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: 14-0161 Worksheet S Peri od: From 10/01/2022 Parts I-III AND SETTLEMENT SUMMARY 09/30/2023 Date/Time Prepared: 2/21/2024 2:01 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 2/21/2024 2:01 pm ] Manually prepared cost report use only Ilf 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: 10. NPR Date: 11. Contractor's Vendor Code: 4
(2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] If line 5, column 1 is 4: Enter 13. Settled with Audit 9. [N] Final Report for this Provider CCN 14. [N] Initial Report for this Provider CCN 15. [N] Final Report for this Provider CCN 16. NPR Date: 11. Contractor's Vendor Code: 4. In Contractor's V 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 SAINT JAMES HOSPITAL (14-0161) 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 SI GNATURE 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	HIT	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-31, 033	-95, 868	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	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
10.00	RURAL HEALTH CLINIC - STREATOR I	0		284, 352		0	10.00
10. 01	RURAL HEALTH CLINIC - PONTIAC II	0		25, 123		0	10. 01
10.02	RURAL HEALTH CLINIC - CULLOM III	0		4, 074		0	10. 02
10.03	RURAL HEALTH CLINIC - DWIGHT IV	0		5, 363		0	10. 03
10.04	RURAL HEALTH CLINIC - FAIRBURY V	0		14, 107		0	10.04
10.05	RURAL HEALTH CLINIC - MINONK VI	0		10, 236		0	10.05
10.06	RURAL HEALTH CLINIC - FLANAGAN VII	0		12, 824		0	10.06
10.07	RURAL HEALTH CLINIC - REYNOLDS VIII	0		19, 833		0	10. 07
10.08	RURAL HEALTH CLINIC - EL PASO IX	0		20, 905		0	10.08
10.09	RURAL HEALTH CLINIC - CLINTON X	0		22, 199		0	10.09
200.00	TOTAL	0	-31, 033	323, 148	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.

1.00   2.00   3.00	4. (	)22   Part   )23   Date/T   2/21/2	eet S-2 ime Pre 024 2:0	pared:
Hospital and Hospital Health Care Complex Address:  1.00 Street: 2500 WEST REYNOLDS STREET PO Box: 2.00 City: PONTIAC State: IL Zip Code: 61764 County:  Component Name CCN CBSA Provider	LIVINGSTON Date Pa		024 2: 0	1 pm
Hospital and Hospital Health Care Complex Address:  1.00 Street: 2500 WEST REYNOLDS STREET PO Box: 2.00 City: PONTIAC State: IL Zip Code: 61764 County:  Component Name CCN CBSA Provider	LIVINGSTON Date Pa	00		
2.00         City:         PONTIAC         State:         IL         Zip Code:         61764         County:           Component Name         CCN         CBSA         Provi der	Date Pa			
Component Name CCN CBSA Provider	Date Pa			1.00
·		ayment Syst	tem (P	2. 00
Number Type C		T, 0, or		
		V XVIII	XIX	
Hospital and Hospital-Based Component Identification:	5. 00 6	5. 00   7. 00	8.00	
	7/01/1966	N P	0	3. 00
4.00 Subprovider - IPF				4. 00
5.00 Subprovi der - IRF 6.00 Subprovi der - (Other)				5. 00 6. 00
	0/10/2002	N P	N	7. 00
8.00 Swing Beds - NF				8. 00
9. 00 Hospital -Based SNF				9. 00
10.00 Hospi tal -Based NF 11.00 Hospi tal -Based OLTC				10. 00 11. 00
12. 00 Hospi tal -Based HHA				12. 00
13.00 Separately Certified ASC				13. 00
14.00 Hospital-Based Hospice   15.00 Hospital-Based Health Clinic - RHC   OSF HEALTHCARE- MED   148624   99914   04	4/05/2021	N O	N	14. 00 15. 00
15.00 Hospital-Based Health Clinic - RHC OSF HEALTHCARE- MED   148624   99914   04	4/05/2021	N O	IN IN	15.00
15.01 Hospital-Based Health Clinic - RHC OSF HEALTHCARE- MED 148654 99914 OSF HEALTHCARE- MED 03	3/02/2023	N O	N	15. 01
15.02 Hospital-Based Health Clinic - RHC OSF HEALTHCARE- MED 148640 99914 03	3/10/2023	N O	N	15. 02
15.03 Hospital-Based Health Clinic - RHC OSF HEALTHCARE- MED 148641 99914 03	3/02/2023	N O	N	15. 03
GRP- FAI RBURY	3/02/2023	N O	N	15. 04
VI GRP- MINONK	3/02/2023	N O	N	15. 05
VII. GRP- FLANAGAN	3/09/2023	N O	N	15. 06
VIII GRP- REYNOLDS	3/02/2023	N O	N	15. 07
IX GRP- EL PASO	3/02/2023	N O	N	15. 08
GRP- CLI NTON	3/02/2023	N O	N	15. 09
16.00 Hospital-Based Health Clinic - FQHC 17.00 Hospital-Based (CMHC) I				16. 00 17. 00
18. 00 Renal Dialysis				18.00
19.00 Other				19. 00
	From: 1.00	To		
20.00 Cost Reporting Period (mm/dd/yyyy)	10/01/2022	2. 2 09/30		20. 00
21.00 Type of Control (see instructions)	1			21. 00
1.00	2.00	2	00	
Inpatient PPS Information	2. 00	3.	00	
22.00 Does this facility qualify and is it currently receiving payments for Y	N			22. 00
disproportionate share hospital adjustment, in accordance with 42 CFR				
§412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment				
hospital?) In column 2, enter "Y" for yes or "N" for no.				
22. 01 Did this hospital receive interim UCPs, including supplemental UCPs, for	Υ			22. 01
this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October				
1. Enter in column 2, "Y" for yes or "N" for no for the portion of the				
cost reporting period occurring on or after October 1. (see				
instructions)  22.02 Is this a newly merged hospital that requires a final UCP to be	N			22. 02
determined at cost report settlement? (see instructions) Enter in column				22.02
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 on or after October 1.				
22. 03 Did this hospital receive a geographic reclassification from urban to	N	N	N	22. 03
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				
yes or "N" for no.				

Ν

Ν

48.00

48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.

61. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06
		Program Name	Program Code	Unweighted IME		
				FTE Count	Direct GME FTE	
		1.00	2. 00	3.00	4. 00	1
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.		2. 00	0.00	0. 00	61. 20
MCRIF:	32 - 21. 3. 178. 2					

10SPI T	AL AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DATA	A Provider Co		Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part I Date/Time Pre 2/21/2024 2:0	pared:
						1.00	
	ACA Provisions Affecting the Hea	Ith Resources and Serv	ices Administration	(HRSA)		1.00	
2. 00	Enter the number of FTE resident	s that your hospital t	rained in this cost		riod for which	0.00	62.0
2. 01	your hospital received HRSA PCRE Enter the number of FTE resident during in this cost reporting pe	s that rotated from a	Teaching Health Cen	ter (THC) int	o your hospital	0.00	62. 0
	Teaching Hospitals that Claim Re						
3. 00	Has your facility trained reside "Y" for yes or "N" for no in col					N	63.0
	TOT YES OF IN TOT HE THE COT	umii i. ii yes, compret	c rriics of through	Unwei ghted		Ratio (col. 1/	
				FTEs Nonprovi der Si te		(col. 1 + col. 2))	
				1. 00	2.00	3. 00	
	Section 5504 of the ACA Base Yea			This base yea	r is your cost r	eporti ng	
	<u>period that begins on or after J</u> Enter in column 1, if line 63 is			0.0	0. 00	0. 000000	64. (
	in the base year period, the num	ber of unweighted non-	primary care				
	resident FTEs attributable to ro settings. Enter in column 2 the						
	resident FTEs that trained in yo	ur hospital. Enter in	column 3 the ratio				
	of (column 1 divided by (column	1 + column 2)). (see i Program Name	nstructions) Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
		1 Togram Name	11 ogi alli code	FTEs		(col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
		1.00	2.00	Si te 3. 00	4.00	5. 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)			Unwei ghted	Unwei ghted	Ratio (col. 1/	
	Section 5504 of the ACA Current		Nonprovider Setting	FTEs Nonprovi der Si te 1.00 sEffecti ve	Hospi tal 2.00	(col. 1 + col. 2)) 3.00 ng periods	
. 00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primary ccurring in all nonpro unweighted non-primary al. Enter in column 3	vider settings. care resident the ratio of	0. (	0.00	0. 000000	66.
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2. 00	3. 00	4.00	5. 00	1

Health Financial Systems SAINT JAMES HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0161 Peri od: Worksheet S-2 From 10/01/2022 Part I Date/Time Prepared: 09/30/2023 2/21/2024 2:01 pm Ratio (col. 3/ Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 0. 00 0. 00 0.000000 67.00 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) 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 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 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 O 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 N 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 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes 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. 80.00 N 80.00 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 for yes and "N" for no. TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85 00 N 85 00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 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 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Adjustment Permanent (Y/N) Adjustments 1.00 2.00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target 0 88.00 Ν

amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line

Column 2: Enter the number of approved permanent adjustments.

89. (see instructions)

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.	N		108. 00		
[	Physi cal	Occupati onal	Speech	Respi ratory	
	1. 00	2.00	3. 00	4.00	
109.00 If this hospital qualifies as a CAH or a cost provider, are	N	N	N	N	109. 00
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.					

ealth Financial Systems HOSPLTAL AND HOSPLTAL HEALTH CARE COMPLEX		ES HOSPITAL  Provider CC	N: 14_0161	Peri od:		u of Form CMS- Worksheet S-2	
NOTITIAL AND HOSTITIAL HEALTH CARE CONNECES	T DENTITICATION DATA	Trovider co	N. 14-0101	From 10	0/01/2022 9/30/2023	Part I	epared:
					1. 00	2.00	
31.00 If this is a Medicare-certified in			erti fi cati		1.00	2.00	131. 00
date in column 1 and termination date.  32.00 If this is a Medicare-certified is in column 1 and termination date,	let transplant program,	enter the certif	ication da	te			132. 00
33.00 Removed and reserved	т арртсавге, тт согаш	11 2.					133. 0
34.00 If this is a hospital-based organ in column 1 and termination date, All Providers			e OPO numb	er			134. 0
40.00 Are there any related organization chapter 10? Enter "Y" for yes or "lare claimed, enter in column 2 the	N" for no in column 1.	If yes, and home	office cos	ts	Υ	HB1728	140. 00
1.00 If this facility is part of a chai		2.00 n lines 141 throu	  ah 143 the	name and	3.00	of the	
home office and enter the home off	ice contractor name and	contractor number	er.				
41.00 Name: OSF HEALTHCARE SYSTEM 42.00 Street: 124 SW ADAMS	Contractor's Name: PO Box:	WPS	Contra	ctor's Nu	mber: 0590	)1	141. 0
43. 00 Ci ty: PEORI A		IL	Zip Co	de:	6160	)2	143. 0
						1.00	-
44.00 Are provider based physicians' cos	ts included in Workshee	t A?				1.00 Y	144. 00
					1.00	0.00	
45.00 If costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility inceperiod? Enter "Y" for yes or "N"	for yes or "N" for no lude Medicare utilization	in column 1. If c	olumn 1 is		1. 00	2.00	145. 00
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	y changed from the prev column 1. (See CMS Pub			If	N		146. 0
						1.00	1
47.00 Was there a change in the statistic						N	147. 0
48.00 Was there a change in the order of 49.00 Was there a change to the simplific				or no.		N N	148. 0 149. 0
	•	Part A	Part B		itle V	Title XIX	
Does this facility contain a provi or charges? Enter "Y" for yes or "				cation of		3. 13)	
55.00 Hospi tal 56.00 Subprovi der - TPF		N N	N N		N N	N N	155. 0 156. 0
57. 00 Subprovi der – IRF		N	N		N	N	157. 0
58. 00 SUBPROVI DER 59. 00 SNF		N	N		N	N	158. 0 159. 0
60.00 HOME HEALTH AGENCY		N N	N N		N N	N N	160. 0
61. 00 CMHC			N		N	N	161. 0
Multicampus						1.00	
65.00 Is this hospital part of a Multical Enter "Y" for yes or "N" for no.	·	<u> </u>				N STE (0	165. 0
	Name 0	County 1.00	2. 00	Zip Code 3.00	4. 00	FTE/Campus 5.00	+
66.00 If line 165 is yes, for each 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)	J	1. 66	2.00	3.00	1. 60		0 166. 0
						1.00	
Health Information Technology (HIT 67.00 s this provider a meaningful user 68.00 of this provider is a CAH (line 10	under §1886(n)? Enter	"Y" for yes or "	N" for no.		the	Y	167. 0 168. 0
reasonable cost incurred for the H 68.01 f this provider is a CAH and is no	IT assets (see instruct	i ons)					168. 0
exception under §413.70(a)(6)(ii)?					on p		1

Health Financial Systems	SAINT JAMES HO	OSPI TAL	In Lie	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	LTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0161 Pe				)		
			From 10/01/2022				
			To 09/30/2023				
				2/21/2024 2:0	) <u>1 pm</u>		
			Begi nni ng	Endi ng			
			1. 00	2. 00			
170.00 Enter in columns 1 and 2 the EHR beging period respectively (mm/dd/yyyy)			170. 00				
			1. 00	2.00			
171.00 If line 167 is "Y", does this provider	have any days for indiv	viduals enrolled in	N	(	171. 00		
section 1876 Medicare cost plans repor							
"Y" for yes and "N" for no in column 1	l. If column 1 is yes, er	nter the number of section	on				
1876 Medicare days in column 2. (see i							

Health Financial Systems SAINT JAMES HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-0161 Peri od: Worksheet S-2 From 10/01/2022 Part II Date/Time Prepared: 09/30/2023 2/21/2024 2:01 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 1.00 N reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2.00 Ν yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Υ 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 4 00 12/21/2023 4 00 Α Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 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. Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 N 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 Ν 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Υ 13.00 13.00 period? If yes, submit copy. 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 Ν 15.00 Part B Y/N Y/N Date 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) 17.00 Was the cost report prepared using the PS&R Report for Υ 12/14/2023 12/14/2023 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 Report data for additional claims that have been billed Ν Ν 18.00 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 Ν Ν 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

ealth Financial Systems SAINT JAMES OSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der CCN: 14-0161 Provi der CCN: 14-0161 Provi der CCN: 14-0161 Province Provin		u of Form CMS-: Worksheet S-2 Part II Date/Time Pre 2/21/2024 2:0	pared:			
	Descr	i pti on	Y/N	Y/N				
		0	1. 00	3. 00				
0.00 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				
1.00 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 I	HOSPI TALS)						
Capital Related Cost 2.00 Have assets been relifed for Medicare purposes? If yes, see	instructions				22. 00			
3.00 Have changes occurred in the Medicare depreciation expense		sale made dur	ring the cost		23. 0			
reporting period? If yes, see instructions.	due to apprais	sais illaue uui	ring the cost		23.0			
4.00 Were new leases and/or amendments to existing leases entere lf yes, see instructions	ed into during	this cost re	eporting period?		24. 0			
5.00 Have there been new capitalized leases entered into during	the cost repor	rting period?	'If yes, see		25. 0			
instructions. 6.00 Were assets subject to Sec. 2314 of DEFRA acquired during th	no cost ronor+	na porioda I	f vos soo		26. 0			
6.00 Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ie cost reporti	ng perrou? i	i yes, see		26.00			
сору.								
<pre>Interest Expense 8.00 Were new Loans, mortgage agreements or Letters of credit en</pre>	reporting		28. 0					
period? If yes, see instructions.  9.00 Did the provider have a funded depreciation account and/or								
	treated as a funded depreciation account? If yes, see instructions							
0.00 Has existing debt been replaced prior to its scheduled matu instructions.								
1.00 Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes	s, see		31.0			
Purchased Services 2.00 Have changes or new agreements occurred in patient care ser	rvi ces furni she	ed through co	ontractual		32. 0			
arrangements with suppliers of services? If yes, see instru	uctions.	-						
3.00 If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	olied pertainii	ng to competi	tive bidding? If		33. C			
Provi der-Based Physi ci ans		ble			1			
4.00 Were services furnished at the provider facility under an a lf yes, see instructions.	arrangement wi	in provider-t	based physicians?		34. C			
5.00 If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based		35. C			
physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date				
lu ossi o i			1. 00	2. 00				
Home Office Costs					1 24 6			
<ul><li>6.00 Were home office costs claimed on the cost report?</li><li>7.00 If line 36 is yes, has a home office cost statement been pr</li></ul>	repared by the	home office?			36. 0 37. 0			
If yes, see instructions. 8.00 If line 36 is yes , was the fiscal year end of the home off	fice different	from that of	7		38. 0			
the provider? If yes, enter in column 2 the fiscal year end 9.00 If line 36 is yes, did the provider render services to othe			5,		39.0			
see instructions. 0.00 If line 36 is yes, did the provider render services to the	home office?	If yes, see			40.0			
i nstructi ons.								
	1.	00	2.	00				
Cost Report Preparer Contact Information	I							
held by the cost report preparer in columns 1, 2, and 3,	REBECCA		ROBI NSON		41.0			
. , , , , , , , , , , , , , , , , , , ,	OSF HEALTHCARE	SYSTEM			42. 0			
preparer. 3.00 Enter the telephone number and email address of the cost	309-624-7644		REBECCA. C. ROBI	  NSON@OSFHFALTH	   43. 0			
report preparer in columns 1 and 2, respectively.			CARE. ORG		.5. 6			

Health Financial Systems	IES HOSPITAL		In Lieu of Form CMS-2552-1			
HOSPITAL AND HOSPITAL HEALTH CAR	E REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0		Peri od:	Worksheet S-	2
				From 10/01/2022 To 09/30/2023	Part II   Date/Time Pr	onarod.
			'	0 09/30/2023	2/21/2024 2:	01 pm
·						
		3.00				
Cost Report Preparer Conta	ct Information					
41.00 Enter the first name, las		STRATEGIC REIMBURSEME	TV			41.00
	reparer in columns 1, 2, and 3,	CONSULTANT				
respecti vel y.						
42.00 Enter the employer/company	name of the cost report					42. 00
preparer.						
43.00 Enter the telephone number						43. 00
report preparer in columns	s 1 and 2, respectively.					

