Parts I and	0	50.00
51. 00		atient ancilla	rv services (f	rom Wkst. D.	sum of Parts II	0	51.00
	and IV)		J	22. 21		_	
52. 00 53. 00	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclud		elated non sh	nysician anost	hetist and	0	
55.00	medical education costs (line 49 minus line !	9 1			motist, and] 55.00
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION						F4 00
54. 00 55. 00	Program discharges Target amount per discharge					0.00	
55. 01	Permanent adjustment amount per discharge					0.00	55. 01
55. 02 56. 00	Adjustment amount per discharge (contractor larget amount (line 54 x sum of lines 55, 55.		`			0.00	1
57. 00	Difference between adjusted inpatient operati			line 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)					0	
59. 00	Trended costs (lesser of line 53 ÷ line 54, of updated and compounded by the market basket)	or line 55 fro	m the cost rep	orting period	l endi ng 1996,	0. 00	59.00
60.00							60.00
61. 00	market basket) Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less					0	61.00
	53) are less than expected costs (lines 54 \times enter zero. (see instructions)	60), or 1 % o	f the target a	nmount (line 5	66), otherwise		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ant (saa instr	uctions)			0	
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST	(300 111311	4011 0113)				00.00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dec	ember 31 of th	ne cost report	ing period (See	306, 143	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decem	ber 31 of the	cost reportir	g period (See	794, 198	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only); for	1, 100, 341	66.00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing		•		•	0	67.00
	(line 12 x line 19)	9					
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after	December 31 of	the cost rep	oorting period	0	68.00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU	routine costs JRSING FACILIT	(line 67 + lir Y. AND ICF/IIC	ne 68) O ONLY		0	69.00
70. 00	Skilled nursing facility/other nursing facili	ity/ICF/IID ro	utine service	cost (line 37	')		70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line		line 70 ÷ line	2)			71. 00 72. 00
73.00	Medically necessary private room cost applica	abĺe to Progra					73.00
74. 00 75. 00	Total Program general inpatient routine servi				Dart II column		74. 00 75. 00
	Capital-related cost allocated to inpatient 26, line 45)		c costs (IIOIII	WOI KSHEEL D,	raitii, corumin		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus						78.00
79.00	Aggregate charges to beneficiaries for excess		•		muo 11 70)		79.00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		cost limitatio	on (iine /8 mi	nus iine 79)		80.00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 8	•				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (: Program inpatient ancillary services (see in:		ns)				83. 00 84. 00
85.00	Utilization review - physician compensation		ons)				85.00
86. 00	Total Program inpatient operating costs (sum	of lines 83 t					86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					384	87.00
07.00							88.00

Health Financial Systems	OSF HOLY FAMI	LY MED CTR		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 10/01/2022 To 09/30/2023	Date/Time Pre 2/20/2024 3:0	pared: 3 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				851, 877	89.00
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line	Observation Bed Pass Through Cost (col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	441, 184	4, 300, 109	0. 10259	851, 877	87, 401	90.00
91.00 Nursing Program cost	o	4, 300, 109	0. 00000	00 851, 877	0	91.00
92.00 Allied health cost	o	4, 300, 109	0. 00000	00 851, 877	0	92.00
93.00 All other Medical Education	o	4, 300, 109	0. 00000	00 851, 877	0	93.00

Health Financial Systems	OSF HOLY FAMILY MED CTR	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Peri od: From 10/01/2022		
		To 09/30/2023	Date/Time Pre 2/20/2024 3:0	
	Title XIX	Hospi tal	PPS	
Cost Center Description				

		Title XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		2, 052	1.00
2.00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		1, 087	2.00
3. 00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	od days)		703	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	210	5.00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	630	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m days) through December	21 of the cost	31	7. 00
7.00	reporting period	iii days) trii ougir beceiiber	31 Of the cost	31	7.00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	94	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t newborn days) (see instructions)	o the Program (excluding	swing-bed and	18	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private r	oom davs)	0	10.00
	through December 31 of the cost reporting period (see instruc				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11.00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		o room days)	0	12.00
12.00	through December 31 of the cost reporting period	A only (Therduring privat	e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			5	13.00
	after December 31 of the cost reporting period (if calendar y				
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT		<u>'</u>		
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 o	f the cost		17. 00
10 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	os after December 21 of	the cost		18. 00
10.00	reporting period	es al tel becember 51 01	the cost		10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19.00
20.00	reporting period			0.00	20.00
20.00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after becember 31 of t	ne cost	0.00	20. 00
21.00	Total general inpatient routine service cost (see instruction	s)		4, 300, 109	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reportin	a ported (line 4	0	23. 00
23.00	x line 18)	31 of the cost reportin	g period (Title 0	U	23.00
24.00		r 31 of the cost reporti	ng period (line	0	24.00
05.00	7 x line 19)	24 . 6 . 1			05.00
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	l			1, 874, 460	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 425, 649	27. 00
20.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	d			00.00
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed ch	arges)	0	28. 00 29. 00
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	1
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	1
34. 00	Average per diem private room charge differential (line 32 mi		ti ons)	0. 00	1
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	1
36.00	Private room cost differential adjustment (line 3 x line 35)		66	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	ттегепtial (line	2, 425, 649	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		2, 231. 51	1
39.00	9 9	•		40, 167	1
40.00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			0 40, 167	•
- 1. 00	Trotal Trogram general impatrent routine service cost (IIIIe 37	, 1111C 1 0)	ı	40, 107	1 -1.00

alth Financial Systems MPUTATION OF INPATIENT OPERATING COST		ILY MED CTR Provider (CCN: 14-1318	Peri od: From 10/01/2022	u of Form CMS-2 Worksheet D-1	
				To 09/30/2023	Date/Time Pre 2/20/2024 3:0	
			le XIX	Hospi tal	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	1	Program Cost (col. 3 x col. 4)	
.00 NURSERY (title V & XIX only)	1. 00	2. 00	3.00	4.00	5. 00	42.
Intensive Care Type Inpatient Hospital Un	ni ts					, , , .
OO INTENSIVE CARE UNIT						43.
.OO CORONARY CARE UNIT .OO BURN INTENSIVE CARE UNIT						44. 45.
OO SURGICAL INTENSIVE CARE UNIT						46.
. 00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description				-	1. 00	\vdash
.00 Program inpatient ancillary service cost	(Wkst. D-3, col.	3, line 200)			11, 737	48.
.01 Program inpatient cellular therapy acquis), column 1)	0	
.00 Total Program inpatient costs (sum of lir PASS THROUGH COST ADJUSTMENTS	nes 41 through 48.	01)(see instru	ictions)		51, 904	49.
.00 Pass through costs applicable to Program	inpatient routine	services (fro	om Wkst. D, su	m of Parts I and	4, 121	50.
				6.5		
.00 Pass through costs applicable to Program and IV)	impatient ancilla	ry services (f	rom WKST. D,	SUM OT Parts II	677	51.
.00 Total Program excludable cost (sum of lin	nes 50 and 51)				4, 798	52.
.00 Total Program inpatient operating cost ex		elated, non-ph	nysician anest	hetist, and	47, 106	53
medical education costs (line 49 minus li TARGET AMOUNT AND LIMIT COMPUTATION	ne 52)					
. 00 Program di scharges					0	54
.00 Target amount per discharge					0.00	
.01 Permanent adjustment amount per discharge.02 Adjustment amount per discharge (contract					0. 00 0. 00	
.00 Target amount (line 54 x sum of lines 55,)			0.00	
.00 Difference between adjusted inpatient ope			(line 56 minus	line 53)	0	
.00 Bonus payment (see instructions) .00 Trended costs (lesser of line 53 ÷ line 5	IA on line EE fro	m +bo ooo+ ror	antina nanias	Londing 1004	0.00	
.00 Trended costs (lesser of line 53 ÷ line 5 updated and compounded by the market bask		iii the cost rep	or tring period	renaring 1996,	0.00	59
00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the						60
market basket) Continuous improvement bonus payment (if 55.01, or line 59, or line 60, enter the 53) are less than expected costs (lines 5	lesser of 50% of	the amount by	which operati	ng costs (line	0	61
enter zero. (see instructions) .00 Relief payment (see instructions)					0	62
.00 Allowable Inpatient cost plus incentive p	payment (see instr	uctions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST						4
.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs through Dec	ember 31 of tr	ie cost report	ing period (See	0	64
.00 Medicare swing-bed SNF inpatient routine	costs after Decem	ber 31 of the	cost reportin	g period (See	0	65
instructions)(title XVIII only)	uutina aaata (lina	44 plug ling	(E) (+: +1 o V)//	II only). for	0	
.00 Total Medicare swing-bed SNF inpatient ro CAH, see instructions	butine costs (iine	64 prus rine	os)(title xvi	ii oniy); ioi	0	66
.00 Title V or XIX swing-bed NF inpatient rou	utine costs throug	h December 31	of the cost r	eporting period	0	67
(line 12 x line 19) .00 Title V or XIX swing-bed NF inpatient rou	itine costs after	December 31 of	the cost rer	orting period	0	68
(line 13 x line 20)			3551 . 35	lor tring por rou	· ·	
.00 Total title V or XIX swing-bed NF inpation					0	69
PART III - SKILLED NURSING FACILITY, OTHE Skilled nursing facility/other nursing fa				') I		70
.00 Adjusted general inpatient routine service	ce cost per diem (71
.00 Program routine service cost (line 9 x li.00 Medically necessary private room cost app		m (line 14 v l	ine 35)			72
.00 Total Program general inpatient routine s						74
.00 Capital-related cost allocated to inpatie	ent routine servic	e costs (from	Worksheet B,	Part II, column		75
26, line 45) .00 Per diem capital-related costs (line 75 =	: line 2)					76
.00 Program capital -related costs (line 9 x l						77
.00 Inpatient routine service cost (line 74 m						78
.00 Aggregate charges to beneficiaries for ex .00 Total Program routine service costs for o		•		nus line 79)		80
.00 Inpatient routine service costs for C	•	SSC TIME LAUT	(11110 70 1111			81
.00 Inpatient routine service cost limitation	n (line 9 x line 8	* .				82
.00 Reasonable inpatient routine service cost .00 Program inpatient ancillary services (see	•	ns)				83
.00 Program inpatient ancillary services (see .00 Utilization review - physician compensati		ons)				85
.00 Total Program inpatient operating costs ((sum of lines 83 t	,				86
PART IV - COMPUTATION OF OBSERVATION BED Total observation bed days (see instructi				1	384	87
. II III a cocci fati ci. bod dayo (coc i listi doti	per diem (line 27				2, 231. 51	

Health Financial Systems	OSF HOLY FAMI	LY MED CTR		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2022 To 09/30/2023		
		Ti tl e	e XIX	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			856, 900	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	441, 184	4, 300, 109	0. 10259	856, 900	87, 916	90.00
91.00 Nursing Program cost	0	4, 300, 109	0.00000	0 856, 900	0	91.00
92.00 Allied health cost	0	4, 300, 109	0.00000	0 856, 900	0	92.00
93.00 All other Medical Education	o	4, 300, 109	0. 00000	0 856, 900	0	93.00

		OSF HOLY FAMILY MED CTR	CON 14 1212	I D		u of Form CMS-	
INPAILENT AN	CILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 14-1318		riod: om 10/01/2022	Worksheet D-3	i
				To		Date/Time Pre 2/20/2024 3:0	
		Ti t	le XVIII		Hospi tal	Cost	
	Cost Center Description		Ratio of Co		I npati ent	I npati ent	
			To Charge	S	Program	Program Costs	
					Charges	(col. 1 x col. 2)	
			1.00		2. 00	3. 00	
I NPAT	ENT ROUTINE SERVICE COST CENTERS		1.00		2.00	0.00	
	ADULTS & PEDIATRICS				830, 388		30.00
	ARY SERVICE COST CENTERS		<u>'</u>		· .		1
	OPERATING ROOM		0. 166	830	0	0	50.00
	ANESTHESI OLOGY		0. 054		0	0	
	RADI OLOGY-DI AGNOSTI C		0. 219		29, 855	6, 563	•
	RADI OI SOTOPE		0. 101		0	0	
	CT SCAN		0.004		50, 569	230	
58. 00 05800 60. 00 06000	MRI LABORATORY		0.110		23, 450	2, 590 24, 912	
1	BLOOD CLOTTING FOR HEMOPHILIACS		0. 114 0. 000		217, 926 0	24, 912	
	INTRAVENOUS THERAPY		0.000		0	0	
	RESPIRATORY THERAPY		0. 202		159, 497	32, 323	
1	PHYSI CAL THERAPY		0. 507		35, 626	18, 085	
1	OCCUPATI ONAL THERAPY		0. 347		22, 149	7, 695	
68. 00 06800	SPEECH PATHOLOGY		0. 204	719	10, 542	2, 158	68.00
59. 00 06900	ELECTROCARDI OLOGY		0. 192	432	31, 289	6, 021	69.00
	MEDICAL SUPPLIES CHARGED TO PATIENT		1. 436	655	0	0	
	IMPL. DEV. CHARGED TO PATIENTS		0. 135		0	0	
	DRUGS CHARGED TO PATI ENTS		0. 193		405, 765	78, 610	
	DI ABETI C SERVI CES		14. 741		0	0	
	WOUND CLINIC		0. 514		0	0	
	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY		0. 000 0. 000		0	0	
	LI THOTRI PSY		0.000		0	0	
	ALLOGENEIC HSCT ACQUISITION		0.000		0	0	
	CAR T-CELL IMMUNOTHERAPY		0.000		0	0	
	FIENT SERVICE COST CENTERS		0.000	000			70.00
	RURAL HEALTH CLINIC		0.000	000		0	88. 00
	RURAL HEALTH CLINIC II		0.000		ļ	0	88. 01
	EMERGENCY		0. 293	184	4, 437	1, 301	91.00
	OBSERVATION BEDS (NON-DISTINCT PART		0. 839	175	0	0	
200. 00	Total (sum of lines 50 through 94 and 96				991, 105	180, 488	•
201. 00	Less PBP Clinic Laboratory Services-Prog	ram only charges (line 61)		0		201.00
202. 00	Net charges (line 200 minus line 201)				991, 105		202.00

Health Financial Systems	OSF HOLY FAMILY MED CTR			u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 14-1318	Peri od: From 10/01/2022	Worksheet D-3	3
	·	CCN: 14-Z318	To 09/30/2023	2/20/2024 3:0	
	Ti tl		Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCILLARY SERVICE COST CENTERS		•	•	•	
50. 00 05000 OPERATING ROOM		0. 1668	30 0	0	50.00
53. 00 05300 ANESTHESI OLOGY		0. 0544	70 0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2198:	· ·	3, 241	
56. 00 05600 RADI 01 SOTOPE		0. 1010		0	
57. 00 05700 CT SCAN		0. 0045		l e	
58. 00 05800 MRI		0. 1104:		0	
60. 00 06000 LABORATORY		0. 1143			
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY		0. 0840 0. 2026			
66. 00 06600 PHYSI CAL THERAPY		0. 5076			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 3474			
68. 00 06800 SPEECH PATHOLOGY		0. 2047			1
69. 00 06900 ELECTROCARDI OLOGY		0. 1924:	· ·		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 4366		l .	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1354		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1937:	367, 682	71, 232	73.00
76. 00 03950 DI ABETI C SERVI CES		14. 7413	22 0	0	76.00
76. 01 03020 WOUND CLINIC		0. 5149			
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 00000		0	1
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 00000		0	
76. 99 07699 LI THOTRI PSY		0.00000		0	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000			
78. 00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS		0.00000	00 0	0	78. 00
88. 00 08800 RURAL HEALTH CLINIC		0.0000	20	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II		0. 00000			
91. 00 09100 EMERGENCY		0. 29318			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 8391			
200.00 Total (sum of lines 50 through 94 and	96 through 98)		938, 124		
201.00 Less PBP Clinic Laboratory Services-Pr	rogram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			938, 124		202. 00