Health Financial Systems SAINTHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 10/01/2022 | Part I | To 09/30/2023 | Date/Time Prepared: Provider CCN: 14-0161

					'	0 09/30/2023	2/21/2024 2:0	
							I/P Days / 0/P	ı pııı
							Visits / Trips	
	Component	Worksheet A Line No.	No.	of Beds	Bed Days Available	CAH/REH Hours	Title V	
		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		39	14, 235	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO I PF Subprovi der							3. 00
4.00	HMO I RF Subprovi der							4. 00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			39	14, 235	0.00	0	6. 00 7. 00
7.00	beds) (see instructions)			37	14, 235	0.00	U	7.00
8.00	INTENSIVE CARE UNIT	31. 00		3	1, 217	0.00	О	8. 00
9. 00	CORONARY CARE UNIT	01.00		· ·	.,	0.00		9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGI CAL INTENSI VE CARE UNI T							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43.00					0	13. 00
14.00	Total (see instructions)			42	15, 452	0.00	0	14.00
15.00	CAH visits						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 24. 00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE							23. 00 24. 00
24. 00	HOSPICE (non-distinct part)	30. 00						24. 00
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC - STREATOR	88. 00					0	26. 00
26. 01	RURAL HEALTH CLINIC - PONTIAC	88. 01					Ö	26. 01
26. 02	RURAL HEALTH CLINIC - CULLOM	88. 02					Ö	26. 02
26. 03	RURAL HEALTH CLINIC - DWIGHT	88. 03					0	26. 03
26. 04	RURAL HEALTH CLINIC - FAIRBURY	88. 04					0	26. 04
26.05	RURAL HEALTH CLINIC - MINONK	88. 05					0	26. 05
26.06	RURAL HEALTH CLINIC - FLANAGAN	88. 06					0	26. 06
26. 07	RURAL HEALTH CLINIC - REYNOLDS	88. 07					0	26. 07
26. 08	RURAL HEALTH CLINIC - EL PASO	88. 08					0	26. 08
26. 09	RURAL HEALTH CLINIC - CLINTON	88. 09					0	26. 09
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			42			_	27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambulance Trips							29. 00
30. 00 31. 00	Employee discount days (see instruction) Employee discount days - IRF							30. 00 31. 00
32.00	Labor & delivery days (see instructions)			0	C			32.00
32. 00	Total ancillary labor & delivery room			Ü				32. 00
JZ. U I	outpatient days (see instructions)							JZ. U1
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01
	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	c		0	

		_				2/21/2024 2: 0	1 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	2	T: 11 \0.0111	T' 11 VI V	T = 1 A11	T	F 1 0	
	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	0.00	7.00	0.00	7.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 531	134	3, 168			1.00
1.00	8 exclude Swing Bed, Observation Bed and	1, 551	134	3, 100			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 211	550				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	O	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	106	0	226			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	1, 637	134	3, 394			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	362	46	1, 065			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)			047			12.00
13.00	NURSERY	1 000	100	217	0.00	225 00	13.00
14.00	Total (see instructions)	1, 999	189 0		0.00	225. 09	14.00
15. 00 15. 10	CAH visits REH hours and visits	٩	U	U			15. 00 15. 10
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVIDER - 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						25. 00
26.00	RURAL HEALTH CLINIC - STREATOR	6, 104	7, 144	27, 984	0.00	35. 98	26. 00
26. 01	RURAL HEALTH CLINIC - PONTIAC	2, 325	3, 673	14, 168	0.00	22. 18	26. 01
26. 02	RURAL HEALTH CLINIC - CULLOM	164	490		0.00	3. 12	
26. 03	RURAL HEALTH CLINIC - DWIGHT	372	620		0.00	5. 18	
26. 04	RURAL HEALTH CLINIC - FAIRBURY	545	662		0.00	7. 75	26. 04
26. 05	RURAL HEALTH CLINIC - MINONK	462	608		0.00	4. 29	26. 05
26. 06	RURAL HEALTH CLINIC - FLANAGAN	447	257	1, 786	0.00	4. 13	
26. 07	RURAL HEALTH CLINIC - REYNOLDS	1, 128	1, 562		0.00	13. 54	26. 07
26. 08	RURAL HEALTH CLINIC - EL PASO	547	453		0.00	7. 29	26. 08
26. 09 26. 25	RURAL HEALTH CLINIC - CLINTON FEDERALLY QUALIFIED HEALTH CENTER	1, 253 0	1, 975 0	1	0. 00 0. 00	10. 06 0. 00	26. 09 26. 25
27. 00	Total (sum of lines 14-26)	U	U	l o	0.00	338. 61	27. 00
28. 00	Observation Bed Days		299	1, 589	0.00	330.01	28. 00
29. 00	Ambul ance Tri ps	0	2//	1, 307			29. 00
30.00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days (see l'istraction)			Ö			31.00
32. 00	Labor & delivery days (see instructions)	0	17				32. 00
32. 01	Total ancillary labor & delivery room		.,	0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	o	0	0			34. 00

						2/21/2024 2:0	1 pm
		Full Time		Di sch	arges		
	Component	Equi val ents Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		C		40	1, 293	1. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			301	160 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions)	0.00	C	574	40	1, 293	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
15. 00 15. 10 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00	CAH visits REH hours and visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	5. 66			Ö	1, 276	15. 00 15. 10 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 10 25. 00
26. 00 26. 01 26. 02 26. 03 26. 06 26. 07 26. 08 26. 09 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 01	RURAL HEALTH CLINIC - STREATOR RURAL HEALTH CLINIC - PONTIAC RURAL HEALTH CLINIC - CULLOM RURAL HEALTH CLINIC - DWIGHT RURAL HEALTH CLINIC - FAIRBURY RURAL HEALTH CLINIC - FAIRBURY RURAL HEALTH CLINIC - FLANAGAN RURAL HEALTH CLINIC - EL PASO RURAL HEALTH CLINIC - EL PASO RURAL HEALTH CLINIC - CLINTON FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00					26. 00 26. 01 26. 02 26. 03 26. 04 26. 05 26. 06 26. 07 26. 08 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 01
33. 00 33. 01 34. 00	LTCH non-covered days LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care			0 0			33. 00 33. 01 34. 00

| Period: | Worksheet S-3 | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 14-0161

		Wkst. A Line	Amount	Recl assi fi cati	Adj usted		2/21/2024 2:0	
		Number		on of Salaries (from Wkst.	,		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2. 00	A-6) 3.00	3) 4.00	col . 4 5. 00	6. 00	
	RT II - WAGE DATA	1.00	2.00	3.00	4.00	3.00	0.00	
	ALARIES otal salaries (see	200. 00	30, 802, 546	168, 449	30, 970, 995	706, 177. 00	43. 86	1. 00
in	nstructions)	200.00	30, 002, 340			·		
2.00 No	on-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3. 00 No	on-physician anesthetist Part		542, 118	О	542, 118	4, 196. 00	129. 20	3. 00
	nysician-Part A -		279, 023	О	279, 023	1, 556. 00	179. 32	4. 00
4. 01 Ph	dministrative nysicians - Part A - Teaching		0	0	_	0.00		4. 01
	nysician and Non nysician-Part B		794, 215	0	794, 215	3, 683. 00	215. 64	5. 00
6. 00 No ho	on-physician-Part B for ospital-based RHC and FQHC		11, 095, 355	-1, 666, 318	9, 429, 037	198, 079. 00	47. 60	6. 00
7. 00 In	ervices nterns & residents (in an opproved program)	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01 Co	ontracted interns and esidents (in an approved		0	0	0	0. 00	0. 00	7. 01
8. 00 Ho	rograms) ome office and/or related rganization personnel		0	0	0	0. 00	0. 00	8. 00
9.00 SN	VF	44. 00	0	О	0	0.00		9. 00
in	kcluded area salaries (see nstructions) THER WAGES & RELATED COSTS		204, 443	1, 818, 101	2, 022, 544	43, 917. 00	46. 05	10. 00
11. 00 Co	ontract labor: Direct Patient		459, 467	0	459, 467	4, 772. 00	96. 28	11. 00
1	are ontract labor: Top level		0	0	0	0. 00	0.00	12. 00
ma ma	anagement and other anagement and administrative ervices							
13. 00 Co	ontract labor: Physician-Part		15, 049	0	15, 049	77. 00	195. 44	13. 00
14. 00 Ho	- Administrative ome office and/or related rganization salaries and		0	0	0	0.00	0. 00	14. 00
	age-related costs ome office salaries		6, 042, 072	0	6, 042, 072	148, 287. 00	40.75	14. 01
14. 02 Re	elated organization salaries		0	Ö	0	0.00	0. 00	14. 02
	ome office: Physician Part A Administrative		0	0	0	0. 00	0. 00	15. 00
16. 00 Ho	ome office and Contract		0	О	0	0.00	0. 00	16. 00
16. 01 Ho	nysicians Part A - Teaching ome office Physicians Part A		0	О	О	0.00	0. 00	16. 01
	Teaching ome office contract		0	0	0	0. 00	0. 00	16. 02
Ph	nysicians Part A - Teaching						0.00	10.02
	GE-RELATED COSTS age-related costs (core) (see		6, 090, 574	0	6, 090, 574			17. 00
18. 00 Wa	nstructions) age-related costs (other) see instructions)							18. 00
19. 00 Ex	ccluded areas on-physician anesthetist Part		624, 966 0	0	624, 966 0			19. 00 20. 00
Α	on-physician anesthetist Part		85, 820	0	85, 820			21. 00
	nysician Part A -		33, 877	0	33, 877			22. 00
22. 01 Ph	dministrative nysician Part A - Teaching		0	0	0			22. 01
1	nysician Part B age-related costs (RHC/FQHC)		80, 254 2, 835, 527		80, 254 2, 835, 527			23. 00 24. 00
25. 00 In	nterns & residents (in an		2, 035, 527	0	2, 835, 527			25. 00
1 .	oproved program) ome office wage-related		2, 490, 383	0	2, 490, 383			25. 50
(c	core)				, , , , , ,			
	elated organization age-related (core)		0	0	0			25. 51
	ome office: Physician Part A Administrative - age-related (core)		0	0	0			25. 52

Provider CCN: 14-0161

					T	09/30/2023	Date/Time Prep 2/21/2024 2:0	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es		Wage (col. 4 ÷	
			·	(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARII							
26. 00	Employee Benefits Department	4. 00	315, 923			2. 00		26. 00
27. 00	Administrative & General	5. 00	1, 219, 327			·		
28. 00	Administrative & General under		429, 087	0	429, 087	2, 353. 00	182. 36	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	255, 897			·		29. 00
30. 00	Operation of Plant	7. 00	420, 382			·		
31. 00	Laundry & Linen Service	8. 00	30, 714	l e		·		
32. 00	Housekeepi ng	9. 00	672, 159	9, 031	681, 190	·		
33. 00	Housekeeping under contract		0	0	0	0. 00	0. 00	33. 00
	(see instructions)							
34. 00	Di etary	10. 00	514, 258	-377, 415	136, 843	·		34. 00
35. 00	Dietary under contract (see		0	0	0	0. 00	0. 00	35. 00
	instructions)	44.00				47 007 00		
36. 00	Cafeteri a	11. 00	0	384, 324	384, 324	·		36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00		
38. 00	Nursing Administration	13. 00	1, 031, 949			·		
39. 00	Central Services and Supply	14. 00	111, 955	1, 504	113, 459	·		
40. 00	Pharmacy	15. 00	0	0	0	0. 00		
41. 00	Medical Records & Medical	16. 00	0	0	0	0. 00	0. 00	41. 00
	Records Li brary		_	_	_			
42. 00	Soci al Servi ce	17. 00	0	0	0	0.00		42. 00
43.00	Other General Service	18. 00	0	0	0	0.00	0. 00	43.00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION In Lieu of Form CMS-2552-10
Worksheet S-3 SAINT JAMES HOSPITAL Provider CCN: 14-0161 Period:

HUSPI I	AL WAGE INDEX INFORMATION			Provider C		Period: From 10/01/2022 To 09/30/2023		
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3.00	4. 00	5. 00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		18, 799, 945	1, 834, 767	20, 634, 71	2 502, 572. 00	41. 06	1.00
	instructions)							
2.00	Excluded area salaries (see		204, 443	1, 818, 101	2, 022, 54	43, 917. 00	46. 05	2.00
	instructions)							
3.00	Subtotal salaries (line 1		18, 595, 502	16, 666	18, 612, 16	8 458, 655. 00	40. 58	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		6, 516, 588	0	6, 516, 58	8 153, 136. 00	42. 55	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		8, 614, 834	0	8, 614, 83	4 0.00	46. 29	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		33, 726, 924	16, 666	33, 743, 59	0 611, 791. 00	55. 16	6.00
7.00	Total overhead cost (see		5, 001, 651	-313, 606	4, 688, 04	5 126, 659. 00	37. 01	7. 00

instructions)

Health Financial Systems	SAINT JAMES HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0161	Peri od: Worksheet S-3
		From 10/01/2022   Part IV
		To 00/20/2022 Doto/Time Dropored.

	To 09/30/2023	Date/Time Prep 2/21/2024 2:0	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 263, 324	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	233, 347	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	o	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	5, 495, 696	8. 02
8. 03	Heal th Insurance (Purchased)	0	8. 03
9. 00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	0	11. 00
12. 00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13. 00	Disability Insurance (If employee is owner or beneficiary)	17, 542	13. 00
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	400, 983	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
10.00	Noncumul attive portion)	ĭ	10.00
	TAXES		
17. 00	FICA-Employers Portion Only	2, 285, 471	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	2	19. 00
	State or Federal Unemployment Taxes	0	20. 00
20.00	OTHER		20.00
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
21.00	instructions))	ĭ	21.00
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	54, 652	
	Total Wage Related cost (Sum of lines 1 -23)	9, 751, 017	24. 00
0	Part B - Other than Core Related Cost	., , ,	
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
	1	'	

Health Financial Systems	SAINT JAMES HOSPITAL	In Lieu of Form CMS-	-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 14-0161	Period: Worksheet S-3 From 10/01/2022 Part V	3

		From 10/01/2022 To 09/30/2023	Part V Date/Time Prep 2/21/2024 2:0	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	459, 467	9, 751, 017	1. 00
2.00	Hospi tal	459, 467	9, 751, 017	2. 00
3.00	SUBPROVI DER - I PF			3. 00
4.00	SUBPROVI DER			4.00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8. 00	SKILLED NURSING FACILITY			8. 00
9. 00	NURSING FACILITY			9. 00
10. 00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA			11. 00
12. 00	AMBULATORY SURGICAL CENTER (D. P. ) I			12.00
13. 00	Hospi tal -Based Hospi ce			13.00
	Hospital-Based Health Clinic RHC	0	0	14.00
14. 01	Hospital-Based Health Clinic RHC 1	0	0	14. 01
14. 02	Hospital-Based Health Clinic RHC 2	0	0	14. 02
14. 03	Hospital-Based Health Clinic RHC 3	0	0	14. 03
14. 04	Hospital-Based Health Clinic RHC 4	0	0	14.04
14. 05	Hospital-Based Health Clinic RHC 5	0	0	14. 05
14. 06	Hospital-Based Health Clinic RHC 6	0	0	14. 06
14. 07	Hospital-Based Health Clinic RHC 7	0	0	14.07
14. 08	Hospital-Based Health Clinic RHC 8	0	0	14. 08
14. 09	Hospital - Based Health Clinic RHC 9	0	0	14. 09
15. 00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	RENAL DIALYSIS I			17. 00
18. 00	Other	0	0	18. 00

Heal th	Financial Systems	SAINT JAMES	S HOSPITAL		In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 14-0161	Peri od:	Worksheet S-8	
			Component	CCN: 14-8624	From 10/01/2022 To 09/30/2023		
					RHC I	Cost	, p
	·						
	01:				1.	00	
1. 00	Clinic Address and Identification Street				111 SPRING STR	EET EL 1	1.00
1.00	Sti ee t		Ci	tv	State	ZIP Code	1.00
				00	2. 00	3. 00	
2.00	City, State, ZIP Code, County		STREATOR		I L	61364	2. 00
						4.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "P" for rur	al or "II" for i	ırhan		1. 00	3.00
3.00	THOSE THE BASED TUNES ONLY. DESIGNATION - EITE	el K loi lui a	91 01 0 101 0		nt Award	Date	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 7. 00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	U(d), PHS ACT)					6. 00 7. 00
8. 00	Look-Alikes						8.00
9. 00	OTHER (SPECIFY)						9. 00
				•			
	I= :				1. 00	2. 00	
10. 00	Does this facility operate as other than a hyes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operation	ns in column	N	C	10.00
	induits.	Sur	nday	N	londay	Tuesday	
		from	to	from	to	from	
		1.00	2. 00	3. 00	4. 00	5. 00	
	Facility hours of operations (1) CLINIC	1	I	08: 00	05: 00	08: 00	11. 00
11.00	I CELINI C			08.00	05.00	08.00	11.00
					1. 00	2.00	
12. 00 13. 00	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report.	d in CMS Pub. ' umn 1. If yes,	100-04, chapter enter in colur	9, section nn 2 the	N N	C	12. 00 13. 00
				Prov	ider name	CCN	
					1. 00	2. 00	
14. 00	RHC/FQHC name, CCN	V (N)	1 1/	20/11/1	VIV	T 1 1 10 11	14. 00
		Y/N 1.00	V 2. 00	3. 00	XI X 4. 00	Total Visits 5.00	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed 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)				4.00	3.00	15. 00
				inty			
				00			
2.00	City, State, ZIP Code, County	T	LASALLE		T:		2.00
		Tuesday	Wedn from	esday to	from	sday to	
		6.00	7.00	8. 00	9. 00	10.00	
	Facility hours of operations (1)	0.00	,	3.00	2.00		
11. 00	CLINIC	05: 00	08: 00	05: 00	08: 00	05: 00	11. 00

Health Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 14-0161	Peri od:	Worksheet S-8	
				From 10/01/2022		
		Component	CCN: 14-8624	To 09/30/2023		
					2/21/2024 2:0	11 pm
			_	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	08: 00	05: 00				11. 00

	FAL-BASED RHC/FQHC STATISTICAL DATA		Provi der 0	CN: 14-0161	Peri od:	eu of Form CN Worksheet S		
			Component	CCN: 14-8654	From 10/01/2022 To 09/30/2023			
			_		RHC II	Cos	t ,	
					1	00	_	
	Clinic Address and Identification					. 00	$\dashv$	
. 00	Street				2500 W REYNOLI	DS ST, STE	$\neg$	1. (
					203, 205-207		4	
				ty	State	ZIP Code	_	
2. 00	City, State, ZIP Code, County		PONTI AC	. 00	2. 00	3. 00 L 61764		2. (
00	orty, State, Zir code, county		IONTIAC		1	L01704		2. (
						1.00		
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for o				0	3. (
					nt Award	Date	_	
	Carrage of Fadaral Frieds				1. 00	2. 00	_	
. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)		1				4. (
5. 00	Migrant Health Center (Section 329(d), PHS Ad							5. (
5. 00	Heal th Services for the Homeless (Section 340							6. (
7.00	Appal achi an Regi onal Commi ssi on							7. (
3. 00	Look-Alikes							8.
. 00	OTHER (SPECIFY)							9.
					1. 00	2. 00	-	
0. 00	Does this facility operate as other than a ho	ospital-based F	RHC or FOHC? Fi	nter "Y" for	N N	2.00	0	10.
0. 00	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	other operation	ns in column				10.
	Tiour 3. )	Sur	iday	l v	londay	Tuesday		
		from	to	from	to	from		
		1.00	2.00	3.00	4. 00	5. 00		
4 00	Facility hours of operations (1)	1	1	loz 00	Top. 00	T		
1.00	TCLEINIC.							11. (
	0E1111 0			07: 00	05: 00	07: 00		
	John G			07:00				
12. 00	Have you received an approval for an exception	on to the produ	uctivity standa		1. 00	2.00		12. (
	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. ´ umn 1. If yes,	100-04, chapte enter in colu	ard? r 9, section nn 2 the			0	
	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column in column.	d in CMS Pub. ´ umn 1. If yes,	100-04, chapte enter in colu	ard? r 9, section mn 2 the ders and	1.00		0	
3. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column number of providers included in this report. numbers below.	d in CMS Pub. ´ umn 1. If yes,	100-04, chapte enter in colu	ard? - 9, section mn 2 the ders and	1. 00 N	2.00	0	13. (
3. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. 2 umn 1. If yes, List the names	100-04, chapte enter in colu s of all provid	ard? r 9, section mn 2 the ders and Provi	1.00 N ider name 1.00	2. 00 CCN 2. 00		13. (
13. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column number of providers included in this report. numbers below.	d in CMS Pub. / umn 1. If yes, List the names	100-04, chapter enter in colur s of all provid	ard? r 9, section mn 2 the ders and Provi	1.00 N ider name 1.00	2.00  CCN 2.00  Total Visit		12. ( 13. ( 14. (
4. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column number of providers included in this report. numbers below.	d in CMS Pub. / umn 1. If yes, List the names  Y/N  1.00	100-04, chapte enter in colu s of all provid	ard? r 9, section mn 2 the ders and Provi	1.00 N ider name 1.00	2. 00 CCN 2. 00		13. (
4. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report. In numbers below.  RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	d in CMS Pub. / umn 1. If yes, List the names  Y/N  1.00	100-04, chapter enter in colur s of all provid	ard? r 9, section mn 2 the ders and Provi	1.00 N ider name 1.00	2.00  CCN 2.00  Total Visit		14.
4. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report. In numbers below.  RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	d in CMS Pub. / umn 1. If yes, List the names  Y/N  1.00	100-04, chapter enter in colur s of all provid	ard? r 9, section mn 2 the ders and Provi	1.00 N ider name 1.00	2.00  CCN 2.00  Total Visit		14.
4. 00	Have you received an approval for an exception of the state of the sta	d in CMS Pub. / umn 1. If yes, List the names  Y/N  1.00	100-04, chapter enter in colur s of all provid	ard? r 9, section mn 2 the ders and Provi	1.00 N ider name 1.00	2.00  CCN 2.00  Total Visit		13. (
4. 00	Have you received an approval for an exception of the state of the sta	d in CMS Pub. / umn 1. If yes, List the names  Y/N  1.00	100-04, chapter enter in colur s of all provid	ard? r 9, section mn 2 the ders and Provi	1.00 N ider name 1.00	2.00  CCN 2.00  Total Visit		13. (
4.00	Have you received an approval for an exception of the state of the sta	d in CMS Pub. / umn 1. If yes, List the names  Y/N  1.00	100-04, chapter enter in colur s of all provid	ard? r 9, section mn 2 the ders and Provi	1.00 N ider name 1.00	2.00  CCN 2.00  Total Visit		13. (
4. 00	Have you received an approval for an exception of the state of the sta	d in CMS Pub. / umn 1. If yes, List the names  Y/N  1.00	V 2.00	ard? r 9, section mn 2 the ders and Provi	1.00 N ider name 1.00	2.00  CCN 2.00  Total Visit		13. (
<ul><li>3. 00</li><li>4. 00</li><li>5. 00</li></ul>	Have you received an approval for an exception of the state of the sta	d in CMS Pub. / umn 1. If yes, List the names  Y/N  1.00	V 2.00	ard? - 9, section nn 2 the ders and - Provi	1.00 N ider name 1.00	2.00  CCN 2.00  Total Visit		14.
3. 00 4. 00 5. 00	Have you received an approval for an exception of the state of the sta	d in CMS Pub. Aumn 1. If yes, List the names  Y/N  1.00	V 2.00  Column 4  LIVINGSTON	ard? r 9, section mn 2 the ders and  Provi  XVIII 3.00	1.00 N Ider name 1.00 XIX 4.00	2. 00  CCN 2. 00  Total Visit 5. 00		14. (
13. 00	Have you received an approval for an exception of the state of the sta	d in CMS Pub. Aumn 1. If yes, List the names  Y/N  1.00	V 2.00  Cool LIVINGSTON  Wedn  Chapter  Chapter  Chapter  Chapter  Chapter  Cool  4  LIVINGSTON  Wedn	ard? r 9, section mn 2 the ders and  Provi  XVIII 3.00  unty 00	1.00  N  Ider name 1.00  XIX  4.00	2.00  CCN 2.00  Total Visit 5.00		14. (
12. 00 13. 00 14. 00 15. 00	Have you received an approval for an exception of the state of the sta	d in CMS Pub. Aumn 1. If yes, List the names  Y/N  1.00	V 2.00  Column 4  LIVINGSTON	ard? r 9, section mn 2 the ders and  Provi  XVIII 3.00	1.00 N Ider name 1.00 XIX 4.00	2. 00  CCN 2. 00  Total Visit 5. 00		13. (

Health Financial Systems	SAINT JAMES	HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0161	Peri od:	Worksheet S-8	1
				From 10/01/2022		
		Component	CCN: 14-8654	To 09/30/2023	Date/Time Pre	pared:
		·			2/21/2024 2:0	i1 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	04: 00				11.00

IUSPI TAL-BASED F	RHC/FQHC STATISTICAL DATA		Provi der (	CCN: 14-0161	Peri od:	Worksheet S-8	-2552- 8
			Component	CCN: 14-8640	From 10/01/2022 To 09/30/2023		
					RHC III	Cost	
					1	00	
Clinic Ad	Idress and Identification				1.	00	
.00 Street					105 W HACK ST		1.
				i ty	State	ZIP Code	-
. 00 Ci ty, Sta	ate, ZIP Code, County		CULLOM	. 00	2. 00	3. 00	2.
00   01 ty, 0 to	ato, 211 odde, county		OOLLOW		1 - 1 -	00727	
00 110001 741	DAGED FOUR ONLY B. I. III			<u> </u>		1. 00	
00 HOSPITAL-	-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for		nt Award	Date	3.
					1. 00	2.00	
	Federal Funds						
	y Health Center (Section 330(d), PHS						4.
	Health Center (Section 329(d), PHS Ac ervices for the Homeless (Section 340				ļ		5.
	an Regional Commission	(G), IIIS ACT)					7.
00 Look-Alik	kes						8
00 OTHER (SP	PECLEY)						9
					1. 00	2.00	+
0.00 Does this	s facility operate as other than a ho	spital-based R	RHC or FQHC? E	nter "Y" for	N N		0 10
	N" for no in column 1. If yes, indica in subscripts of line 11 the type of						
11.5 2.1 5,1 )		Sun	day	Mo	onday	Tuesday	
		from	to	from	to	from	
Facility	hours of operations (1)	1. 00	2. 00	3.00	4. 00	5. 00	
1. 00 CLINIC	flours or operations (1)			08: 00	05: 00	08: 00	11.
2. 00 Have you	received an approval for an exception	on to the produ	ictivity stand		1. 00	2. 00	12
3.00 Is this a	a consolidated cost report as defined ter "Y" for yes or "N" for no in colu	in CMS Pub. 1 umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N	(	0 13
number of	f providers included in this report.	LIST the names					
	·	LIST THE NAMES		Provi	der name	CCN	
number of	pel ow.	List the names			der name 1.00	CCN 2. 00	
number of	pel ow.			•	1. 00	2. 00	
number of	pel ow.	Y/N 1.00	V 2.00				
number of numbers b  i. 00 RHC/FOHC  i. 00 Have you GME cost? column 1. 4 the num Intern &	provided all or substantially all? Enter "Y" for yes or "N" for no in If yes, enter in columns 2, 3 and mber of program visits performed by Residents for titles V, XVIII, and	Y/N	V	XVIII	1. 00 XI X	2.00 Total Visits	
number of numbers b  1.00 RHC/FQHC  5.00 Have you GME cost? column 1. 4 the num Intern & XIX, as a number of	provided all or substantially all? Enter "Y" for yes or "N" for no in If yes, enter in columns 2, 3 and mber of program visits performed by	Y/N	V 2.00	XVIII 3. 00	1. 00 XI X	2.00 Total Visits	
number of numbers b  1.00 RHC/FQHC  1.00 Have you GME cost? column 1. 4 the num Intern & XIX, as a number of	provided all or substantially all? Enter "Y" for yes or "N" for no in If yes, enter in columns 2, 3 and mber of program visits performed by Residents for titles V, XVIII, and applicable. Enter in column 5 the f total visits for this provider.	Y/N	V 2.00	XVIII	1. 00 XI X	2.00 Total Visits	
number of numbers b  i.00 RHC/FOHC  i.00 Have you GME cost? column 1. 4 the num Intern & XIX, as a number of (see inst	provided all or substantially all? Enter "Y" for yes or "N" for no in If yes, enter in columns 2, 3 and mber of program visits performed by Residents for titles V, XVIII, and applicable. Enter in column 5 the f total visits for this provider.	Y/N	V 2.00	XVIII 3.00	1. 00 XI X	2.00 Total Visits	15.
number of numbers b  4.00 RHC/FOHC  5.00 Have you GME cost? column 1. 4 the num Intern & XIX, as a number of (see inst	provided all or substantially all? Enter "Y" for yes or "N" for no in If yes, enter in columns 2, 3 and mber of program visits performed by Residents for titles V, XVIII, and applicable. Enter in column 5 the f total visits for this provider. tructions)	Y/N 1.00	V 2.00  Co 4 LI VI NGSTON Wedr	XVIII 3.00  unty .00	1. 00  XI X  4. 00  Thur	2.00 Total Visits 5.00	15.
number of numbers b  4.00 RHC/FQHC  5.00 Have you GME cost? column 1. 4 the num Intern & XIX, as a number of (see inst	provided all or substantially all? Enter "Y" for yes or "N" for no in If yes, enter in columns 2, 3 and mber of program visits performed by Residents for titles V, XVIII, and applicable. Enter in column 5 the f total visits for this provider. tructions)	Y/N 1.00	V 2. 00 Co	XVIII 3.00	1. 00 XI X 4. 00	2.00 Total Visits 5.00	14.