Health Financial Systems	OSF HOLY FAMILY	MED CTR		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C		Peri od:	Worksheet D-3	
				From 10/01/2022 To 09/30/2023	Date/Time Pre	narod:
				10 04/30/2023	2/20/2024 3:0	3 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
LANDATI ENT. DOUTLAND OFFICE COOT OFFITEDO			1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				20.004		00.00
30. 00 03000 ADULTS & PEDIATRICS				38, 284		30.00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM			0. 16683	0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY			0. 16683		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 03447		225	
56. 00 05600 RADI OI SOTOPE			0. 21762		0	56.00
57. 00 05700 CT SCAN			0. 00455		32	
58. 00 05800 MRI			0. 11043		0	58.00
60. 00 06000 LABORATORY			0. 11431		1, 735	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS			0. 00000		0	62. 30
64. 00 06400 I NTRAVENOUS THERAPY			0. 08401		0	64.00
65. 00 06500 RESPIRATORY THERAPY			0. 20265	15, 449	3, 131	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 50762	6 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY			0. 34741	4 0	0	67.00
68.00 06800 SPEECH PATHOLOGY			0. 20471	9 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY			0. 19243	· ·	675	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			1. 43665		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 13547		0	
73. 00 07300 DRUGS CHARGED TO PATI ENTS			0. 19373	· ·	4, 199	
76. 00 03950 DI ABETI C SERVI CES			14. 74132		0	
76. 01 03020 WOUND CLINIC			0. 51497		0	
76. 97 07697 CARDI AC REHABI LI TATI ON			0.00000		0	
76. 98 O7698 HYPERBARI C OXYGEN THERAPY 76. 99 O7699 LI THOTRI PSY			0. 00000 0. 00000		0	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION			0.00000		0	1
78. 00 07800 CAR T-CELL IMMUNOTHERAPY			0.00000		0	
OUTPATIENT SERVICE COST CENTERS			0.00000	0	0	78.00
88. 00 08800 RURAL HEALTH CLINIC			0. 94127	7 0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II			0. 97060		Ö	
91. 00 09100 EMERGENCY			0. 29318		573	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			0. 83917		1, 167	92.00
200.00 Total (sum of lines 50 through 94 and 9	6 through 98)			67, 163	11, 737	
201.00 Less PBP Clinic Laboratory Services-Pro	ogram only charges	(line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)				67, 163		202. 00

	Title XVIII	Hospi tal	2/20/2024 3:0 Cost	3 pm
			4.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		1.00	
1. 00	Medical and other services (see instructions)		5, 032, 516	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3. 00	OPPS or REH payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions)		0.000	4. 01 5. 00
6. 00	Line 2 times line 5		0.000	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7. 00
8.00	Transitional corridor payment (see instructions)		0	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES		5, 032, 516	11.00
	Reasonable charges			
12.00			0	12.00
13.00			0	13.00
14. 00			0	14.00
15. 00	Customary charges Aggregate amount actually collected from patients liable for payment for services	on a chargo basis	0	15.00
16. 00				16.00
.0.00	had such payment been made in accordance with 42 CFR §413.13(e)	o on a onar gozaor o		
17.00			0. 000000	17.00
18.00	, , , ,		0	18.00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds instructions)	line 11) (see	0	19. 00
20. 00		line 18) (see	0	20.00
20.00	instructions)	10) (000		20.00
21.00	Lesser of cost or charges (see instructions)		5, 082, 841	21.00
22. 00	·		0	22.00
23. 00			0	23.00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	24. 00
25. 00			53, 934	25. 00
26. 00	· · · · · · · · · · · · · · · · · · ·	structions)	4, 603, 094	26.00
27. 00		22 and 23] (see	425, 813	27. 00
20.00	instructions)			20.00
28. 00 28. 50			0	28. 00 28. 50
29. 00			0	29.00
30.00			425, 813	
31. 00			0	31.00
32. 00			425, 813	32.00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34. 00			83, 851	34.00
35. 00			54, 503	
36. 00			72, 944	
37.00			480, 316	
38. 00 39. 00			0	38. 00 39. 00
39. 50				39.50
39. 75			0	39. 75
39. 97			0	39. 97
39. 98		ructions)	0	39. 98
39. 99			0	39. 99
40. 00 40. 01			480, 316 9, 606	40. 00 40. 01
40. 01	1 ' · · · · · · · · · · · · · · · · · ·		9,000	40. 01
40. 03				40. 03
41.00	Interim payments		-15, 466	41.00
41. 01				41.01
42.00	,		0	42.00
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)		486, 176	42. 01 43. 00
43. 01	Balance due provider/program-PARHM (see instructions)		400, 170	43. 01
44. 00		2, chapter 1,	59, 742	44.00
	§115. 2	· · ·		
00.05	TO BE COMPLETED BY CONTRACTOR		-	00.00
90.00			0 0	90. 00 91. 00
91. 00 92. 00	· · · · · · · · · · · · · · · · · · ·		0.00	
93. 00	· · · · · · · · · · · · · · · · · · ·		0.00	93.00
94.00			0	

Health Financial Systems	OSF HOLY FAMILY	MED CTR	In Lieu	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1318	Peri od:	Worksheet E	
			From 10/01/2022		
			To 09/30/2023	Date/Time Pr	
				2/20/2024 3:	03 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				(0 200. 00

Peri od: Worksheet E-1 From 10/01/2022 Part I To 09/30/2023 Date/Time Prepared: 2/20/2024 3:03 pm Provider CCN: 14-1318

					2/20/2024 3: 0:	3 pm
		Title	: XVIII	Hospi tal	Cost	<u> </u>
		Inpatier	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2, 00	3, 00	4. 00	
1. 00	Total interim payments paid to provider		901, 09	4	937, 655	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,			Ö	0	2. 00
3. 00	write "NONE" or enter a zero 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. 00
	Program to Provider					
3. 01 3. 02 3. 03 3. 04	ADJUSTMENTS TO PROVIDER			0 0 0 0	0 0	3. 01 3. 02 3. 03 3. 04
3. 05				0	0	3. 05
5. 05	Provider to Program		1	<u></u>	-	5.05
3. 50	ADJUSTMENTS TO PROGRAM	05/25/2023	41, 59	9 05/25/2023	812, 551	3. 50
3. 51	ADSOSTMENTS TO TROOKIN	09/05/2023	10, 86		140, 570	3. 51
3. 52		077 037 2023	1	0	140, 370	3. 52
3. 53			1	o	0	3. 53
3. 54			1	0		3. 54
3. 99	Subtotal (sum of lines 2 01 2 40 minus sum of lines			<u> </u>		3. 99
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-52, 46		-953, 121	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		848, 63	4	-15, 466	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	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. 00
	Program to Provider		·			
5. 01	TENTATI VE TO PROVI DER			o	0	5. 01
5. 02	TENTATI VE TO TROVIDER		1	Ö	0	5. 02
5. 03				Ö	0	5. 03
5. 05	Provider to Program			<u> </u>		3.03
5. 50	TENTATI VE TO PROGRAM		1	ol	0	5. 50
5. 51	TENTATI VE TO TROGIVIW		l .	0	0	5. 51
5. 52				0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
4 01	SETTLEMENT TO PROVIDER		41 01	_	40/ 17/	6 01
6. 01	1 in the second		41, 81		486, 176	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		890, 44		470, 710	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1. 00	2.00	
8. 00	Name of Contractor	·		1.00	2.00	8. 00
0.00	Industry of Solitification			1	1 1	0.00

Provi der CCN: 14-1318 | Peri od: From 10/01/2022 | Part I | Part I | Portion | Portion | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Par

					2/20/2024 3: 0	3 pm
				ving Beds - SNF		
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 236, 080		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3. 03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	05/25/2023	37, 039		0	3. 50
3. 51		09/05/2023	13, 652		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54	Cubtatal (aum of lines 2 01 2 40 minus aum of lines		0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-50, 691		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 185, 389		0	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		1, 105, 507		O O	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			l.		
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Dravi dan ta Dragnam		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 51	TENTATI VE TO TROGRAM		0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		Ö	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		125, 025		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 310, 414		0	7. 00
				Contractor	NPR Date	
		(1	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		,	1.00	2.00	8. 00
3.00	Indine of contractor			I	l .	0.00

Heal th	Financial Systems	OSF HOLY FAMILY	MED CTR	In Lie	u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 14-1318 Period: V					
	From 10/01/2022 P To 09/30/2023 D					
				10 09/30/2023	2/20/2024 3:0	
			Title XVIII	Hospi tal	Cost	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION					
	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					1.00
	2.00 Medicare days (see instructions)					2.00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col.	6. line 2				3.00
4.00	Total inpatient days (see instructions)					4.00
5.00	Total hospital charges from Wkst C, Pt. I, co	ol. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst	t. S-10, col. 3 l	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for t	the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168					
8.00	Calculation of the HIT incentive payment (see	e instructions)				8.00
9. 00	Sequestration adjustment amount (see instruct	tions)				9. 00
10.00	Calculation of the HIT incentive payment after	er sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS &	CAH				1
30.00	Initial/interim HIT payment adjustment (see i	nstructions)				30.00
	Other Adjustment (specify)	•				31.00
32.00	Balance due provider (line 8 (or line 10) mir	nus line 30 and l	ine 31) (see instruction	ns)		32.00
						•

Health Financial Systems OSF HOL	LY FAMILY MED CTR	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provi der CCN: 14-1318		Worksheet E-2
	Component CCN: 14-Z318	From 10/01/2022 To 09/30/2023	