Health Financial Systems	SAINT JAMES	S HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 14-0161	Peri od:	Worksheet S-8	
			0011 44 0740	From 10/01/2022		
		Component	CCN: 14-8640	To 09/30/2023	2/21/2024 2:0	pared: 1 pm
				RHC III	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13.00	14. 00		
Facility hours of operations (1)						
11. 00   CLI NI C	08: 00	04: 30				11. 00

	FAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0161	Peri od:	Worksheet S-8	2552-
	THE BASED KNOT GIVE STATESTICKE BATA			CCN: 14-8641	From 10/01/2022 To 09/30/2023	Date/Time Pre	pared
					RHC IV	2/21/2024 2:0 Cost	i pm
					INIO I V	0031	
					1.	00	
	Clinic Address and Identification				1		
00	Street		Ci	ty	107 WATTERS DR State	ZIP Code	1.
				00	2. 00	3. 00	
. 00	City, State, ZIP Code, County		DWI GHT			60420	2.
	THOCH TALL BACED FOLIO ONLY D	II DII C				1.00	
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ento	er "R" Tor rura	I or "U" for L		nt Award	Date 0	3.
					1. 00	2. 00	
	Source of Federal Funds						
. 00	Community Health Center (Section 330(d), PHS						4.
. 00	Migrant Health Center (Section 329(d), PHS Ad						5.
. 00	Health Services for the Homeless (Section 340 Appalachian Regional Commission	U(d), PHS Act)					6. 7.
00	Look-Alikes			•			8.
. 00	OTHER (SPECIFY)						9.
				•			
				. ""	1.00	2.00	1.0
0. 00	Does this facility operate as other than a hoyes or "N" for no in column 1. If yes, indical 2. (Enter in subscripts of line 11 the type or hours.)	ate number of o	ther operation	s in column	N	0	10.
	Thousand St. )	Sun	day	Mo	onday	Tuesday	
		from	to	from	to	from	
	E '11'   C   1' (4)	1.00	2. 00	3. 00	4. 00	5. 00	
1 00	Facility hours of operations (1)	1.00	2.00				11
1. 00	Facility hours of operations (1)	1.00	2.00	08: 00	4. 00 05: 00	5. 00	11.
1. 00		1.00	2.00				11.
2. 00		on to the produ d in CMS Pub. 1 umn 1. If yes,	ctivity standa 00-04, chapter enter in colum	08:00 ard? 9, section an 2 the	05: 00	07: 30	12.
2. 00	Have you received an approval for an exception list his a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	on to the produ d in CMS Pub. 1 umn 1. If yes,	ctivity standa 00-04, chapter enter in colum	08:00  ord? 9, section n 2 the elers and  Provi	05:00 1.00 N	07: 30 2. 00 0	12.
2. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colon number of providers included in this report. numbers below.	on to the produ d in CMS Pub. 1 umn 1. If yes,	ctivity standa 00-04, chapter enter in colum	08:00  ord? 9, section n 2 the elers and  Provi	05: 00 1. 00 N	07: 30 2. 00 0	12.
2. 00	Have you received an approval for an exception list his a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	on to the produ d in CMS Pub. 1 umn 1. If yes, List the names	ctivity standa 00-04, chapter enter in colum of all provic	o8:00  ord? og. section on 2 the elers and  Provi	05: 00 1. 00 N der name	07: 30 2. 00 0 CCN 2. 00	12.
2. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colon number of providers included in this report. numbers below.	on to the produ d in CMS Pub. 1 umn 1. If yes,	ctivity standa 00-04, chapter enter in colum	08:00  ord? 9, section n 2 the elers and  Provi	05:00 1.00 N	07: 30 2. 00 0	11. 12. 13.
2. 00 3. 00	Have you received an approval for an exception of the state of the sta	on to the produ d in CMS Pub. 1 umn 1. If yes, List the names  Y/N 1.00	ctivity standa 00-04, chapter enter in colum of all provic	08:00  ard? 9, section n 2 the ders and  Provi	05: 00 1. 00 N der name 1. 00	07: 30 2. 00 0 CCN 2. 00 Total Visits	12. 13.
2. 00 3. 00	Have you received an approval for an exception of the state of the sta	on to the produ d in CMS Pub. 1 umn 1. If yes, List the names  Y/N 1.00	ctivity standa 00-04, chapter enter in colum of all provic	08:00  ard? 9, section n 2 the ders and  Provi	05: 00 1. 00 N der name 1. 00	07: 30 2. 00 0 CCN 2. 00 Total Visits	12. 13.
2. 00 3. 00	Have you received an approval for an exception of the state of the sta	on to the produ d in CMS Pub. 1 umn 1. If yes, List the names  Y/N 1.00	ctivity standa 00-04, chapter enter in colum of all provic  V 2.00	08:00  ard? 9, section n 2 the lers and  Provi  XVIII 3.00	05: 00 1. 00 N der name 1. 00	07: 30 2. 00 0 CCN 2. 00 Total Visits	12. 13.
2. 00 3. 00 4. 00	Have you received an approval for an exception of the state of the sta	on to the produ d in CMS Pub. 1 umn 1. If yes, List the names  Y/N 1.00	ctivity standa 00-04, chapter enter in colum of all provic  V 2.00	08:00  ord? 9, section n 2 the lers and  Provi  XVIII 3.00	05: 00 1. 00 N der name 1. 00	07: 30 2. 00 0 CCN 2. 00 Total Visits	12. 13.
2. 00 3. 00 4. 00 5. 00	Have you received an approval for an exception of the state of the sta	on to the produ d in CMS Pub. 1 umn 1. If yes, List the names  Y/N 1.00	ctivity standa 00-04, chapter enter in colum of all provic  V 2.00  Cou	08:00  ard? 9, section n 2 the ders and  Provi  XVIII 3.00	05: 00 1. 00 N der name 1. 00 XIX 4. 00	07: 30 2. 00 0 CCN 2. 00 Total Visits 5. 00	12. 13.
2. 00 3. 00 4. 00 5. 00	Have you received an approval for an exception of the state of the sta	on to the produ d in CMS Pub. 1 umn 1. If yes, List the names  Y/N 1.00	ctivity standa 00-04, chapter enter in colum of all provic  V 2.00  Cou 4. LIVINGSTON Wedn	08:00  ard? 9, section 10:2 the 10:3 and  Provi  XVIII 3.00  anty 00  esday	05: 00  1. 00  N  der name 1. 00  XIX  4. 00	07: 30  2. 00  0  CCN 2. 00  Total Visits 5. 00	12.
2. 00	Have you received an approval for an exception of the state of the sta	on to the produ d in CMS Pub. 1 umn 1. If yes, List the names  Y/N 1.00	ctivity standa 00-04, chapter enter in colum of all provic  V 2.00  Cou	08:00  ard? 9, section n 2 the ders and  Provi  XVIII 3.00	05: 00 1. 00 N der name 1. 00 XIX 4. 00	07: 30 2. 00 0 CCN 2. 00 Total Visits 5. 00	12. 13.

Health Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 14-0161	Peri od:	Worksheet S-8	
		Component	CCN, 14 0/41	From 10/01/2022	Doto/Time Dro	nanad.
		Component	CCN: 14-8041	To 09/30/2023	2/21/2024 2:0	
				RHC IV	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	08: 00	04: 30				11. 00

Heal th	Financial Systems	SAINT JAMES	S HOSPITAL		In Li∈	eu of Form CMS-	-2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 14-0161	Peri od:	Worksheet S-	
			Component	CCN: 14-8643	From 10/01/2022 To 09/30/2023		
					RHC V	Cost	эт рш
			-			-	
	I				1.	00	
1 00	Clinic Address and Identification				10/ C FLDCT CT	CTF 100	1 00
1.00	Street		Ci	ty	106 S FIRST ST State	ZIP Code	1.00
				00	2. 00	3. 00	
2.00	City, State, ZIP Code, County		FAI RBURY			61739	2. 00
3.00	HOSPITAL-BASED FOHCs ONLY: Designation - Ent	or "D" for rur	al or "II" for i	ırhan		1.00	3.00
3.00	HOSPITAL-BASED FUNCS UNLT. DESIGNATION - EITE	ei k ioi iuia	ai 0i 0 10i t		nt Award	Date	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 7. 00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	o(u), PHS ACT)				1	6. 00 7. 00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9. 00
10.00			50100 F	1 111/11 6	1.00	2. 00	10.00
10. 00	Does this facility operate as other than a hyes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operation	ns in column	N		10. 00
	Thou 3. )	Sur	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) CLINIC	1	1	08: 00	05: 00	08: 00	11. 00
11.00	I CELINI C			08.00	05.00	08.00	11.00
					1. 00	2. 00	
12. 00 13. 00	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapteı enter in colur	9, section nn 2 the	N	(	12. 00 13. 00
				Prov	ider name	CCN	
					1. 00	2. 00	
14. 00	RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visits	14. 00
		1.00	2.00	3.00	4. 00	5. 00	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed 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)		2.00	3.00		3.30	15. 00
				unty			
2.00	City Ctata 71D Cada C			00			0.00
2.00	City, State, ZIP Code, County	Tuesday	LI VI NGSTON	esday	Thur	sday	2. 00
		to	from	to	from	to	
		6.00	7. 00	8.00	9. 00	10.00	
	Facility hours of operations (1)	_					
11. 00	CLINIC	06: 00	08: 00	05: 00	08: 00	05: 00	11.00

Health Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der 0	CCN: 14-0161	Peri od:	Worksheet S-8	
				From 10/01/2022		
		Component	CCN: 14-8643	To 09/30/2023		
					2/21/2024 2:0	1 pm
				RHC V	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	08: 00	04: 00				11.00

Health Financial Systems	SAINT JAMES	S HOSPLTAL		In Lie	eu of Form CMS	-2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0161	Peri od:	Worksheet S-	
		Component	CCN: 14-8653	From 10/01/2022 To 09/30/2023	Date/Time Pr	enared:
		Component	CON: 14 0033	10 077 307 2023	2/21/2024 2:	
				RHC VI	Cost	
				1	00	-
Clinic Address and Identification				1.	00	
1.00 Street		1		120 E 7TH ST		1.00
			ty	State	ZIP Code	
2.00 City, State, ZIP Code, County		MI NONK	00	2. 00	3. 00 61760	2.00
2.00 orty, State, 211 code, county		INIT INOTAL		16	01700	2.00
					1. 00	
3.00   HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for ι				3.00
				nt Award 1.00	2. 00	
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 7.00 Appalachian Regional Commission	0(d), PHS Act)					6. 00 7. 00
8.00 Look-Alikes						8.00
9. 00 OTHER (SPECIFY)						9. 00
10 00 Day this facility are the ather than a		NIC FOLICO F		1.00	2.00	10.00
10.00 Does this facility operate as other than a hyges or "N" for no in column 1. If yes, indic.				N	1	10.00
2. (Enter in subscripts of line 11 the type of						
hours.)						
		day I .		londay	Tuesday	
	1.00	2. 00	3.00	4. 00	from 5.00	
Facility hours of operations (1)	1.00	2.00	3.00	4.00	3.00	
11. 00 CLINIC			08: 00	05: 30	08: 00	11. 00
				4.00	0.00	
12.00 Have you received an approval for an exception	on to the produ	uctivity standa	urd2	1.00	2. 00	12.00
13.00 Is this a consolidated cost report as define				N		13.00
30.8? Enter "Y" for yes or "N" for no in col	umn 1. If yes,	enter in colum	n 2 the			
number of providers included in this report.	List the names	s of all provid	lers and			
numbers below.			Prov	ider name	CCN	
			1100	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
GME cost? Enter "Y" for yes or "N" for no in						13.00
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)			L			
			inty 00			
2.00 City, State, ZIP Code, County		WOODFORD 4.	00			2.00
	Tuesday		esday	Thur	sday	2.00
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1) 11.00 CLINIC	05: 00	07: 30	05: 00	07: 30	05: 00	11. 00
TI. OO JOLINIO	po. 00	01.30	ps. 00	01.30	100.00	1 11.00

Health Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der	CCN: 14-0161	Peri od:	Worksheet S-8	
				From 10/01/2022		
		Component	CCN: 14-8653	To 09/30/2023	Date/Time Pre	pared:
		'			2/21/2024 2:0	
				RHC VI	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	08: 00	05: 00				11. 00

Heal th	Financial Systems	SAINT JAMES	S HOSPITAL		In Lie	u of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 14-0161	Peri od:	Worksheet S-8	
			Component	CCN: 14-8644	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/21/2024 2:0	
					RHC VII	Cost	и рііі
					1.	00	
1. 00	Clinic Address and Identification Street				103 W SOUTH ST		1.00
1.00	<u>  311 66 t</u>		Ci	ty	State	ZIP Code	1.00
				00	2.00	3. 00	
2.00	City, State, ZIP Code, County		FLANAGAN		IL	61740	2. 00
						1. 00	
3. 00	HOSPITAL-BASED FOHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for u	ırban		1.00	3.00
					nt Award	Date	
	I				1. 00	2. 00	
4 00	Source of Federal Funds Community Health Center (Section 330(d), PHS			T			4 00
4. 00 5. 00	Migrant Health Center (Section 330(d), PHS A						4. 00 5. 00
6. 00	Health Services for the Homeless (Section 34						6. 00
7.00	Appalachian Regional Commission						7. 00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
					1. 00	2. 00	
10. 00	Does this facility operate as other than a h 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 o	other operation	ns in column	N	O	10.00
	inour s. )	Sur	nday	l N	Monday	Tuesday	
		from	to	from	to	from	
		1.00	2. 00	3. 00	4. 00	5. 00	
	Facility hours of operations (1) CLINIC			07: 30	04: 30	07: 30	11. 00
11.00	I CELINI C			07.30	04. 30	07.30	11.00
					1. 00	2. 00	
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. ' umn 1. If yes,	100-04, chapter enter in colum	9, section nn 2 the	N	С	12. 00 13. 00
				Prov	ider name	CCN	
11.00	True (Four				1. 00	2. 00	11.00
14.00	RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visits	14. 00
		1.00	2.00	3.00	4. 00	5. 00	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed 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)						15. 00
				inty			
2.00	City State 71D Code County			00			2.00
2. 00	City, State, ZIP Code, County	Tuesday	LI VI NGSTON	esday	Thur	sday	2.00
		to	from	to	from	to	
		6.00	7. 00	8. 00	9. 00	10. 00	
	Facility hours of operations (1)						
11. 00	CLINIC	04: 30	07: 30	04: 30	07: 30	04: 00	11.00

Health Financial Systems	SAINT JAMES	HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der 0	CCN: 14-0161	Peri od:	Worksheet S-8	
		Component	CCN: 14 9644	From 10/01/2022 To 09/30/2023	Dato/Timo Pro	narod:
		Component	CCN. 14-0044	10 09/30/2023	2/21/2024 2:0	
				RHC VII	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: 30	04: 30				11. 00

Heal th	Financial Systems	SAINT JAMES	S HOSPITAL		In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 14-0161	Peri od:	Worksheet S-8	
			Component	CCN: 14-8650	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/21/2024 2:0	
					RHC VIII	Cost	л рііі
					1.	00	
1 00	Clinic Address and Identification				1506 W REYNOLD	сст	1 00
1.00	Street		Ci	ty	State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		PONTI AC			61764	2. 00
						1 00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for rur	al or "II" for i	ırhan		1.00	3.00
3.00	THOSE TAL-BASED TUNES ONLT. DESIGNATION - LITE	el K loi lui a	ai 0i 0 10i 0		nt Award	Date	3.00
					1. 00	2. 00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						4.00
5. 00 6. 00	Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34						5. 00 6. 00
7. 00	Appalachian Regional Commission	o(u), FIIS ACT)					7.00
8. 00	Look-Alikes						8. 00
9. 00	OTHER (SPECIFY)						9. 00
					4.00		
10. 00	Does this facility operate as other than a h	osnital based [	DUC or ENUC2 Er	ator "V" for	1. 00 N	2.00	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 o	other operation	ns in column	IV		10.00
	Hour 3. )	Sur	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)			08: 00	05: 30	08: 00	11. 00
11.00	CET NI C			08.00	05. 30	08.00	11.00
					1. 00	2.00	
12. 00 13. 00	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in colur	9, section nn 2 the	N	С	12. 00 13. 00
	Thamber of Ser em			Prov	ider name	CCN	
	T				1. 00	2.00	
14. 00	RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visits	14. 00
		1.00	2.00	3.00	4. 00	5. 00	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed 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)		2.00	0.00	00	3. 00	15. 00
				unty			
2.00	City Ctata 71D Cada Causty		+	00			2.00
2.00	City, State, ZIP Code, County	Tuesday	LI VI NGSTON	esday	Thur	sday	2.00
		to	from	to	from	to	
		6.00	7. 00	8.00	9. 00	10.00	
	Facility hours of operations (1)			_			
11. 00	CLI NI C	05: 30	08: 00	05: 30	08: 00	05: 30	11.00

Health Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 14-0161	Peri od:	Worksheet S-8	
		Component	CCN, 14 04F0	From 10/01/2022	Doto/Time Dro	namad.
		Component	CCN: 14-8650	To 09/30/2023	2/21/2024 2:0	
				RHC VIII	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	08: 00	05: 00				11. 00

Heal th	Financial Systems	SAINT JAMES	6 HOSPITAL		In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 14-0161	Peri od:	Worksheet S-8	
			Component	CCN: 14-8642	From 10/01/2022 To 09/30/2023		
					RHC I X	Cost	эт рііі
	[				1.	00	
	Clinic Address and Identification				100 DELANEY DR	1.7/5	1.00
1.00	Street		Ci	ty	State	ZIP Code	1.00
				00	2. 00	3. 00	
2.00	City, State, ZIP Code, County		EL PASO			61738	2. 00
2.00	HOCDITAL DACED FOLICE ONLY Designation Fort	"D"				1.00	2 00
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er k for rura	al or U for t		nt Award	Date	3.00
					1. 00	2.00	
	Source of Federal Funds			1			
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 8. 00	Appalachian Regional Commission Look-Alikes						7. 00 8. 00
9. 00	OTHER (SPECIFY)						9. 00
7.00	Torrier (or correspond						7.00
					1. 00	2. 00	
10. 00	Does this facility operate as other than a hyes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operation	ns in column	N	(	10.00
	Tiour 5. )	Sun	iday	l N	londay	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3. 00	4. 00	5. 00	
	Facility hours of operations (1) CLINIC	1	1	08: 00	05: 00	08: 00	11. 00
11.00	I CELINI C			06.00	05.00	06.00	11.00
					1. 00	2. 00	
12. 00 13. 00	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in colum	9, section nn 2 the	N	C	12. 00 13. 00
-				Prov	ider name	CCN	
					1.00	2. 00	
14. 00	RHC/FQHC name, CCN	\ \ \/ \/ \\	1 1/	20/11/1	VIV	T 1 1 10 11	14. 00
		Y/N 1.00	V 2. 00	3. 00	XI X 4. 00	Total Visits 5.00	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed 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)		2.00	3.00	4. 00	3.00	15. 00
				unty			
0.60	01.1. 01.1. 71.0.1. 0			00			6.55
2. 00	City, State, ZIP Code, County	Tuesday	WOODFORD Wedn	esday	Thur	sday	2. 00
		to	from	to	from	to	
		6. 00	7. 00	8.00	9. 00	10.00	
	Facility hours of operations (1)						
11. 00	CLINIC	05: 00	08: 00	05: 00	08: 00	05: 00	11. 00

Health Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider 0	CCN: 14-0161	Peri od:	Worksheet S-8	
			001 44 0740	From 10/01/2022	D 1 /T' D	
		Component	CCN: 14-8642	To 09/30/2023	2/21/2024 2:0	
				RHC IX	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	08: 00	04: 30				11. 00

Heal th	Financial Systems	SAINT JAMES	S HOSPITAL		In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 14-0161	Peri od:	Worksheet S-8	
			Component	CCN: 14-8639	From 10/01/2022 To 09/30/2023		
					RHC X	Cost	эт рііі
	·						
	01:				1.	00	
1. 00	Clinic Address and Identification Street				1231 KLEEMANN	DD	1.00
1.00	Sti ee t		Ci	tv	State	ZIP Code	1.00
				00	2.00	3. 00	
2.00	City, State, ZIP Code, County		CLINTON		IL	61727	2. 00
						4.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "D" for rurs	al or "II" for i	ırhan		1.00	3.00
3.00	THOSE THE BASED TUNES ONLY. DESIGNATION - EITE	el K loi lui a	91 01 0 101 0		nt Award	Date	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 7. 00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	U(d), PHS ACT)					6. 00 7. 00
8. 00	Look-Alikes						8.00
9. 00	OTHER (SPECIFY)						9. 00
				•			
	I= :				1.00	2. 00	
10. 00	Does this facility operate as other than a hyes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operation	ns in column	N		10.00
	induits.	Sur	nday	N	londay	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	Facility hours of operations (1) CLINIC	1	I	08: 00	04: 00	08: 00	11. 00
11.00	I CELINI C			08.00	04.00	08.00	11.00
					1. 00	2. 00	
12. 00 13. 00	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in colur	9, section nn 2 the	N	C	12. 00 13. 00
-				Prov	ider name	CCN	
					1.00	2. 00	
14. 00	RHC/FQHC name, CCN	V (N	1 1/	20/11/1	VIV	T 1 1 10 11	14. 00
		Y/N 1.00	V 2. 00	3. 00	XI X 4. 00	Total Visits 5.00	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed 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)		2.00	3.00	4.00	3.00	15. 00
				unty			
0.55				00			
2.00	City, State, ZIP Code, County	Tuocdov	DEWI TT	ocday	TL	eday	2. 00
		Tuesday to	from wean	esday to	from	sday to	
		6. 00	7. 00	8. 00	9. 00	10.00	
	Facility hours of operations (1)						
11. 00	CLINIC	04: 00	08: 00	04: 00	08: 00	04: 00	11. 00

Health Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der 0	CCN: 14-0161	Peri od:	Worksheet S-8	
				From 10/01/2022		
		Component	CCN: 14-8639	To 09/30/2023		
					2/21/2024 2:0	1 pm
				RHC X	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	08: 00	04: 00				11. 00

IOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CCN: 14-01	F	eriod: rom 10/01/2022 o 09/30/2023		pared			
					1.00				
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA								
	Uncompensated and Indigent Care Cost-to-Charge Ratio					4			
. 00	Cost to charge ratio (see instructions)				0. 240862	1.			
	Medicaid (see instructions for each line)				1	4			
. 00	Net revenue from Medicaid				3, 904, 854				
. 00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.			
. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental		edi cai	d?	Y	4.			
. 00	If line 4 is no, then enter DSH and/or supplemental payments from	Medi cai d			0				
. 00	Medi cai d charges				44, 468, 970				
. 00	Medicaid cost (line 1 times line 6)				10, 710, 885				
00	Difference between net revenue and costs for Medicaid program (see				6, 806, 031	8.			
	Children's Health Insurance Program (CHIP) (see instructions for e	each line)			T 0	9.			
00									
0.00	Stand-allone CHIP charges				0	1			
. 00									
12.00 Difference between net revenue and costs for stand-alone CHIP (see instructions)  Other state or local government indigent care program (see instructions for each line)									
					1	13.			
3. 00									
4. 00	Thanges for patients covered under state or rocal indigent care pr	rogram (Not Inci	uaea i	n Tines 6 or	0	14.			
5. 00									
6.00 Difference between net revenue and costs for state or local indigent care program (see instructions)									
	Grants, donations and total unreimbursed cost for Medicaid, CHIP a	and state/local	ndi ge	nt care program	ms (see	Ī			
7. 00	instructions for each line) Private grants, donations, or endowment income restricted to fundi	ing charity care			1 0	17.			
3. 00	Government grants, appropriations or transfers for support of hosp					1			
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local in			(sum of lines	6, 806, 031	1			
,. 00	8, 12 and 16)	nargent care pro	gi dilis	(Sam of Titles	0,000,001	' '			
		Uni nsı	ıred	Insured	Total (col. 1				
		pati e	nts	pati ents	+ col . 2)				
		1.0	0	2. 00	3.00				
	Uncompensated care cost (see instructions for each line)								
0. 00	Charity care charges and uninsured discounts (see instructions)		89, 511	· ·					
. 00	Cost of patients approved for charity care and uninsured discounts	s (see 6	71, 887	613, 035	1, 284, 922	21.			
	instructions)								
. 00	Payments received from patients for amounts previously written off	f as	0	0	0	22.			
	charity care		74 007	(40.005	4 004 000				
8. 00	Cost of charity care (see instructions)		71, 887	613, 035	1, 284, 922	23.			
					1. 00	-			
. 00	Does the amount on line 20 col. 2, include charges for patient day	vs beyond a Leng	th of	stav limit	N N	24			
- 0	imposed on patients covered by Medicaid or other indigent care pro		0.		"	1			
. 00	If line 24 is yes, enter the charges for patient days beyond the i		ogram'	s Lenath of	1 0	25			
- 0	stay limit	g oa. o pi	. J. a			-			
01	Charges for incured notiontal lightlity (and instructions)				1	ا م			

25.01

26.00

27.01

28.00

2, 644, 746

2, 467, 635

115, 122 177, 111

656, 349 29. 00 1, 941, 271 30. 00 8, 747, 302 31. 00

25.01 Charges for insured patients' liability (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

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)
28.00 Non-Medicare bad debt amount (see instructions)

Bad debt amount (see instructions)

10SPI 1	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCI	N: 14-0161	Peri od: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Pre				
				7,7 30,7 2020	2/21/2024 2: 0				
					1. 00				
	PART II - HOSPITAL DATA								
00	Uncompensated and Indigent Care Cost-to-Charge Ratio				0.470400				
00	Cost to charge ratio (see instructions)				0. 178480	1.			
00	Medicaid (see instructions for each line) 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 supplement	tal navments	from Medica	ni d?		4.			
00	If line 4 is no, then enter DSH and/or supplemental payments fi					5.			
00	Medi cai d charges					6.			
00	Medicaid cost (line 1 times line 6)					7.			
00	Difference between net revenue and costs for Medicaid program	(see instruc	tions)			8.			
	Children's Health Insurance Program (CHIP) (see instructions for	or each line	)						
00	Net revenue from stand-alone CHIP					9			
. 00	Stand-alone CHIP charges					10 11			
. 00									
00									
00	Other state or local government indigent care program (see inst Net revenue from state or local indigent care program (Not incl					   13			
00	Charges for patients covered under state or local indigent care					14			
00	10)	e program (N	ot meruded	TILLINGS 6 01		'4			
00	State or local indigent care program cost (line 1 times line 1	4)				15			
. 00									
	Grants, donations and total unreimbursed cost for Medicaid, CHI	IP and state	/local indig	gent care program	ıs (see				
	instructions for each line)					ı			
. 00	Private grants, donations, or endowment income restricted to for	•	,			17			
. 00	Government grants, appropriations or transfers for support of I					18			
. 00	Total unreimbursed cost for Medicaid , CHIP and state and local	l indigent c	are programs	s (sum of lines		19			
	[8, 12 and 16)		Uni nsured	Insured	Total (col. 1				
			patients	patients	+ col . 2)				
		Γ	1.00	2. 00	3. 00				
	Uncompensated care cost (see instructions for each line)								
00	Charity care charges and uninsured discounts (see instructions)		2, 789, 5		3, 402, 546				
00	Cost of patients approved for charity care and uninsured discou	unts (see	497, 87	72 613, 035	1, 110, 907	21			
00	instructions)	-66			0	1 22			
. 00	Payments received from patients for amounts previously written charity care	orr as			0	22			
. 00	1		497, 87	72 613, 035	1, 110, 907	23			
00	joost of chairty care (see that detrois)		477,0	013,033	1, 110, 707	23			
					1. 00				
00	Does the amount on line 20 col. 2, include charges for patient imposed on patients covered by Medicaid or other indigent care		la length of	stay limit	N	24			
00	If line 24 is yes, enter the charges for patient days beyond the stay limit		care program	n's length of	0	25			
01	Charges for insured patients' liability (see instructions)				0	25			
00	Bad debt amount (see instructions)				2, 644, 746				
. 00	Medicare reimbursable bad debts (see instructions)				115, 122				
. 01	Medicare allowable bad debts (see instructions)				177, 111				
	Non-Medicare bad debt amount (see instructions)				2, 467, 635				

2, 467, 635 28. 00

502, 412 29. 00 1, 613, 319 30. 00 1, 613, 319 31. 00

27.01 Medicare allowable bad debts (see instructions)
28.00 Non-Medicare bad debt amount (see instructions)

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

	FINANCIAL SYSTEMS	SAINI JAMES		CN: 14 01/1		Westebeet A	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Period: From 10/01/2022	Worksheet A	
					To 09/30/2023	Date/Time Pre	
				I = 1	D 1 10 11	2/21/2024 2:0	1 pm
	Cost Center Description	Sal ari es	Other		Reclassificati	Reclassified	
				+ col . 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 377, 738	1, 377, 73	8 66, 968	1, 444, 706	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		1, 077, 780			1, 117, 205	2.00
3.00	00300 OTHER CAP REL COSTS		0		o	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	315, 923	8, 817, 372	9, 133, 29	5 -112, 441	9, 020, 854	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 219, 327	13, 997, 438	15, 216, 76	5 -525, 859	14, 690, 906	5. 00
6.00	00600 MAINTENANCE & REPAIRS	255, 897	1, 209, 427			453, 827	6. 00
7.00	00700 OPERATION OF PLANT	420, 382	722, 559			1, 566, 100	1
8.00	00800 LAUNDRY & LINEN SERVICE	30, 714	135, 536			166, 663	
9.00	00900 HOUSEKEEPI NG	672, 159	117, 549			798, 739	
10.00	01000 DI ETARY	514, 258	215, 945	i .		191, 404	1
11.00	01100 CAFETERI A	1 021 040	(2.414		0 545, 708	545, 708	1
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CE & SUPPLY	1, 031, 949	62, 414			1, 115, 414	•
16. 00	01600 MEDICAL RECORDS & LIBRARY	111, 955 0	196, 013 342			373, 171 124, 238	•
17. 00	01700 SOCIAL SERVICE	0	0	i	0 619, 260	619, 260	
19. 00	01900 NONPHYSICIAN ANESTHETISTS	542, 118	0			542, 118	
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	342, 110		J 372, 11	<u>σ</u>	342, 110	17.00
30. 00	03000 ADULTS & PEDI ATRI CS	3, 753, 417	2, 602, 666	6, 356, 08	3 -653, 478	5, 702, 605	30.00
31. 00	03100 I NTENSI VE CARE UNI T	614, 830	47, 902				
43. 00	04300 NURSERY	0	0	1	0 251, 682	251, 682	1
	ANCILLARY SERVICE COST CENTERS	-					
50.00	05000 OPERATING ROOM	1, 149, 719	1, 299, 016	2, 448, 73	5 -720, 030	1, 728, 705	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 428, 657	428, 657	1
53.00	05300 ANESTHESI OLOGY	955, 544	257, 968	1, 213, 51	2 1, 127	1, 214, 639	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	561, 394	27, 687	589, 08	1 640, 791	1, 229, 872	54.00
54. 10	03630 ULTRA SOUND	284, 477	13, 946	298, 42	3, 822	302, 245	54. 10
54. 20	03440 MAMMOGRAPHY	112, 015	9, 781	121, 79	6 1, 466	123, 262	54. 20
56.00	05600 RADI 0I SOTOPE	459	201, 680	202, 13	9 6	202, 145	56.00
57.00	05700 CT SCAN	227, 559	242, 744	470, 30	3, 057	473, 360	57.00
58.00	05800 MRI	211, 717	23, 833	235, 55	0 2, 585	238, 135	58.00
60.00	06000 LABORATORY	1, 032, 581	962, 957	1, 995, 53	8 135, 830	2, 131, 368	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	138, 342	138, 34	2 0	138, 342	63.00
64.00	06400 I NTRAVENOUS THERAPY	191, 866	25, 242	217, 10	5, 452	222, 560	64. 00
65.00	06500 RESPI RATORY THERAPY	487, 099	123, 109	610, 20	8 10, 281	620, 489	65. 00
66. 00	06600 PHYSI CAL THERAPY	932, 803	29, 077	961, 88	0 8, 138	970, 018	
67. 00	06700 OCCUPATI ONAL THERAPY	241, 966	4, 537	246, 50	3 40, 805	287, 308	67. 00
68. 00	06800 SPEECH PATHOLOGY	136, 237	713			159, 645	1
69. 00	06900 ELECTROCARDI OLOGY	277, 165	12, 585			294, 484	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	123, 139	101, 370			226, 603	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	-36, 964	1		295, 121	•
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 348, 095	348, 095	
73.00	07300 DRUGS CHARGED TO PATIENTS	573, 705	3, 139, 783			3, 800, 975	
	03950 DI ABETES SERVI CES 07697 CARDI AC REHABI LI TATI ON	125, 974	1, 957			129, 624	
76. 97	07700 ALLOGENEI C HSCT ACQUISITION	96, 727 0	2, 283	1	0 446 0 0	99, 456 0	
77. 00 78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0			0	
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	<u> </u>		70.00
88. 00	08800 RURAL HEALTH CLINIC - STREATOR	3, 250, 560	1, 497, 266	4, 747, 82	6 -200, 654	4, 547, 172	88. 00
88. 01	08801 RURAL HEALTH CLINIC - PONTIAC	2, 344, 073	714, 971			2, 311, 106	1
88. 02	08802 RURAL HEALTH CLINIC - CULLOM	267, 122	133, 633			292, 140	1
88. 03	08803 RURAL HEALTH CLINIC - DWIGHT	462, 172	380, 725			629, 013	
88. 04	08804 RURAL HEALTH CLINIC - FAIRBURY	659, 383	417, 206			808, 139	
88. 05	08805 RURAL HEALTH CLINIC - MINONK	463, 636	223, 806			501, 745	
88. 06	08806 RURAL HEALTH CLINIC - FLANAGAN	347, 290	177, 931			378, 642	1
88. 07	08807 RURAL HEALTH CLINIC - REYNOLDS	1, 410, 605	676, 449			1, 463, 578	1
88. 08	08808 RURAL HEALTH CLINIC - EL PASO	703, 171	251, 911			702, 775	1
88. 09	08809 RURAL HEALTH CLINIC - CLINTON	1, 187, 343	525, 533			1, 262, 374	
90.00	09000 CLI NI C	73, 748	9, 120			84, 146	90.00
91.00	09100 EMERGENCY	2, 223, 925	2, 052, 707	4, 276, 63	2 -65, 277	4, 211, 355	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	0		0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		30, 598, 103	44, 223, 585	74, 821, 68	8 -2, 563, 413	72, 258, 275	118. 00
	NONREI MBURSABLE COST CENTERS			1			1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19, 395	10, 410				190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	161, 637	253, 693	1		2, 982, 790	
	19201 CARDI AC PHASE III	0	0	1	0 1, 189		192. 01
	19202 FUND DEVELOPMENT	23, 411	62, 899	86, 31	0 -15, 553		192. 02
	19203 PULMONARY FUNCTION	0	0		0		192. 03
192.04	19204 RESEARCH	0	0	1	0 0	0	192. 04