		Component CCN: 14-Z318	To 09/30/2023	Date/Time Pre 2/20/2024 3:0	
		Title XVIII	Swing Beds - SNF		э рш
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1, 111, 344	0	
2.00	Inpatient routine services - swing bed-NF (see instructions)	. A D	220 422	0	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swir	. A, and sum or wkst. D,	238, 422	0	3.00
	instructions)				
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4. 00	Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	4.00
	instructions)	3 1 3 (
5.00	Program days		496	0	5.00
6. 00	Interns and residents not in approved teaching program (see in			0	
7.00	Utilization review - physician compensation - SNF optional met	thod only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 349, 766	0	
9. 00 10. 00	Primary payer payments (see instructions) Subtotal (line 8 minus line 9)		1, 349, 766	0	
11. 00	Deductibles billed to program patients (exclude amounts applic	able to physician	1, 347, 700	0	
11.00	professional services)	cable to physician		O	11.00
12.00	Subtotal (line 10 minus line 11)		1, 349, 766	0	12.00
13.00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	13, 241	0	13.00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)			0	
15. 00	Subtotal (see instructions)		1, 336, 525	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`	0	0	
16. 50	Pioneer ACO demonstration payment adjustment (see instructions				16.50
16. 55	Rural community hospital demonstration project (§410A Demonstradjustment (see instructions)	atron) payment	U		16. 55
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		973	0	
17. 01	Adjusted reimbursable bad debts (see instructions)		632	0	17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	973	0	18.00
19.00	Total (see instructions)		1, 337, 157	0	19.00
19. 01	Sequestration adjustment (see instructions)		26, 743	0	
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	
19. 03	Sequestration adjustment-PARHM pass-throughs				19.03
19. 25 20. 00	Sequestration for non-claims based amounts (see instructions)		1, 185, 389	0	19. 25 20. 00
20. 00	Interim payments Interim payments-PARHM		1, 100, 309	U	20.00
21. 00	Tentative settlement (for contractor use only)		0	0	21.00
21. 01	Tentative settlement-PARHM (for contractor use only)			Ü	21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02	2, 19.25, 20, and 21)	125, 025	0	22.00
22. 01	Balance due provider/program-PARHM (see instructions)	,			22. 01
23.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0	0	23.00
	chapter 1, §115.2				ļ
000 00	Rural Community Hospital Demonstration Project (§410A Demonstr				000 00
200. UC	Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	Tod under the ZIST			200. 00
	Cost Reimbursement				1
201.00	Medicare swing-bed SNF inpatient routine service costs (from V	Vkst. D-1, Pt. II, line			201. 00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3, col. 3, lin	e		202.00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)	C' C II			204.00
	Computation of Demonstration Target Amount Limitation (N/A in period)	irrst year or the curre	nt 5-year demons	tration	
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
207.00	Program reimbursement under the §410A Demonstration (see instr	ructions)			207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2		1		208.00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209.00
210.00	Reserved for future use				210. 00
21E 00	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line 2	200 plus Line 210) (222			215. 00
∠ 13. UU	instructions)	107 prus rine 210) (See			210.00
	1.1.51. 451. 5115)		1		I

Health Financial Systems	OSF HOLY FAMILY	MED CTR	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1318	From 10/01/2022 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/20/2024 3:03 pm
		Title XVIII	Hospi tal	Cost

		Ti +Lo. YVIII	Hospi tal	2/20/2024 3: 0: Cost	3 pm
		Title XVIII	поѕрі таі	COST	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PA	ART A SERVICES - COST	REI MBURSEMENT		
1.00	Inpatient services			1, 034, 584	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions	0	2.00		
3.00	Organ acqui si ti on			0	3.00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4.00	Subtotal (sum of lines 1 through 3.01)			1, 034, 584	4.00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 044, 930	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
7 00	Reasonabl e charges				7.00
7. 00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9.00
10. 00	Total reasonable charges Customary charges			0	10. 00
11. 00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge hasis	0	11. 00
12. 00	Amounts that would have been realized from patients liable for p			0	12.00
12.00	had such payment been made in accordance with 42 CFR 413.13(e)	payment for services o	ii a charge basi s	J	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	13. 00
14. 00	Total customary charges (see instructions)			0	14. 00
15.00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	ne 6) (see	0	15. 00
	instructions)		, ,		
16.00	Excess of reasonable cost over customary charges (complete only	if line 6 exceeds lin	e 14) (see	0	16.00
	instructions)				
17.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18. 00	Direct graduate medical education payments (from Worksheet E-4,	line 49)			18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			1, 044, 930	
20.00	Deductibles (exclude professional component)			151, 032	
21. 00	Excess reasonable cost (from line 16)			0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			893, 898	
23. 00	Coinsurance			800	
24. 00 25. 00	Subtotal (line 22 minus line 23)	a) (ass instructions)		893, 098	
26. 00	Allowable bad debts (exclude bad debts for professional service: Adjusted reimbursable bad debts (see instructions)	s) (see mistructions)		23, 882 15, 523	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		20, 842	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	ctions)		908, 621	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			700, 021	29.00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			908, 621	
30. 01	Seguestration adjustment (see instructions)			18, 172	
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM				30. 03
31.00	Interim payments			848, 634	31.00
31.01	Interim payments-PARHM				31.01
32.00	Tentative settlement (for contractor use only)			0	32.00
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02,			41, 815	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minute)				33. 01
34.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	8, 200	34.00
	§115. 2		l		

Health Financial Systems OSF HOLY F
BALANCE SHEET (If you are nonproprietary and do not maintain
fund-type accounting records, complete the General Fund column
only)

Provi der CCN: 14-1318

Peri od: Worksheet G From 10/01/2022 To 09/30/2023 Date/Time Prepared:

onl y)			10	09/ 30/ 2023	2/20/2024 3: 0	
		General Fund	Speci fi c	Endowment	Plant Fund	
		1. 00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	0.00	1. 00	
1. 00	Cash on hand in banks	67, 616, 501	0	0	0	1.00
2.00	Temporary investments	0		0	0	2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	11, 042, 921		0	0	3. 00 4. 00
5. 00	Other recei vable	11,042,721		0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable	-6, 290, 056		0	0	6.00
7.00	Inventory	283, 995		0	0	7. 00
8. 00	Prepai d expenses	2, 975		0	0	8. 00
9.00	Other current assets	296, 220	1	0	0	9.00
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	2, 699, 714 75, 652, 270		0	0 0	10.00 11.00
11.00	FIXED ASSETS	73,032,270	η σ		0	11.00
12.00	Land	325, 000	0	0	0	12.00
13.00	Land improvements	484, 925	0	0	0	13.00
14. 00	Accumulated depreciation	-351, 339	1	0	0	14.00
15.00	Buildings	27, 087, 416		0	0	15.00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-8, 993, 446		0	0	16. 00 17. 00
18. 00	Accumulated depreciation			0	Ö	18.00
19.00	Fi xed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21. 00	Automobiles and trucks	0	0	0	0	21.00
22. 00	Accumulated depreciation	0 044 010		0	0	22.00
23. 00 24. 00	Major movable equipment Accumulated depreciation	9, 846, 919 -6, 429, 706	1	0	0	23. 00 24. 00
25. 00	Mi nor equi pment depreciable	-0, 429, 700		0	0	25.00
26. 00	Accumulated depreciation	0	o	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29.00	Minor equipment-nondepreciable	366, 272	1	0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	22, 336, 041	<u> </u>	0	0	30.00
31. 00	Investments	1, 747, 969	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	6, 631, 798		0	0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	8, 379, 767 106, 368, 078		0	0	35. 00 36. 00
30.00	CURRENT LIABILITIES	100, 300, 070	0		0	30.00
37.00	Accounts payable	676, 608	0	0	0	37.00
38.00	Salaries, wages, and fees payable	208, 722	0	0	0	38. 00
39. 00	Payroll taxes payable	0	0	0	0	39.00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	0		0	0	40. 00 41. 00
41.00	Accel erated payments			U	0	42.00
43. 00	Due to other funds	662, 323	s o	0	0	43.00
44.00	Other current liabilities	115, 126	0	0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	1, 662, 779	0	0	0	45.00
47.00	LONG TERM LIABILITIES					47.00
46. 00 47. 00	Mortgage payable Notes payable	0		0	0	46. 00 47. 00
48. 00	Unsecured Loans			0	0	48.00
49. 00	Other long term liabilities	113, 494	1	0	Ö	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	113, 494	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	1, 776, 273	0	0	0	51.00
F2 00	CAPITAL ACCOUNTS	104 501 005				
52. 00 53. 00	General fund balance Specific purpose fund	104, 591, 805				52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	104, 591, 805		0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	104, 371, 003	1	0	Ö	60.00
	59)					

			From 10/01/2022 To 09/30/2023	Date/Time Pre 2/20/2024 3:0	
General	Fund	Speci al	Purpose Fund	Endowment Fund	