Heal th Financ	ial Systems	HOSPITAL In Lieu of Form CMS-				2552-10	
RECLASSI FI CAT	TION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		eri od:	Worksheet A	
					rom 10/01/2022		aarad.
				'	o 09/30/2023	Date/Time Prep 2/21/2024 2:0	
(	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
200.00	TOTAL (SUM OF LINES 118 through 199)	30, 802, 546	44, 550, 587	75, 353, 133	0	75, 353, 133	200.00

Cost Center Description	n CMS-2552-	In Lieu of Form CMS	HOSPI TAL	SAINT JAMES	alth Financial Systems
COST CENTER* DESCRIPTION		Peri od: Worksheet A			
Cost Center Description	mo Proparod				
Cost Control Description   Adjustments   Substances   Cost Acid File	ne Prepared 24 2:01 pm	2/21/2024 2			
SENTEAL SERVICE COST CENTERS			Net Expenses	Adjustments	Cost Center Description
CERTERAL SERVICE COST CENTERS   1,000   1,00					
1.00   OTOCO CAP REL COSTS-WINEL FOUR   9-69, 028   2, 086, 233			7.00	6. 00	CENEDAL CEDALCE COCT CENTEDS
2.00   0.0020   CAP REL COSTS-WALE FOULP   969, 028   2, 086, 233   4.00   0.0030   OTHER CAP REL COSTS   0.0   0.00   0.000   OTHER CAP REL COSTS   0.0   0.000   OTHER CAP REL COSTS   0.000   0.000   0.	1. (		1 304 006	_130_710	
0.0300   OTHER CAP REL COSTS	2. 0				
4.00         0.0400 [ EMPLOYER ERWEFT TS DEPARTMENT         -3.3, 35.2         8, 99.7, 90.2           5.00         0.0500 [AUNI NISTRATI VE & GENERAL         -4.6, 30.9, 60.8         10, 05.2, 238           6.00         0.0500 [AUNI NISTRATI VE & GENERAL         -4.6, 30.9, 60.8         1, 565, 799           8.00         0.0800 [AUNISER SEPI NIK         0         1, 565, 799           9.00         0.00         0.00 [AUNISER SEPI NIK         2, 44           11.00         0.00         0.00 [AUNISER SEPI NIK         2, 44           11.00         0.00 [AUNISER SEPI NIK         2, 44           11.00         0.00 [AUNISER NIK ARMINI STRATI ON         8.70, 349           14.00         0.00 [AUNISER SEPI NIK SEPI	3. 0		· · · · · · · · · · · · · · · · · · ·		, , , , , , , , , , , , , , , , , , ,
0.00   00000   MAINTERNANCE & REPAIRS   -20, 392   433, 435   8.00   00800   LAURRY & LINEN SERVICE   0   166, 663   9.00   00900   CHANTON OF PELANT   -3040   191, 053   9.00   00900   CAFFERRY   -346   191, 053   9.00   00900   CAFFERRY   -346   191, 053   9.00   00900   CAFFERRY   -346   -191, 053   9.00   00900   CAFFERRY   -346   -460   9.00   00900   CAFFERRY   -347   -346   -460   9.00   00900   CAFFERRY   -347   -347   -348   9.00   00900   CAFFERRY   -347   -348   -348   9.00   00900   CAFFERRY   -347   -348   -348   9.00   00900   CAFFERRY   -347   -348   -348   9.00   00900   CAFFERRY   -348   -348   -348   -348   -348   -348   -348   9.00   00900   CAFFERRY   -348   -348   -348   -348   -348   -348   -348   9.00   00900   CAFFERRY   -348   -34	4. 0		8, 987, 502	-33, 352	1 1
0.000   00000   MAINTERNANCE & REPAIRS   -20, 392   433, 435   8.00   00800   LAUNDRY & LINEN SERVICE   0   166, 663   9.00   00900   CAPTERE   191, 055   9.00   00900   CAP	5. 0		10, 052, 238	-4, 638, 668	00 00500 ADMINISTRATIVE & GENERAL
9. 00   00900   LAUNDRY & LINEN SERVICE   0   166, 663   191, 058	6.0			-20, 392	00 00600 MAINTENANCE & REPAIRS
9.00   0.0900   HOUSEKEEPING   0   798, 739   11.00   0.0000   DETARY   3.44   191, 0.058   11.00   0.1100   CAFETERI A   1.14, 222   396, 486   1.100   0.1000   UNISN INS ADMINISTRATION   870, 349   1.985, 763   1.995, 763	7. 0		1, 565, 798	-302	00   00700   OPERATION OF PLANT
10.00   01000   DIETARY	8. 0			-	
11.00   01100   CAFETERI	9. 0			- 1	
13.00   01300 NURSING ADMINISTRATION	10.0				1
14. 00	11. 0				, , , , , , , , , , , , , , , , , , ,
16.00   01600   MEDICAL RECORDS & LIBRARY   67.775   192.013   190.00   170.00   1	13.0		· · · · · · · · · · · · · · · · · · ·		, , , , , , , , , , , , , , , , , , ,
17. 0.0 0 17700 SOCI AL SERVICE	14. (			- 1	1
19.00   01900   NONPHYSIC LAN ANESTHETI STS   -542, 118   0	16. 0				
INPATIENT ROUTINE SERVICE COST CENTERS   31.00   03100   ADULTS & PEDIATRIC S   0   676, 382   31.00   03100   NUTSIN VE CARE UNI T   0   676, 382   321, 300   04300   NUTSIN VE CARE UNI T   0   251, 682   321, 300   04300   NUTSIN VE CARE UNI T   0   251, 682   321, 300   04300   NUTSIN VE CARE UNI T   0   251, 682   321, 300   04300   OPERATINE ROOM   0   1, 728, 705   321, 322   321, 321   321, 321   321, 321   321, 321   321, 321   321, 321, 321   321, 321, 321, 321, 321, 321, 321, 321,	17. 0 19. 0				1 1
30. 00   30000 ADULTS & PEDI ATRI CS   -1,822,277   3,880,328   31. 00   3100   NITENSI VE CARE UNIT   0   251,682	19.0		U	-342, 110	
31.00   0.3100   INTERSIVE CASE UNIT   0   676, 382   251, 682	30.0		3 880 328	-1 822 277	
A3. 00   O4300   O4300   O4300   O4300   O4300	31.0				1 1
ANCIL LARY SERVICE COST CENTERS	43. 0				1 1
50.00   05000   0FEATH INC ROOM			== 17 = 2=	-1	
53. 00       05300 ANESTHESI OLOGY       -877, 298       337, 341         54. 00       03600 RADI OLOGY DIAGNOSTI C       -31, 417       1, 198, 455         54. 10       03630 ULTRA SOUND       0       302, 245         54. 20       03440 MAMMOGRAPHY       0       123, 262         57. 00       05500 CRD (SOUT) CT SCAN       0       202, 145         60. 00       05000 MRI       0       238, 135         60. 00       06000 LABORATORY       -8,773       2, 122, 595         64. 00       06400 JITRAVENOUS THERAPY       0       222, 560         65. 00       06500 RESPIRATORY THERAPY       0       222, 560         66. 00       06600 PHYSI CAL THERAPY       -59, 272       910, 746         66. 00       06600 PHYSI CAL THERAPY       -59, 272       910, 746         67. 00       06700 OCCUPATI ONAL THERAPY       -59, 272       910, 746         68. 00       08600 SPEECH PATHOLOGY       -2, 100       292, 384         69. 00       08900 ELECTROCARDI OLLOGY       -2, 100       292, 384         71. 00       07000 DILOLE SUPPLIES CHARGED TO PATIENTS       0       368, 095         73. 00       07000 DIMPL. DEV. CHARGED TO PATIENTS       0       3,86, 095         76. 07	50. 0		1, 728, 705	0	
5.4. 00 05400 RADI OLOGY-DI ACNOSTI C -31, 417 1, 1.98, 455 4, 10 03630 ULTRA SOUND 0 302, 245 54. 10 03630 ULTRA SOUND 0 123, 262 56. 00 05600 RADI OI SOTOPE 0 0 202, 145 57. 00 05700 CT SCAN 0 473, 360 58. 00 05800 MRI 0 238, 135 50. 00 05800 MRI 0 238, 135 50. 00 05800 MRI 0 238, 135 50. 00 05800 LABORATORY -8, 773 2, 122, 595 63. 00 06300 LABORATORY 0 138, 342 64. 00 06400 INTRAVENOUS THERAPY 0 222, 560 65. 00 06500 PHYSI CAL THERAPY 0 222, 560 66. 00 06600 PHYSI CAL THERAPY 0 522, 560 66. 00 06600 PHYSI CAL THERAPY 9 7. 00 620, 489 66. 00 06600 PHYSI CAL THERAPY 876 288, 184 68. 00 06500 SPEECH PATHOLOGY 486 160, 131 67. 00 06700 OCCUPATI ONAL THERAPY 876 288, 184 68. 00 06500 SPEECH PATHOLOGY 486 160, 131 67. 00 07000 ELECTROCARDI OLOGY 7 2, 100 292, 384 70. 00 07000 PLECTROCARDI OLOGY 7 2, 100 292, 384 70. 00 07000 PLECTROCARDI OLOGY 7 2, 100 292, 384 70. 00 07000 PLECTROCARDI OLOGY 9 226, 603 70. 00 07000 PLECTROCARDI OLOGY 10 PATIENTS 0 256, 121 72. 00 07200 IMPL DEV CHARGED TO PATIENTS 0 348, 095 71. 00 0700 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 348, 095 71. 00 0700 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 348, 095 71. 00 0700 DELOG CARREED TO PATIENTS 0 348, 095 71. 00 0700 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 348, 095 71. 00 0700 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 348, 095 71. 00 07000 CAL T-CELL IMMUNOTHERAPY 0 0 292, 506 71. 00 07000 CAL T-CELL IMMUNOTHERAPY 0 0 0 0 00 07000 CAL T-CELL IMMUNOTHERAPY 0 0 0 0 00 07000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 00 07000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 00 07000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 00 07000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 00 07000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 00 07000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 00 07000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 00 07000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 00 07000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 00 07000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 00 07000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 00 07000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 00 00 00 00 00 00 00 00 00 0	52.0			0	.00 05200 DELIVERY ROOM & LABOR ROOM
5.4. 1.0   0.33.63   ULTRA SOUND   0   302. 245   5.6. 0.0   0.3440   MAMMOGRAPHY   0   123. 262   5.6. 0.0   0.5600   RADI OI SOTOPE   0   202. 145   5.7. 0.0   0.5700   CT SCAN   0   473. 360   5.8. 0.0   0.5800   MRI   0   2.38. 135   6.0. 0.0   0.0000   LABORATORY   -8, 773   2, 122. 595   6.0. 0.0   0.0000   LABORATORY   -8, 773   2, 122. 595   6.0. 0.0   0.0000   LABORATORY   -8, 773   2, 122. 595   6.0. 0.0   0.0000   LABORATORY   0   133. 342   6.0. 0.0   0.0000   LABORATORY   -8, 773   2, 122. 595   6.0. 0.0   0.0000   LABORATORY   140. 0   133. 342   6.0. 0.0   0.0000   RESPIRATORY   140. 0   0.0000   6.0. 0.0   0.0000   RESPIRATORY   140. 0   0.0000   6.0. 0.0   0.0000   RESPIRATORY   140. 0   6.0. 0.0   0.0000   0.0000   140. 0   6.0. 0.0   0.0000   0.0000   140. 0   6.0. 0.0   0.0000   0.0000   140. 0   6.0. 0.0   0.0000   0.0000   140. 0   6.0. 0.0   0.0000   0.0000   140. 0   6.0. 0.0   0.0000   0.0000   140. 0   6.0. 0.0   0.0000   0.0000   140. 0   71. 0.0   0.0000   0.0000   140. 0   71. 0.0   0.0000   0.0000   0.0000   71. 0.0   0.0000   0.0000   72. 0.0   0.0000   0.0000   73. 0.0   0.0000   0.0000   74. 0.0   0.0000   0.0000   75. 0.0   0.0000   0.0000   76. 0.0   0.0000   0.0000   77. 0.0   0.0000   0.0000   78. 0.0   0.0000   0.0000   79. 0.0   0.0000   79. 0.0   0.0000   0.0000   79. 0.0   0.0000	53. 0		337, 341	-877, 298	. 00 05300 ANESTHESI OLOGY
54. 20	54. 0		1, 198, 455	-31, 417	. 00   05400   RADI OLOGY-DI AGNOSTI C
56 00   05600 RADIOI SOTOPE   0   202, 145	54. 1		302, 245	0	. 10   03630   ULTRA SOUND
57.00   05700   CT SCAN   0   473, 360   58.00   05800   MRI   0   0   238, 135   58.00   05800   MRI   0   0   238, 135   58.00   05800   MRI   0   0   222, 595   63.00   05800   MRI   0   0   222, 595   64.00   05800   NTRAVENOUS THERAPY   0   0   620, 489   66.00   06600   PHYSI CAL THERAPY   0   0   620, 489   66.00   06600   PHYSI CAL THERAPY   876   288, 184   68.00   06800   PHYSI CAL THERAPY   876   288, 184   68.00   06800   SPEECH PATHOLOGY   486   160, 131   69.00   6900   ELECTROCARDI OLOGY   2-1, 100   292, 384   70.00   07000   ELECTROCARDI OLOGY   2-1, 100   292, 384   70.00   07000   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   295, 121   70.00   70.00   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   295, 121   70.00   70.00   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   295, 121   70.00   70.00   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   3, 800, 975   70.00   70.00   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   3, 800, 975   70.00   70.00   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   3, 800, 975   70.00   70.00   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   295, 121   70.00   70.00   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   295, 506   70.00   70.00   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   295, 506   70.00   70.00   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   295, 506   70.00	54. 2		123, 262	0	. 20 03440 MAMMOGRAPHY
58. 00   0500   MR    0   0500   LABORATORY   -8,773   2,122,595   0   0500   CASPIRIOR, PROCESSI NG & TRANS.   0   138,342   0   0   0   0   0   0   0   0   0	56.0			0	
60.00   06000   LABORATORY   -8,773   2,122,595	57.0			-1	
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0   138, 342     64.00   06400   INTRAVENOUS THERAPY   0   222, 560     65.00   06500   RESPIRATORY THERAPY   0   620, 489     66.00   06600   PHYSI CAL THERAPY   759, 272   910, 746     67.00   06700   06CUPATIONAL THERAPY   876   288, 184     68.00   06800   SPEECH PATHOLOGY   486   160, 131     69.00   06900   ELECTROCARDI OLOGY   -2, 100   292, 384     69.00   06900   ELECTROCARDI OLOGY   -2, 100   292, 384     71.00   07700   ELECTROCROEPHALOGRAPHY   0   226, 603     71.00   07700   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   295, 121     72.00   07300   ORUGE CHARGED TO PATIENTS   0   348, 095     73.00   07300   DRUGE CHARGED TO PATIENTS   0   3, 800, 975     76.00   03950   DIABETES SERVICES   0   129, 624     76.97   07697   CARDI AC REHABILITATION   -6, 950   92, 506     07700   ALLOGENEIC HSCT ACQUISITION   0   0     07700   07700   ALLOGENEIC HSCT ACQUISITION   0   0     07700   07700   ALLOGENEIC CHARCED TO PATIENTS   0   3, 800, 975     88.00   08800   RURAL HEALTH CLINIC - STREATOR   209, 321   4, 756, 493     88.01   08801   RURAL HEALTH CLINIC - PONTIAC   103, 505   2, 414, 611     88.02   08802   RURAL HEALTH CLINIC - FUNITAC   103, 505   2, 414, 611     88.03   08802   RURAL HEALTH CLINIC - FUNITAC   103, 505   2, 414, 611     88.04   08804   RURAL HEALTH CLINIC - FUNITAC   103, 505   2, 414, 611     88.05   08805   RURAL HEALTH CLINIC - FLANAGAN   0   501, 745     88.06   08806   RURAL HEALTH CLINIC - FLANAGAN   0   378, 642     88.07   08807   RURAL HEALTH CLINIC - EL PASO   0   702, 775     88.09   08808   RURAL HEALTH CLINIC - EL PASO   0   702, 775     88.00   08809   RURAL HEALTH CLINIC - EL PASO   0   702, 775     88.00   08809   RURAL HEALTH CLINIC - EL PASO   0   702, 775     88.00   08809   RURAL HEALTH CLINIC - EL PASO   0   702, 775     88.00   08809   RURAL HEALTH CLINIC - EL PASO   0   702, 775     88.00   08909   RURAL HEALTH CLINIC - EL PASO   0   702, 775     88.00   09900   0EL RURA   HEALTH CLINIC - EL PASO   0   702, 77	58. 0			-1	
64.00   06400   INTRAVENOUS THERAPY   0   620, 489   65.00   06500   RESPI RATORY THERAPY   0   620, 489   66.00   06600   PHYSI CAL THERAPY   -59, 272   910, 746   67.00   06600   PHYSI CAL THERAPY   876   288, 184   68.00   06800   SPEECH PATHOLOGY   486   160, 131   69.00   06900   ELECTROCARDI OLOGY   -2, 100   292, 384   70.00   07000   ELECTROENCEPHALOGRAPHY   0   226, 603   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   348, 095   73.00   07300   DRUGS CHARGED TO PATIENTS   0   348, 095   73.00   07300   DRUGS CHARGED TO PATIENTS   0   3, 800, 975   76.00   03950   DI ABETES SERVI CES   0   129, 624   76.07   07697   CARDI AC REHABILITATION   -6, 950   92, 506   77.00   07700   ALLOGENEI C HSCT ACQUISITION   0   0   78.00   07800   CAR T-CELL I IMMUNOTHERAPY   0   0   78.00   07800   CAR T-CELL I IMMUNOTHERAPY   0   0   78.00   07800   CAR T-CELL I IMMUNOTHERAPY   0   0   78.01   08801   RURAL HEALTH CLINIC - STREATOR   209, 321   4, 756, 493   78.01   08801   RURAL HEALTH CLINIC - DWI GHT   30, 303   659, 316   78.02   08802   RURAL HEALTH CLINIC - DWI GHT   30, 303   659, 316   78.04   08804   RURAL HEALTH CLINIC - DWI GHT   30, 303   659, 316   78.05   08805   RURAL HEALTH CLINIC - FLANAGAN   0   378, 642   78.06   08806   RURAL HEALTH CLINIC - FLANAGAN   0   378, 642   78.07   08807   RURAL HEALTH CLINIC - FLANAGAN   0   378, 642   78.08   08808   RURAL HEALTH CLINIC - FLANAGAN   0   378, 642   78.09   08809   RURAL HEALTH CLINIC - FLANAGAN   0   378, 642   78.09   08809   RURAL HEALTH CLINIC - FLANAGAN   0   378, 642   78.09   08809   RURAL HEALTH CLINIC - FLANAGAN   0   378, 642   79.00   09000   CLINIC   0   84, 146   79.00   09000   CLINIC	60.0				1 1
65.00   06500   RESPI RATORY THERAPY   0   620, 489   66.00   06600   PHYSI CAL THERAPY   -59, 272   910, 746   67.00   06700   0CCUPATI ONAL THERAPY   876   288, 184   68.00   06800   SPECH PATHOLOGY   486   160, 131   69.00   06900   ELECTROCARDIOLOGY   -2, 100   292, 384   70.00   07000   ELECTROCROCEPHALOGRAPHY   0   226, 603   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   295, 121   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   348, 095   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   348, 095   74.00   07300   DRUGS CHARGED TO PATI ENTS   0   129, 624   76.97   07697   CARDI AC REHABI LITATI ON   -6, 950   92, 506   77.00   07690   CAR T-CELL   IMMUNOTHERAPY   0   0   007800   CAR T-CELL   IMMUNOTHERAPY   0   0   00TRATT ENT SERVI CE COST CENTERS  88.00   08800   RURAL HEALTH CLINIC - STREATOR   209, 321   4, 756, 493   88.01   08801   RURAL HEALTH CLINIC - PONTI AC   103, 505   2, 414, 611   88.02   08802   RURAL HEALTH CLINIC - DWIGHT   30, 303   659, 316   88.04   08804   RURAL HEALTH CLINIC - DWIGHT   30, 303   659, 316   88.04   08806   RURAL HEALTH CLINIC - DWIGHT   30, 303   659, 316   88.04   08806   RURAL HEALTH CLINIC - FLANAGAN   0   501, 745   88.05   08805   RURAL HEALTH CLINIC - FLANAGAN   0   378, 642   88.07   08807   RURAL HEALTH CLINIC - FLANAGAN   0   378, 642   88.09   08808   RURAL HEALTH CLINIC - EL PASO   0   702, 775   88.09   08808   RURAL HEALTH CLINIC - EL PASO   0   702, 775   88.09   08808   RURAL HEALTH CLINIC - EL PASO   0   702, 775   88.09   08809   RURAL HEALTH CLINIC - EL PASO   0   702, 775   88.09   08809   RURAL HEALTH CLINIC - EL PASO   0   702, 775   88.09   08809   RURAL HEALTH CLINIC - EL PASO   0   702, 775   88.09   08809   RURAL HEALTH CLINIC - EL PASO   0   702, 775   88.09   08809   RURAL HEALTH CLINIC - EL PASO   0   702, 775   88.09   08809   RURAL HEALTH CLINIC - EL PASO   0   702, 775   88.09   08809   RURAL HEALTH CLINIC - EL PASO   0   702, 775   88.09   08809   RURAL HEALTH CLINIC - EL PASO   0   702, 775   88.09   09900   OUTO	63.0				·
66.00   06600   PHYSI CAL THERAPY   -59, 272   910, 746   67.00   06700   0CUPATI ONAL THERAPY   876   288, 184   68.00   06800   SPEECH PATHOLOGY   486   160, 131   69.00   06900   ELECTROCARDI OLOGY   -2, 100   292, 384   70.00   07000   ELECTROENCEPHALOGRAPHY   0   226, 603   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   295, 121   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   3.48, 095   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   3.48, 095   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   3.800, 975   76.00   03950   DI ABETES SERVI CES   0   129, 624   76.97   07697   CARDI AC REHABI LITATI ON   -6, 950   92, 506   77.00   07700   ALLOGENEI C HSCT ACQUI SITION   0   0   0   0   0   0   0   0   0	64. 0			0	
67. 00   06700   0CCUPATI ONAL THERAPY   876   288, 184   68. 00   06800   SPEECH PATHOLOGY   486   160, 131   69. 00   06900   ELECTROCARDI OLOGY   -2, 100   292, 384   70. 00   07000   ELECTROCARDI OLOGY   0   226, 603   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   0   295, 121   72. 00   07200   MPLD DEV. CHARGED TO PATI ENTS   0   348, 095   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   348, 095   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   3, 800, 975   76. 90   07390   DRUGS CHARGED TO PATI ENTS   0   129, 624   76. 97   07697   CARDI AC REHABI LI TATI ON   -6, 950   92, 506   77. 00   07700   ALLOGENEI C HSCT ACQUI SI TI ON   0   0   0   0   0   0   0   0   0	65. 0 66. 0			EQ 272	1 1
68. 00	67.0				
69. 00   06900   ELECTROCARDI OLOGY   -2, 100   292, 384   70. 00   07000   ELECTROCREPHALOGRAPHY   0   226, 603   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   295, 121   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   348, 095   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   3, 800, 975   76. 00   03950   DI ABETES SERVI CES   0   129, 624   76. 97   07697   CARDI AC REHABI LI TATI ON   -6, 950   92, 506   77. 00   07700   ALLOGENEI C HSCT ACQUI SI TI ON   0   0   0   0   0   0   0   0   0	68.0				
70. 00	69.0				
71. 00	70.0				
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   348, 095   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   3, 800, 975   76. 00   03950   DI ABETES SERVICES   0   129, 624   76. 97   07697   CARDIAC REHABILITATION   -6, 950   92, 506   07700   ALLOGENEIC HSCT ACQUISITION   0   0   0   0   0   0   0   0   0	71. 0			- 1	
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   3,800,975   76. 00   03950   DI ABETES SERVI CES   0   129,624   76. 97   77697   CARDI AC REHABI LI TATI ON   -6,950   92,506   77. 00   07700   ALLOGENEI C HSCT ACQUI SI TI ON   0   0   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0    00   00   0   0   0    00   00   0	72. 0			- 1	1 1
76. 00 03950 DI ABETES SERVI CES 76. 97 07697 CARDI AC REHABI LI TATI ON -6, 950 92, 506 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 78. 00 07800 CAR T -CELL IMMUNOTHERAPY 0 0 0  OUTPATI ENT SERVI CE COST CENTERS  88. 00 08800 RURAL HEALTH CLINI C - STREATOR 209, 321 4, 756, 493 88. 01 08801 RURAL HEALTH CLINI C - PONTI AC 103, 505 2, 414, 611 88. 02 08802 RURAL HEALTH CLINI C - CULLOM 0 292, 140 88. 03 08803 RURAL HEALTH CLINI C - DWI GHT 30, 303 659, 316 88. 04 08804 RURAL HEALTH CLINI C - FAI RBURY 33, 723 841, 862 88. 05 08805 RURAL HEALTH CLINI C - FIANGAN 0 501, 745 88. 06 08806 RURAL HEALTH CLINI C - FIANGAN 0 378, 642 88. 07 08807 RURAL HEALTH CLINI C - FEANGAN 0 378, 642 88. 08 08808 RURAL HEALTH CLINI C - REYNOLDS -9, 561 1, 454, 017 88. 08 08808 RURAL HEALTH CLINI C - EL PASO 0 702, 775 88. 09 08809 RURAL HEALTH CLINI C - CLINTON 0 1, 262, 374 90. 00 09000 CLINI C 0 84, 146 91. 00 09100 EMERGENCY -1, 388, 343 2, 823, 012 00100 OPSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	73. 0				
77. 00	76. 0		129, 624	0	. 00 03950 DI ABETES SERVI CES
78. 00	76. 9		92, 506	-6, 950	. 97   07697   CARDI AC REHABI LI TATI ON
SECTION   SECT	77. 0		0	0	1 1
88. 00	78. 0		0	0	
88. 01					
88. 02	88. 0				
88. 03	88. 0				
88. 04	88. 0			-1	
88. 05	88. 0 88. 0				1 1
88. 06	88.0				
88. 07	88.0			- 1	, , , , , , , , , , , , , , , , , , ,
88. 08	88. 0			-1	1 1
88. 09	88.0				
90. 00	88. 0			- 1	
91. 00	90.0			ol n	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	91. 0			-1, 388, 343	
OTHER REIMBURSABLE COST CENTERS	92. 0				
102. UU 1020U UT UID IKEAIWENI PKUUKAW UU U	102. 0		0	0	2.00 10200 OPIOID TREATMENT PROGRAM
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1 through 117) -7, 423, 329 64, 834, 946	118. 0		64, 834, 946	-7, 423, 329	
NONREI MBURSABLE COST CENTERS					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 40, 122	190. 0			- 1	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 2, 982, 790	192. 0			0	
192. 01 19201 CARDI AC PHASE I I I 0 1, 189	192. (			O	1 1
192. 02 19202 FUND DEVELOPMENT 0 70, 757	192. (			0	1 1
192. 03 19203 PULMONARY FUNCTION 0 0	192. (		0	0	1 1
192.04 19204 RESEARCH 0 0 0 200.00 TOTAL (SUM OF LINES 118 through 199) -7,423,329 67,929,804	192. 0 200. 0		67 920 904	-7 422 220l	1 1
200. 00	<sub>1</sub> 200. (		01,727,004	-1,423,329	0.00   TOTAL (300 OF LINES 110 LITOUGH 199)

Health Financial Systems RECLASSIFICATIONS Provider CCN: 14-0161

Cost Center   Li ne # Sal ary Other   2.00   3.00   4.00   5.00	
2.00 3.00 4.00 5.00	
1. 00 OTHER CAP REL COSTS 3. 00 0 106, 393	1.00
2. 00 0 0 0 0 0 0 0	2.00
3.00 0.00 0	3.00
4.00 0.00 0	4.00
5. 00	5. 00
0 0 106, 393	
B - CAFETERIA - DIETARY	1.00
1. 00   CAFETERI A	
C - REHAB ADMIN	
1. 00 OCCUPATI ONAL THERAPY 67. 00 25, 486 2, 142	1.00
2. 00 SPEECH PATHOLOGY 68. 00 14, 160 1, 190	
0 39, 646 3, 332	
D - NON-ALLOWABLE CARDIAC PHASE III COST	
1. 00   CARDIAC PHASE	
0 1, 162 27 E - IMPLANT DEVICE	
1. 00 IMPL. DEV. CHARGED TO 72. 00 0 348, 095	1.00
PATI ENTS	1.00
2.00 0.00 0	2. 00
3.00 0.00 0	3.00
4.00 0.00 0	4.00
5.000000	5. 00
0 0 348,095 F - MED SUPPLIES CHARGED TO PATIENTS	
1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 429, 134	1.00
PATI ENT	1.00
0 — — — — — — — — — — — — 429, 134	
G - DRUGS CHARGED TO PATIENTS	
1. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 4, 763	1.00
2.00 0.00 0	· ·
3.00 4.00 0.00 0 0	3. 00 4. 00
5.00	5. 00
0	
I - ALTERNATI VE BIRTHING CTR	
1. 00 NURSERY 43. 00 237, 830 13, 852	
2. 00 DELIVERY ROOM & LABOR ROOM 52. 00 405, 064 23, 593	
0 642, 894 37, 445	
J - HTM SERVI CE COST  1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 633, 400	1.00
2. 00 LABORATORY 60. 00 122, 012	
3. 00 OPERATION OF PLANT 7. 00 0 441, 920	
0	
K - MINISTRY ALLOCATION	
1. 00 MAINTENANCE & REPAIRS 6. 00 0 182, 397	
2. 00   SOCI AL SERVI CE   17. 00   619, 260	
3. 00 PHYSI CAL THERAPY 66. 00 0 37, 672 4. 00 OCCUPATI ONAL THERAPY 67. 00 0 9, 654	3. 00 4. 00
5. 00 SPEECH PATHOLOGY 68. 00 0 5, 364	5.00
6. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 75, 016	
7. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 351, 700	
0 1, 281, 063	
L - CONTRACT ADMIN FEES	
1.00   CENTRAL SERVI CE & SUPPLY   14.00   0   63,699	
TOTALS 0 63, 699 M - OSFMG HOSPI TALI ST AND PALL	
1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 10,098	1.00
2. 00 ADULTS & PEDIATRICS 30. 00 19, 618 0	
0 19,618 10,098	
N - STD & OTHER BENEFITS	
1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 1 0	
2.00 ADMINISTRATIVE & GENERAL 5.00 17,778 0	· ·
3. 00 MAINTENANCE & REPAIRS 6. 00 3, 438 0	
4.00 OPERATION OF PLANT 7.00 5,648 1,798 5.00 LAUNDRY & LINEN SERVICE 8.00 413 0	4. 00 5. 00
6. 00 HOUSEKEEPING 9. 00 9, 031 0	6.00
7. 00 DI ETARY 10. 00 6, 909 0	7.00
8. 00 NURSING ADMINISTRATION 13. 00 21, 850 0	8.00
9.00 CENTRAL SERVI CE & SUPPLY 14.00 1,504 0	9.00
10. 00 ADULTS & PEDIATRICS 30. 00 63, 553 4, 280	
11. 00   INTENSIVE CARE UNIT 31. 00 13, 650 0	
12. 00   OPERATI NG ROOM   50. 00   26, 654   682	12.00

Health Financial Systems RECLASSIFICATIONS Peri od: From 10/01/2022 To 09/30/2023 Date/Ti me Prepared: 2/21/2024 2:01 pm Provider CCN: 14-0161