						2/20/2024 3:0	3 pm
		General	Fund	Special Pu	urpose Fund	Endowment	
						Fund	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	Fund balances at beginning of period		88, 689, 047		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		18, 048, 667				2. 00
3.00	Total (sum of line 1 and line 2)		106, 737, 714		0		3. 00
4.00	Additions (credit adjustments) (specify)	0		(0	
5.00		0		(0	
6.00		0		(0	
7.00		0		(0	
8.00		0		(0	
9.00		0		()	0	
10. 00	Total additions (sum of line 4-9)		0		0		10.00
11. 00	Subtotal (line 3 plus line 10)		106, 737, 714		0		11.00
12.00	EQUI TY TRANSFER	2, 145, 909		C		0	
13.00		0		()	0	
14. 00		0		()	0	
15. 00		0		C)	0	
16. 00		0		()	0	
17. 00		0		()	0	
18. 00	Total deductions (sum of lines 12-17)		2, 145, 909		0		18. 00
19. 00	Fund balance at end of period per balance		104, 591, 805		0		19. 00
	sheet (line 11 minus line 18)			L			
		Endowment	PI ant	Fund			
		Fund		I			
		6. 00	7. 00	8. 00			
1. 00	Fund balances at beginning of period	0.00	7.00	8.00	1		1.00
2. 00	Net income (loss) (from Wkst. G-3, line 29)	o _l			'		2.00
3. 00	Total (sum of line 1 and line 2)	0)		3.00
4. 00	Additions (credit adjustments) (specify)	o _l	0		'		4.00
5. 00	Additions (credit adjustments) (specify)		0				5.00
6. 00			0				6.00
7. 00			0				7.00
8. 00			0				8.00
9. 00			0				9.00
10.00	Total additions (sum of line 4-9)	0	O				10.00
11. 00	Subtotal (line 3 plus line 10)	0					11.00
12. 00	EQUITY TRANSFER	٥	0				12.00
13. 00	EQUITI TRANSIER		0				13.00
14. 00			0	1			14.00
15. 00			0				15.00
16. 00			0				16.00
17. 00			0				17.00
18. 00	Total deductions (sum of lines 12-17)	0	U	C			18.00
19. 00	Fund balance at end of period per balance	0					19.00
17. 50	sheet (line 11 minus line 18)	9					
	1	ı		1	1		1

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-1318

2/20/2024 3: 03	1.00
PART I - PATIENT REVENUES	1. 00
PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospital 1,589,492 1,589,492 2.00 SUBPROVIDER - IPF	1. 00
1. 00 Hospi tal 1, 589, 492 1, 589, 492 2. 00 SUBPROVI DER - I PF	1. 00
2. 00 SUBPROVI DER - I PF	1.00
3.00 SUBPROVIDER - IRF	2.00
	3.00
4. 00 SUBPROVI DER	4.00
5. 00 Swing bed - SNF 1, 175, 485 1, 175, 485	5.00
6.00 Swing bed - NF 174, 923 174, 923	6.00
7.00 SKILLED NURSING FACILITY	7.00
8.00 NURSING FACILITY	8.00
9.00 OTHER LONG TERM CARE	9.00
10.00 Total general inpatient care services (sum of lines 1-9) 2,939,900 2,939,900 2,939,900	10.00
Intensive Care Type Inpatient Hospital Services	
	11. 00
	12.00
	13. 00
	14. 00
	15. 00
	16. 00
[11-15]	
	17.00
	18.00
	19.00
	20.00
	20. 01
	21.00
	22.00
	23.00
	24.00
	25. 00 26. 00
	26. 00 27. 00
	28.00
G-3, line 1)	20.00
PART II - OPERATING EXPENSES	
	29. 00
	30.00
	31. 00
32.00	32.00
	33.00
	34.00
35.00	35. 00
36.00 Total additions (sum of lines 30-35)	36. 00
37.00 DEDUCT (SPECIFY)	37. 00
38.00	38. 00
39.00	39. 00
40.00	40. 00
41.00	41. 00
	42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 33,708,814	43. 00
to Wkst. G-3, line 4)	

Heal th	Financial Systems	OSF HOLY FAMILY	MED CTR		In lie	u of Form CMS-2	2552-10
	MENT OF REVENUES AND EXPENSES	OOI HOLI IAMILLI	Provi der CCN: 1	4-1318	Peri od:	Worksheet G-3	
					From 10/01/2022 To 09/30/2023	Date/Time Pre 2/20/2024 3:0	
1 00	Total anti-ont annual (from What C 2 David	11 2 11	- 20)			1.00	1 00
1. 00 2. 00	Total patient revenues (from Wkst. G-2, Part Less contractual allowances and discounts on					115, 710, 825	1. 00 2. 00
3. 00	Net patient revenues (line 1 minus line 2)	patrents accoun	ıs			68, 699, 514 47, 011, 311	
4. 00	Less total operating expenses (from Wkst. G-2	Dort II lino	12)			33, 708, 814	
5. 00	Net income from service to patients (line 3 m		43)			13, 302, 497	5. 00
5.00	OTHER I NCOME	illus Illie 4)				13, 302, 477	3.00
6. 00	Contributions, donations, bequests, etc					2, 841, 823	6. 00
7. 00	Income from investments					-44, 667	
8. 00	Revenues from telephone and other miscellaneo	us communication	servi ces			0	
9. 00	Revenue from television and radio service	ao comman catron	00. 1. 000			0	9. 00
10.00	Purchase di scounts					0	
11. 00	Rebates and refunds of expenses					0	
12. 00	Parking Lot receipts					0	12.00
13.00	Revenue from Laundry and Linen service					0	13.00
14.00	Revenue from meals sold to employees and gues	ts				74, 262	14.00
15.00	Revenue from rental of living quarters						15.00
16.00	Revenue from sale of medical and surgical sup	plies to other t	han patients			0	16.00
17.00	Revenue from sale of drugs to other than pati-	ents	•			670, 706	17.00
18.00	Revenue from sale of medical records and abst	racts				40	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, e	tc.)				0	19.00
20.00	Revenue from gifts, flowers, coffee shops, an	d canteen				0	20.00
21.00	Rental of vending machines					0	21.00
22.00	Rental of hospital space					4, 704	22.00
23.00	Governmental appropriations					0	23.00
24.00	OTHER I NCOME					1, 199, 315	24.00
	COVI D-19 PHE Funding					0	24.50
25.00	Total other income (sum of lines 6-24)					4, 746, 183	25.00
	Total (line 5 plus line 25)					18, 048, 680	
27 00	POLINDI NG					12	27 00

13 27.00 13 28.00 18,048,667 29.00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

27. 00 ROUNDING

	Financial Systems	OSF HOLY FAMI				u of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co		Peri od:	Worksheet M-1	
			Component (From 10/01/2022 To 09/30/2023	Date/Time Pre	pared.
			22			2/20/2024 3:0	
					RHC I	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1. 00	Physi ci an	796, 095	0	796, 09	·		
2.00	Physician Assistant	422, 854	0	422, 85		420, 457	2.00
3.00	Nurse Practitioner	577, 417	0	577, 41		1	
4. 00	Visiting Nurse	0	0		0	0	
5.00	Other Nurse	1, 495, 254	0	1, 495, 25	8, 180	1, 503, 434	
6. 00	Clinical Psychologist	0	0		0	0	6.00
7. 00	Clinical Social Worker	135, 863	0	135, 86	· ·		
8.00	Laboratory Techni ci an	0	36, 793	36, 79		36, 793	
9. 00	Other Facility Health Care Staff Costs	0	0		0	0	
10.00	Subtotal (sum of lines 1 through 9)	3, 427, 483	36, 793	3, 464, 27	6 -7, 765	3, 456, 511	10.00
11. 00	Physician Services Under Agreement	0	0		0	0	11.00
12. 00	Physician Supervision Under Agreement	0	0		0	0	12.00
13.00		0	0		0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14.00
15.00	Medical Supplies	0	358, 284	358, 28		358, 284	
16. 00	Transportation (Health Care Staff)	0	5, 513	5, 51		5, 513	
17. 00		0	0		0	0	
18. 00	Professional Liability Insurance	0	6, 123	6, 12		6, 123	
19.00	1	0	6, 576	6, 57	6 0	6, 576	
20.00	Allowable GME Costs	_			_		20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	376, 496			376, 496	
22. 00	Total Cost of Health Care Services (sum of	3, 427, 483	413, 289	3, 840, 77	2 -7, 765	3, 833, 007	22. 00
	lines 10, 14, and 21)						
22 00	COSTS OTHER THAN RHC/FQHC SERVICES	0					22 00
23. 00	1	0	0		0 0	0	
24. 00	Dental	0	0			0	24.00
25. 00	Optometry	0	0		0 15 020	15.000	
25. 01	Tel eheal th	0	0		0 15, 938		
25. 02	9	0	0		0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0	0	26.00
27.00	Nonallowable GME costs	0	_		15 020	15 000	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 15, 938	15, 938	28. 00
	through 27)						-
20 00	FACILITY OVERHEAD Facility Costs	0	15, 897	15, 89	-13, 738	2, 159	29. 00
	Administrative Costs	388 887					

15, 897 1, 805, 093 1, 820, 990

2, 234, 279

388, 887

388, 887

3, 816, 370

15, 897 2, 193, 980

2, 209, 877

6, 050, 649

-13, 738 -1, 026, 824

-1, 040, 562

-1, 032, 389

2, 159 1, 167, 156 1, 169, 315

5, 018, 260

30.00

31.00

32.00

30.00 Administrative Costs

Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	OSF HOLY FAMILY MED CTR	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1318	Period: Worksheet M-1 From 10/01/2022
	Component CCN: 14-3461	To 09/30/2023 Date/Time Prepared: 2/20/2024 3: 03 pm

			Component	CCN: 14-3461	10	09/30/2023	Date/IIMe Pre 2/20/2024 3:0	
						RHC I	Cost	<i>у</i> о рііі
		Adjustments	Net Expenses			1110 1	0031	
		naj astilionts	for					
			Allocation					
			(col. 5 +					
			col . 6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS			I .				
1.00	Physi ci an	-13, 700	776, 775					1.00
2. 00	Physician Assistant	0	420, 457	1				2.00
3. 00	Nurse Practitioner	0	568, 442	1				3.00
4. 00	Visiting Nurse	0	0	1				4.00
5. 00	Other Nurse	0	1, 503, 434					5.00
6. 00	Clinical Psychologist	0	0					6.00
7. 00	Clinical Social Worker	0	136, 910					7. 00
8. 00	Laboratory Techni ci an	0	36, 793					8.00
9. 00	Other Facility Health Care Staff Costs	0	00,770	1				9.00
10.00	Subtotal (sum of lines 1 through 9)	-13, 700		1				10.00
11. 00	Physician Services Under Agreement	10, 700	0, 112, 011	1				11.00
12. 00	Physician Supervision Under Agreement	0	0	1				12.00
13. 00	Other Costs Under Agreement	0	0	1				13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0	1				14.00
15. 00	Medical Supplies	0	358, 284	1				15.00
16. 00	Transportation (Health Care Staff)	0	5, 513	1				16.00
17. 00	Depreciation-Medical Equipment	0	0,513					17. 00
18.00	Professional Liability Insurance	0	6, 123	•				18.00
19. 00	Other Health Care Costs	0	6, 576	1				19.00
20.00	Allowable GME Costs	U	0,570					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	376, 496					21.00
21.00	Total Cost of Health Care Services (sum of	-13, 700		1				22.00
22.00	lines 10, 14, and 21)	-13,700	3,019,307					22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23. 00	Pharmacy	0	0					23. 00
24. 00	Dental	0	0					24.00
25. 00	Optometry	0	0					25. 00
25. 00	Tel eheal th	0	15, 938					25. 00
25. 01	Chronic Care Management	0	15, 736	1				25. 01
26. 00	All other nonreimbursable costs	0	0					26.00
27. 00	Nonallowable GME costs	U	U					27.00
28. 00	1	0	15, 938					28.00
26.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	U	10, 930					20.00
	FACILITY OVERHEAD							1
29. 00	Facility Overhead Facility Costs	0	2, 159					29. 00
30.00	Administrative Costs	-317, 019						30.00
31.00	Total Facility Overhead (sum of lines 29 and							31.00
31.00	30)	-317,019	002, 290					31.00
32. 00	Total facility costs (sum of lines 22, 28	-330, 719	4, 687, 541					32.00
32.00	and 31)	-330, /19	4,007,341					32.00
	ana 31)		1	I				1

	Financial Systems	OSF HOLY FAMI		CN 14 1210		eu of Form CMS-	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 14-1318	Peri od: From 10/01/2022	Worksheet M-1	
		Component CCN: 14-8621		To 09/30/2023			
					RHC II	Cost	
		Compensation	Other Costs		1 Reclassi fi cat		
				+ col . 2)	i ons	Tri al Balance	
						(col. 3 +	
		1 00	2.00	2.00	4.00	col . 4)	
	FACILITY HEALTH CARE STAFF COSTS	1. 00	2.00	3. 00	4. 00	5. 00	
1. 00		0	0		0 222	0.222	1.00
2.00	Physician Physician Assistant	0			0 9, 233 0 1, 321		2.00
3.00	Nurse Practitioner	117, 649			· ·	· ·	
4. 00	Visiting Nurse	117,049	0	117,02	0, 334	· ·	1
5.00	Other Nurse	123, 388	0	123, 38	٥		
6. 00	Clinical Psychologist	123, 300	0	123, 30	0		1
7. 00	Clinical Social Worker	0	0		0 0	0	
8. 00	Laboratory Techni ci an	0	0		0 0	ő	
9. 00	Other Facility Health Care Staff Costs	0	0		0 0	o o	1
10. 00	Subtotal (sum of lines 1 through 9)	241, 037	0	241, 03	19, 754	_	
11. 00	Physician Services Under Agreement	0	0	2, 00	0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	26, 974	26, 97	'4 O	26, 974	15.00
16.00	Transportation (Health Care Staff)	0	1, 800	1, 80	0 0	1, 800	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	389	38	39 0	389	18. 00
19.00	Other Health Care Costs	0	0		0	0	19. 00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	29, 163			29, 163	1
22. 00	Total Cost of Health Care Services (sum of	241, 037	29, 163	270, 20	19, 754	289, 954	22. 00
	lines 10, 14, and 21)						-
22.00	COSTS OTHER THAN RHC/FQHC SERVICES	0			0 0	0	22.00
23. 00 24. 00	Pharmacy Dental	0			0 0		
25. 00	Optometry	0	0		0 0	0	
25. 00	Tel eheal th	0	0		0 331	_	
25. 01	Chronic Care Management	0	0		0 0		
26. 00	All other nonreimbursable costs	0	0		0 0	o o	1
27. 00	Nonallowable GME costs	O	0			1	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 331	331	
20.00	through 27)	Ö	Ĭ		001		20.00
	FACILITY OVERHEAD			·	<u> </u>		1
29. 00	Facility Costs	0	5, 780	5, 78	-2, 742	3, 038	29. 00
30.00	Administrative Costs	47, 319				· ·	1
31.00	Total Facility Overhead (sum of lines 29 and	47, 319	174, 183	221, 50	-83, 322	138, 180	31.00
	30)				1	1	1

288, 356

203, 346

32.00 Total facility costs (sum of lines 22, 28 and 31)

32.00

428, 465

-63, 237

491, 702

Health Financial Systems	OSF HOLY FAMILY MED CTR	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1318	Period: Worksheet M-1 From 10/01/2022
	Component CCN: 14-8621	To 09/30/2023 Date/Time Prepared: 2/20/2024 3:03 pm

			Component	CN: 14-8621	10	09/30/2023	Date/IIMe Pre 2/20/2024 3:0	
						RHC II	Cost	o piii
		Adjustments	Net Expenses			INTO TT	0031	
		Adj d3tillo11t3	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7.00					
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00					
1.00	Physi ci an	-12, 000	-2, 767					1.00
2. 00	Physician Assistant	12, 000	1, 321					2.00
3.00	Nurse Practitioner	0	125, 983					3.00
4. 00	Visiting Nurse	0	123, 709					4. 00
5. 00	Other Nurse	0	124, 254					5. 00
6. 00	Clinical Psychologist	0	124, 234					6.00
7. 00	Clinical Social Worker	0	0					7. 00
8. 00	Laboratory Techni ci an	0	0					8.00
9. 00	Other Facility Health Care Staff Costs	0	0					9.00
	1	12 000	- 1					
10.00	Subtotal (sum of lines 1 through 9)	-12, 000	248, 791					10.00 11.00
11.00	Physician Services Under Agreement	0	0					
12.00	Physician Supervision Under Agreement	0	0					12.00
13.00	Other Costs Under Agreement	0	0					13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0					14.00
15.00	Medical Supplies	0	26, 974					15.00
16.00	Transportation (Health Care Staff)	0	1, 800					16.00
17.00	Depreciation-Medical Equipment	0	0					17. 00
18. 00	Professional Liability Insurance	0	389					18. 00
19. 00	Other Health Care Costs	0	0					19. 00
20.00	Allowable GME Costs		00.440					20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29, 163					21.00
22. 00	Total Cost of Health Care Services (sum of	-12, 000	277, 954					22. 00
	lines 10, 14, and 21)							-
	COSTS OTHER THAN RHC/FQHC SERVICES							
23. 00	Pharmacy	0	0					23. 00
24. 00	Dental	0	0					24.00
25. 00	Optometry	0	0					25. 00
25. 01	Tel eheal th	0	331					25. 01
25. 02	Chronic Care Management	0	0					25. 02
26. 00	All other nonreimbursable costs	0	0					26. 00
27. 00	Nonallowable GME costs	_						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	331					28. 00
	through 27)							1
	FACILITY OVERHEAD							
29. 00	Facility Costs	0	3, 038					29.00
30.00	Administrative Costs	-30, 363	104, 779					30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-30, 363	107, 817					31. 00
00.00	30)	40.040	20/ 122					00.00
32. 00	Total facility costs (sum of lines 22, 28	-42, 363	386, 102					32.00
	and 31)							I

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC		LY MED C			Peri od:	u of Form CMS-2 Worksheet M-2	
			0			From 10/01/2022	D. I. (T' D.	
			Compo	onent (CCN: 14-3461	Го 09/30/2023	Date/Time Prep 2/20/2024 3:03	
						RHC I	Cost	
		Number of FTE	Total Vi	i si ts	Producti vi ty	Mi ni mum	Greater of	
		Personnel			Standard (1)	Visits (col.	col. 2 or	
						1 x col. 3)	col. 4	
		1. 00	2.00	0	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY							
	Posi ti ons							
1.00	Physi ci an	1. 76		8, 340				1.00
2.00	Physician Assistant	2. 36		8, 339	2, 100			2.00
3.00	Nurse Practitioner	3. 49		12, 011	2, 100			3. 00
4.00	Subtotal (sum of lines 1 through 3)	7. 61		28, 690		19, 677	28, 690	4.00
5.00	Visiting Nurse	0.00		0			0	5.00
6.00	Clinical Psychologist	0.00		0			0	6.00
7.00	Clinical Social Worker	1. 37		1, 734			1, 734	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00		0			0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00		0			0	7. 02
0 00	only)	0.00	_	20 424			20 424	0 00
8. 00	Total FTEs and Visits (sum of lines 4	8. 98	3	30, 424			30, 424	8. 00
9. 00	through 7) Physician Services Under Agreements			0			0	9. 00
9.00	Priysi ci aii sei vi ces under Agreements			U			U	9.00
							1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	ED RHC/FQ	OHC SEF	RVICES			
10.00	Total costs of health care services (from We						3, 819, 307	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,			,			15, 938	11.00
12.00	Cost of all services (excluding overhead) (s						3, 835, 245	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I			12)			0. 995844	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	rom Worksheet. !	M-1, col.	7, li	ne 31)		852, 296	14.00
15. 00	Parent provider overhead allocated to facili	ty (see instruc	ctions)		•		4, 114, 986	15.00
16.00	Total overhead (sum of lines 14 and 15)	- ,	•				4, 967, 282	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						4, 967, 282	18.00
19. 00	Overhead applicable to hospital-based RHC/FC	QHC services (li	ne 13 x	line 1	18)		4, 946, 638	19.00
	Total allowable cost of hospital-based RHC/F		6 1 1			ı	8, 765, 945	00 00

	Financial Systems	OSF HOLY FAM					u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi de	CCN: 14-1318		Period: From 10/01/2022	Worksheet M-2	
			Compone	nt CCN: 14-862		To 09/30/2023	Date/Time Pre 2/20/2024 3:0	
						RHC II	Cost	- p
		Number of FTE	Total Visi	ts Productiv	/i ty	Mi ni mum	Greater of	
		Personnel		Standard	(1)	Visits (col.	col. 2 or	
						1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00		4. 00	5. 00	
	VISITS AND PRODUCTIVITY							
	Posi ti ons		T					
1. 00	Physi ci an	0. 03			1, 200			1.00
2.00	Physician Assistant	0. 01			2, 100			2.00
3.00	Nurse Practitioner	0. 91			2, 100		0.500	3.00
4.00	Subtotal (sum of lines 1 through 3)	0. 95		588		2, 058	2, 588	
5.00	Visiting Nurse	0.00		0			0	5. 00 6. 00
6. 00 7. 00	Clinical Psychologist Clinical Social Worker	0. 00 0. 00					0	7.00
7. 00 7. 01	Medical Nutrition Therapist (FQHC only)	0.00		0			0	7.00
7. 01 7. 02	Diabetes Self Management Training (FQHC	0.00		0			0	7.01
7.02	only)	0.00		٩			U	7.02
8. 00	Total FTEs and Visits (sum of lines 4	0. 95	2	588			2, 588	8.00
0.00	through 7)	0.70					2,000	0.00
9. 00	Physician Services Under Agreements			О			0	9.00
	<u> </u>							
							1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC	SERVI CES				
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)				277, 954	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)				331	11.00
12. 00	Cost of all services (excluding overhead) (s						278, 285	12.00
13. 00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12				0. 998811	13.00
14. 00	Total hospital-based RHC/FQHC overhead - (fr			line 31)			107, 817	
15. 00	Parent provider overhead allocated to facili	ty (see instru	ctions)				420, 974	
16. 00	Total overhead (sum of lines 14 and 15)						528, 791	
17. 00	Allowable GME overhead (see instructions)						0	
	Enter the amount from line 16			>			528, 791	
	Overhead applicable to hospital-based RHC/FC						528, 162	
20. 00	Total allowable cost of hospital-based RHC/F	·QHC services (sum of line	s 10 and 19)			806, 116	20.00

	Financial Systems OSF HOLY FAMILY			u of Form CMS-2		
SERVI (ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-1318	Peri od: From 10/01/2022	Worksheet M-3	eet M-3	
		Component CCN: 14-3461	To 09/30/2023	Date/Time Pre 2/20/2024 3:0		
		Title XVIII	RHC I	Cost		
				1. 00		
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	· · · · · · · · · · · · · · · · · · ·		8, 765, 945	1.00	
2. 00 3. 00	Cost of injections/infusions and their administration (from W			441, 376 8, 324, 569	2. 00 3. 00	
4. 00	Total allowable cost excluding injections/infusions (line 1 m Total Visits (from Wkst. M-2, column 5, line 8)	illus IIIIe 2)		30, 424	4.00	
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			30, 424	6.00	
7. 00	Adjusted cost per visit (line 3 divided by line 6)			273. 62	7.00	
			Cal cul ati on	of Limit (1)		
			Rate Period 1			
			(10/01/2022	(01/01/2023		
			through 12/31/2022)	through 09/30/2023)		
			1.00	2. 00		
8. 00			308. 78	320. 51	8. 00	
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		273. 62	273. 62	9.00	
10 00		contractor records)	1 470	4 200	10 00	
10.00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from contractor records) Program cost excluding costs for mental health services (line 9 x line 10) Program covered visits for mental health services (from contractor records)		1, 473 403, 042	4, 300 1, 176, 566	1	
12. 00	ON Program cost excluding costs for mental health services (line 9 x line 10) Program covered visits for mental health services (from contractor records)		47	104	ı	
13.00			12, 860	28, 456	13.00	
14.00	Program covered cost from mental health services (line 9 x line 12) Limit adjustment for mental health services (see instructions) Graduate Medical Education Pass Through Cost (see instructions)		12, 860	28, 456	•	
15.00	Program covered cost from mental health services (line 9 x line 12) Limit adjustment for mental health services (see instructions) Graduate Medical Education Pass Through Cost (see instructions) Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			1 (20 024	15.00	
16. 00 16. 01	OO Graduate Medical Education Pass Through Cost (see instructions) OO Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	1, 620, 924 1, 532, 025	•	
16. 02	Total program preventive charges (see instructions) (from prov			21, 971	•	
16.03	Total program preventive costs ((line 16.02/line 16.01) times	•		23, 246		
16.04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		1, 153, 114	16. 04	
1/ 05	(Titles V and XIX see instructions.)			1 17/ 2/0	1/ 05	
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		0	1, 176, 360 0	16. 05 17. 00	
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		156, 285		
	records)	•		•		
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		269, 516	19.00	
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			1, 176, 360	20.00	
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		121, 369	•	
22. 00				1, 297, 729		
23.00	Allowable bad debts (see instructions)			0	23.00	
23. 01 24. 00	` ` '	ructions)		0	23. 01 24. 00	
25. 00		ructions)		0	25.00	
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	ı	
25. 99	Demonstration payment adjustment amount before sequestration			0		
26.00	Net reimbursable amount (see instructions)			1, 297, 729	1	
26. 01 26. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			25, 955 0	26. 01 26. 02	
27. 00	Interim payments			1, 216, 889		
	Tentative settlement (for contractor use only)			0	28.00	
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.			54, 885	•	
30.00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	nce with CMS Pub. 15-II	,	0	30.00	

	Financial Systems OSF HOLY FAMILY ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		In Lie	wof Form CMS-2 Worksheet M-3	
SERVI (From 10/01/2022		
		Component CCN: 14-8621	To 09/30/2023	Date/Time Pre 2/20/2024 3:0	
		Title XVIII	RHC I I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			806, 116	1
2.00	Cost of injections/infusions and their administration (from W			58, 641	2.00
3. 00 4. 00	Total allowable cost excluding injections/infusions (line 1 m Total Visits (from Wkst. M-2, column 5, line 8)	irnus i i ne 2)		747, 475 2. 588	
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		2, 300	
6. 00	Total adjusted visits (line 4 plus line 5)			2, 588	
7. 00	Adjusted cost per visit (line 3 divided by line 6)			288. 82	
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(10/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	09/30/2023) 2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor) Rate for Program covered visits (see instructions)		280. 66	291. 33	8.00
9.00			280. 66	288. 82	1
	CALCULATION OF SETTLEMENT				
10.00	.00 Program covered visits excluding mental health services (from contractor records)		186	401	1
11. 00 12. 00	00 Program cost excluding costs for mental health services (line 9 x line 10)		52, 203 0	115, 817 0	1
13. 00	,	,	0	0	1
14. 00	Program covered visits for mental health services (from contractor records) Program covered cost from mental health services (line 9 x line 12) Limit adjustment for mental health services (see instructions)		0	0	
15. 00	00 Graduate Medical Education Pass Through Cost (see instructions)				15.00
16. 00	OO Graduate Medical Education Pass Through Cost (see instructions) OO Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	168, 020	1
16. 01	Total program charges (see instructions)(from contractor's re			153, 352	1
16. 02 16. 03	Total program preventive charges (see instructions) (from prov	•		1, 502	1
16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0	*		1, 646 117, 438	1
10.01	(Titles V and XIX see instructions.)	and roy trines . coy		117, 100	10.01
16. 05	Total program cost (see instructions)		0	119, 084	16.05
17. 00	Primary payer amounts			0	
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		19, 576	18.00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		26, 415	19.00
	records)	, (
20. 00	Net Medicare cost excluding vaccines (see instructions)			119, 084	1
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		20, 266	
22. 00 23. 00				139, 350	1
23. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	1
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
25. 00				0	
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration			0	1
26.00	Net reimbursable amount (see instructions)			139, 350	1
26. 01 26. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			2, 787 0	1
27. 00	Interim payments			116, 307	1
	Tentative settlement (for contractor use only)			0	1
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		20, 256	1
30.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-II	,	0	30.00

COMPUT	ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provi der CC	CN: 14-1318	Peri od: From 10/01/2022	Worksheet M-4	
		Component (To 09/30/2023	Date/Time Prep 2/20/2024 3:0	
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00 2.00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health	3, 442, 811 0. 002323	3, 442, 8° 0. 0071°		3, 442, 811 0. 000000	1. 00 2. 00
3. 00	care staff time Injection/infusion health care staff cost (line 1 x line 2)	7, 998	24, 48	0	0	3.00
1. 00	Injections/infusions and related medical supplies costs (from your records)	117, 307	42, 51	0	0	4. 0
5. 00 6. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	125, 305 3, 819, 307	67, 00 3, 819, 30		0 3, 819, 307	5. 00 6. 00
7. 00 3. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	4, 946, 638 0. 032808	4, 946, 63 0. 01754		4, 946, 638 0. 000000	7. 00 8. 00
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	162, 289 287, 594	86, 77 153, 78		0	9. 00 10. 00
11. 00 12. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11)	563 510. 82	1, 72 89. 2		0 0. 00	11. 00 12. 00
3. 00	Number of injection/infusion administered to Program beneficiaries	144	53	0	0	13.00
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.0
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	73, 558	47, 81	0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	•	columns 1,		441, 376	15. 00
6.00	Total Program cost of injections/infusions and their admin		s (sum of		121, 369	16.0

OMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	CN: 14-1318	Peri od:	Worksheet M-4	
		Component C	CCN: 14-8621	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/20/2024 3:0	
		Title	XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	248, 791 0. 002579	248, 79 0. 01008	·	248, 791 0. 000000	1. 00 2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	642	2, 50	09	0	3.00
1. 00	Injections/infusions and related medical supplies costs (from your records)	11, 668	5, 40	0	0	4.00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	12, 310	7, 9	10 0	0	5.00
o. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	277, 954	277, 95	·	277, 954	6.0
7.00	Total overhead (from Wkst. M-2, line 19)	528, 162	528, 16		528, 162	
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 044288	0. 0284		0. 000000	
0. 00	Overhead cost - injection/infusion (line 7 x line 8)	23, 391	15, 03		0	
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	35, 701	22, 94		0	
1.00	Total number of injections/infusions (from your records)	56		19 0	0	
2.00	Cost per injection/infusion (line 10/line 11)	637. 52	104.			12.0
3.00	Number of injection/infusion administered to Program beneficiaries	17	C	90 0	0	
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees	10,000	0.44	0	0	
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	10, 838	9, 42	28 0	0	14.00
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI O	
				1.00	N	
F 00	Total cost of injections (infections and their selections)	n costo (our ef	E galumna 1	1. 00	2. 00	15 ^
o. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		corumns I,		58, 641	15.0
6 00	Total Program cost of injections/infusions and their admin		(SUM OF		20, 266	16 0
5. 50	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou		•		20, 200	'0. 0

Health Financial Systems	OSF HOLY FAMILY	MED CTR	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC SERVICES RENDERED TO PROGRAM BENEFICIARIES			Period: From 10/01/2022	
		Component Con. 14 5401	RHC I	2/20/2024 3:03 pm Cost

		Component Con. 14-5401	10 07/30/2023	2/20/2024 3: 03	
			RHC I	Cost	-
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			1, 302, 704	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		o	2
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero				
0	List separately each retroactive lump sum adjustment amount	based on subsequent			3
	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)				
	Program to Provider				
)1				0	3
)2				0	3
)3				0	3
04				0	3
)5				0	3
	Provider to Program				
50			05/25/2023	85, 815	3
51				0	,
52				0	3
3				0	
54				0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			-85, 815	
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		1, 216, 889	4
	27)				
20	TO BE COMPLETED BY CONTRACTOR	l a la la la la la la la la la la la la			
00	List separately each tentative settlement payment after des	k review. Also show date d)T		í
	each payment. If none, write "NONE" or enter a zero. (1) Program to Provider				
)1	Program to Provider			0	Ę
)2					į
3					Ę
, 0	Provider to Program			J J	,
0				0	Ę
1				o	Ę
2				0	Ę
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	Ę
0	Determined net settlement amount (balance due) based on the				6
1	SETTLEMENT TO PROVIDER			54, 885	6
2	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			1, 271, 774	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	
00	Name of Contractor				8

Health Financial Systems	OSF HOLY FAMILY	MED CTR	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provi der CCN: 14-1318 Component CCN: 14-8621	From 10/01/2022	
•			DUIG 1.1	

		Component CCN. 14-8621	10 04/30/2023	2/20/2024 3: 03	
			RHC II	Cost	-
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2, 00	
00	Total interim payments paid to hospital-based RHC/FQHC			130, 691	1
00	Interim payments payable on individual bills, either submitted	d or to be submitted to		0	2
	the contractor for services rendered in the cost reporting per				
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount ba	ased on subsequent			3
	revision of the interim rate for the cost reporting period. Al	Iso show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
)1				0	(
)2				0	
)3				0	
)4				0	
)5				0	(
	Provider to Program				
0			05/25/2023	14, 384	;
1				0	;
2				0	
3				0	
4				0	
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			-14, 384	;
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfe	r to Worksheet M-3, line	Э	116, 307	
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after desk	review. Also show date o	Df		į
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				١.
)1				0	í
2 3				0	
3	Provider to Program			U	1
0	Provider to Program			0	
1					
2					
9	 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			
0	Determined net settlement amount (balance due) based on the co	•			
1	SETTLEMENT TO PROVIDER	331 Topol I. (1)		20, 256	
02 SETTLEMENT TO PROGRAM				20, 230	
0	Total Medicare program liability (see instructions)			136, 563	
	Total modification program frability (500 fractions)		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	