					2/21/2024 2:	O1 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
10.00	2. 00	3.00	4.00	5. 00		10.00
13.00	ANESTHESI OLOGY	53.00	20, 122	0		13. 00
14. 00	RADI OLOGY-DI AGNOSTI C	54.00	7, 543	3, 896		14. 00
15. 00	ULTRA SOUND	54. 10	3, 822	0		15. 00
16. 00 17. 00	MAMMOGRAPHY	54. 20 56. 00	1, 505	0		16.00
18.00	RADI OI SOTOPE CT SCAN	56. 00 57. 00	3, 057	705		17. 00 18. 00
19. 00	MRI	58. 00	2, 844	703		19. 00
20. 00	LABORATORY	60.00	13, 873	0		20.00
21. 00	I NTRAVENOUS THERAPY	64.00	5, 452	o		21. 00
22. 00	RESPIRATORY THERAPY	65. 00	10, 281	0		22. 00
23. 00	PHYSI CAL THERAPY	66.00	13, 006	Ö		23. 00
24. 00	OCCUPATI ONAL THERAPY	67. 00	3, 251	Ō		24. 00
25. 00	SPEECH PATHOLOGY	68. 00	1, 830	0		25. 00
26.00	ELECTROCARDI OLOGY	69. 00	4, 874	0		26. 00
27.00	ELECTROENCEPHALOGRAPHY	70. 00	2, 094	0		27. 00
28.00	DRUGS CHARGED TO PATIENTS	73. 00	7, 708	0		28. 00
29.00	DI ABETES SERVI CES	76.00	1, 693	0		29. 00
30.00	CARDIAC REHABILITATION	76. 97	1, 300	0		30. 00
31.00	RURAL HEALTH CLINIC -	88. 00	43, 672	0		31. 00
	STREATOR					
32. 00	RURAL HEALTH CLINIC -	88. 01	31, 493	0		32. 00
22.00	PONTI AC	00.00	2 500	0		22.00
33. 00	RURAL HEALTH CLINIC - CULLOM	88. 02	3, 589	0		33. 00
34. 00	RURAL HEALTH CLINIC - DWIGHT	88. 03	6, 209	0		34. 00
35. 00	RURAL HEALTH CLINIC - FAIRBURY	88. 04	8, 859	0		35. 00
36. 00	RURAL HEALTH CLINIC - MINONK	88. 05	6, 229	0		36. 00
37. 00	RURAL HEALTH CLINIC -	88. 06	4, 666	0		37. 00
07.00	FLANAGAN	00.00	1, 000	J		07.00
38.00	RURAL HEALTH CLINIC -	88. 07	18, 952	1, 980		38. 00
	REYNOLDS					
39. 00	RURAL HEALTH CLINIC - EL	88. 08	9, 447	0		39. 00
	PAS0					
40. 00	RURAL HEALTH CLINIC -	88. 09	15, 952	0		40. 00
41. 00	CLI NTON CLI NI C	90.00	1, 278	0		41. 00
42.00	EMERGENCY	91.00	49, 483	0		42.00
43. 00	GIFT, FLOWER, COFFEE SHOP &	190.00	586	0		43. 00
43.00	CANTEEN	170.00	300	J		43.00
44.00	PHYSICIANS' PRIVATE OFFICES	192. 00	2, 632	0		44. 00
45.00	FUND DEVELOPMENT	192. 02	315	0		45. 00
	0		478, 052	13, 341		
	O - MINISTRY OSFMG					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	976, 221		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00	•	0.00	0	0		5. 00
6. 00 7. 00		0. 00 0. 00	o	0		6. 00 7. 00
8. 00		0.00	0	0		8. 00
9. 00		0.00	0	0		9. 00
10. 00		0.00	Ö	0		10.00
11. 00		0.00	o	0		11. 00
12. 00		0.00	o	0		12. 00
13.00		0.00	0	0		13. 00
	0		0	976, 221		
	P - PHYSICIAN EXPENSE					
1.00	ADULTS & PEDIATRICS	3000	6 <u>2, 5</u> 00	0		1. 00
	0		62, 500	0		
1 00	Q - FOUNDATION EXPENSE	// 0.5	اء	04.1		1 00
1.00	PHYSI CAL THERAPY	66.00	0	911		1.00
2.00	OCCUPATI ONAL THERAPY	67.00	0	272		2.00
3.00	SPEECH PATHOLOGY	68. 00 76. 97	0	151 335		3. 00 4. 00
4. 00 5. 00	CARDIAC REHABILITATION GIFT, FLOWER, COFFEE SHOP &	76. 97 190. 00	ν V	10, 057		5. 00
5.00	CANTEEN	170.00	٩	10, 037		3.00
6.00	PHYSICIANS' PRIVATE OFFICES	192. 00	o	4, 142		6. 00
7. 00	FUND DEVELOPMENT	192. 02	ol	3, 795		7. 00
				19, 663		
	R - MEDICAL RECORDS & LIBRARY	′				
1.00	MEDICAL RECORDS & LIBRARY	1600	0	12 <u>3, 8</u> 96		1. 00
	0		0	123, 896		

Health Financial Systems

RECLASSIFICATIONS

SAINT JAMES HOSPITAL

Provider CCN: 14-0161

Period:
From 10/01/2022
To 09/30/2023 Date/Time Prepared:

					To 09/30/2023 Date/Time Pre	pared: 1 pm
		Increases		•		
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4.00	5. 00		
	T - CABLE TV					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	26, 803	3	1. 00
2.00		0. 00	0	0		2.00
	TOTALS		0	26, 803	3	
	U - NON-ALLOWABLE RHC					
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	1, 813, 406	778, 259		1. 00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
	TOTALS		1, 813, 406	778, 259		
500.00	Grand Total: Increases		3, 441, 602	5, 580, 948	3	500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 14-0161

						2.	/21/2024 2:01 pm
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	65, 500	0		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	11	0		2. 00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	6, 849			3.00
4.00	ADMI NI STRATI VE & GENERAL	5.00	0	12, 297	l 1		4. 00
5. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00		2 <u>1, 7</u> 36			5. 00
	D CAFETERIA DIETARY		0	106, 393			
1. 00	B - CAFETERIA - DIETARY DIETARY	10.00	384, 324	161, 384	O		1.00
1.00	0		384, 324	161, 384			1.00
	C - REHAB ADMIN		304, 324	101, 304			
1.00	PHYSI CAL THERAPY	66.00	39, 646	3, 332	O		1. 00
2. 00	THISTORE MEIONI	0.00	37, 040	0, 332			2. 00
2.00			39, 646	$\frac{3}{3,332}$			2.00
	D - NON-ALLOWABLE CARDI AC PHA	SE III COST	077010	0,002			
1.00	CARDI AC REHABI LI TATI ON	76. 97	1, 162	27	0		1.00
			1, 162	<sub>27</sub>			
	E - IMPLANT DEVICE		, ,				
1.00	OPERATING ROOM	50.00	0	313, 237	0		1.00
2.00	EMERGENCY	91.00	0	961	0		2. 00
3.00	ELECTROCARDI OLOGY	69. 00	0	140	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	407	0		4. 00
5.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	33, 350	0		5. 00
	PATI ENT						
	0		0	348, 095			
	F - MED SUPPLIES CHARGED TO P.						
1. 00	OPERATI NG ROOM	50.00	•	429, 134			1.00
	0		0	429, 134			
	G - DRUGS CHARGED TO PATIENTS						
1.00	OPERATING ROOM	50.00	0	4, 258	0		1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	152	0		2. 00
3.00	MAMMOGRAPHY	54. 20	0	39			3. 00
4.00	MRI	58.00	0	259			4. 00
5. 00	LABORATORY	60.00		55			5. 00
	I - ALTERNATIVE BIRTHING CTR		UU	4, 763			
1. 00	ADULTS & PEDIATRICS	30.00	642, 894	37, 445	ol		1. 00
2.00	ADOLIS & FEDIATRICS	0.00	042, 074	37, 443	0		2.00
2.00			642, 894				2.00
	J - HTM SERVICE COST		042, 074	37, 443			
1.00	MAINTENANCE & REPAIRS	6.00	0	1, 197, 332	0		1. 00
2. 00	and the same of the same	0.00	o	0	o		2.00
3. 00		0.00	o	0	o		3. 00
				1, 197, 332			
	K - MINISTRY ALLOCATION		<u> </u>	· · ·	1		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 281, 063	0		1. 00
2.00		0.00	o	0	o		2. 00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4. 00
5.00		0.00	0	0	0		5. 00
6.00		0.00	0	0	0		6. 00
7. 00		0.00	0_	0	0		7. 00
	0		0	1, 281, 063			
	L - CONTRACT ADMIN FEES		1				
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	63, 699	0		1.00
	PATI ENT	+		— <u>, , , , , , , , , , , , , , , , , , ,</u>	<del> </del>		
	TOTALS		0	63, 699			
4 00	M - OSFMG HOSPITALIST AND PAL			00.747			4.00
1.00	ADULTS & PEDIATRICS	30.00	0	29, 716	l .		1.00
2.00		0.00	•	0	0		2. 00
	O		0	29, 716			
1 00	N - STD & OTHER BENEFITS  EMPLOYEE BENEFITS DEPARTMENT	4 00	315, 880	150 2/0	ol		1 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL	4. 00 5. 00	315, 880	158, 360 1, 394			1.00
3.00	OPERATION OF PLANT	7. 00	1, 798	1, 394	l 1		3.00
4.00	NURSING ADMINISTRATION	13. 00	1, 790	799	- 1		4. 00
5.00	ADULTS & PEDIATRICS	30.00	4, 280	765			5. 00
6. 00	OPERATING ROOM	50.00	682	55			6. 00
7. 00	RADI OLOGY-DI AGNOSTI C	54.00	3, 896	0			7. 00
8. 00	CT SCAN	57.00	705	0			8. 00
9. 00	PHYSI CAL THERAPY	66.00	703	473			9. 00
10. 00	RURAL HEALTH CLINIC -	88. 07	1, 980	0	l .		10.00
	REYNOLDS		.,	· ·			121.00
	'		'				•

In Lieu of Form CMS-2552-10

Provider CCN: 14-0161

						2/21/2024 2	
		Decreases				I	
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
11 00	6. 00	7. 00 190. 00	8. 00	9. 00	10. 00		11.00
11. 00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	۷	326	Ü		11. 00
12.00	OANTEEN	0.00	o	0	0		12. 00
13. 00		0.00	o	0	0	1	13.00
14.00		0.00	o	0	0		14. 00
15.00		0.00	0	0	0		15. 00
16.00		0.00	О	0	0		16. 00
17.00		0.00	0	0	0		17. 00
18.00		0.00	0	0	0	1	18. 00
19. 00		0. 00	0	0	0	1	19. 00
20. 00		0. 00	0	0	0	1	20. 00
21. 00		0.00	0	0	0	1	21. 00
22. 00		0.00	0	0	0		22. 00
23. 00 24. 00		0. 00 0. 00	0	0	0	•	23. 00 24. 00
25. 00		0.00	0	0	0	1	25. 00
26. 00		0.00	0	0	0	•	26. 00
27. 00		0.00	0	o	0	1	27. 00
28. 00		0.00	o	Ö	0		28. 00
29. 00		0.00	o	0	0		29. 00
30.00		0.00	o	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0	1	32. 00
33. 00		0. 00	0	0	0	1	33. 00
34. 00		0. 00	0	0	0		34.00
35.00		0.00	0	0	0	1	35. 00
36.00		0.00	0	0	0	1	36.00
37. 00		0. 00 0. 00	0	0	0	1	37. 00
38. 00 39. 00		0.00	0	0	0	1	38. 00 39. 00
40. 00		0.00	0	0	0	•	40.00
41. 00		0.00	0	Ö	0	1	41. 00
42. 00		0.00	o	Ö	0	•	42. 00
43.00		0.00	O	0	0		43.00
44.00		0.00	О	0	0		44. 00
45.00		0.00	0	0	0		45. 00
	0		329, 221	162, 172			
	O - MINISTRY OSFMG						
1.00	ADULTS & PEDIATRICS	30.00	0	87, 922	0		1.00
2.00	ANESTHESI OLOGY	53.00	0	18, 995	0	•	2.00
3. 00	RURAL HEALTH CLINIC - STREATOR	88. 00	0	244, 326	0		3. 00
4.00	EMERGENCY	91.00	o	113, 799	0		4. 00
5. 00	RURAL HEALTH CLINIC -	88. 01	o	144, 933	0	•	5. 00
	PONTI AC		-	,	_		
6.00	RURAL HEALTH CLINIC - CULLOM	88. 02	o	19, 093	0		6. 00
7.00	RURAL HEALTH CLINIC - DWIGHT	88. 03	0	33, 736	0		7. 00
8.00	RURAL HEALTH CLINIC -	88. 04	0	36, 922	0		8. 00
	FAI RBURY						
9.00	RURAL HEALTH CLINIC - MINONK	88. 05	0	30, 393	0	1	9.00
10. 00	RURAL HEALTH CLINIC - FLANAGAN	88. 06	U	24, 360	0		10. 00
11. 00	RURAL HEALTH CLINIC -	88. 07	0	99, 553	0		11. 00
11.00	REYNOLDS	00.07	ď	77, 333	O		11.00
12.00	RURAL HEALTH CLINIC - EL	88. 08	o	40, 628	0		12. 00
	PAS0			,			
13.00	RURAL HEALTH CLINIC -	88. 09	0	81, 561	0		13. 00
	CLINTON						
	0		0	976, 221			_
1 00	P - PHYSICIAN EXPENSE	F 00	(0.500			I	4 00
1. 00	ADMI NI STRATI VE & GENERAL		6 <u>2, 5</u> 00	0	0		1. 00
	O FOUNDATION EXPENSE		62, 500	U			$\perp$
1. 00	Q - FOUNDATION EXPENSE FUND DEVELOPMENT	192. 02	O	19, 663	0		1.00
2. 00	I OND DEVELOTIVILIVI	0.00	0	17, 003	0	1	2. 00
3. 00		0.00	0	0	0	1	3. 00
4. 00		0.00	0	0	0	1	4. 00
5. 00		0.00	Ö	Ö	0	1	5. 00
6. 00		0.00	ō	Ō	0	1	6. 00
7. 00		0.00	o	0	0		7. 00
	0 — — — — —		<u> </u>	19, 663			

| Period: | Worksheet A-6 | From 10/01/2022 | To 09/30/2023 | Date/Time Prepared: Health Financial Systems RECLASSIFICATIONS SAINT JAMES HOSPITAL Provider CCN: 14-0161

						To 09/30/2023	Date/Time Prepared: 2/21/2024 2:01 pm
		Decreases					2,21,2021 2101 8
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00	1	
	R - MEDICAL RECORDS & LIBRARY						
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	123, 896			1. 00
	0		0	123, 896			
	T - CABLE TV						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2, 394	C	)	1.00
2.00	OPERATION OF PLANT	7.00	0	<u> </u>			2. 00
	TOTALS		0	26, 803			
	U - NON-ALLOWABLE RHC						
1.00	RURAL HEALTH CLINIC -	88. 01	475, 615	158, 883	C		1.00
	PONTI AC						
2.00	RURAL HEALTH CLINIC - CULLOM	88. 02	63, 415	29, 696		)	2. 00
3.00	RURAL HEALTH CLINIC - DWIGHT	88. 03	101, 751	84, 606		)	3. 00
4.00	RURAL HEALTH CLINIC -	88. 04	147, 675	92, 712	C	)	4. 00
	FAI RBURY						
5.00	RURAL HEALTH CLINIC - MINONK	88. 05	111, 798	49, 735		)	5. 00
6. 00	RURAL HEALTH CLINIC -	88. 06	87, 345	39, 540	C	)	6. 00
	FLANAGAN				_		
7. 00	RURAL HEALTH CLINIC -	88. 07	392, 553	150, 322	C	)	7. 00
0.00	REYNOLDS	00.00	1/5 14/	FF 000			0.00
8. 00	RURAL HEALTH CLINIC - EL PASO	88. 08	165, 146	55, 980	C	)	8. 00
9. 00	RURAL HEALTH CLINIC -	88. 09	268, 108	116, 785			9. 00
9.00	CLINTON	00.09	200, 100	110, 703		<b>'</b>	9.00
	TOTALS	+	1, 813, 406		<del> </del>	+	
500 00	Grand Total: Decreases		3, 273, 153	5, 749, 397		+	500.00
300.00	prand rotar. Decreases	I	3, 273, 133	5, 147, 371	1		500.00

				T	09/30/2023	Date/Time Pre	
						2/21/2024 2:0	1 pm
			ъ . Т	Acqui si ti ons	T	D: 1	
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances	2.00	3. 00	4. 00	Retirements 5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	1.00	2.00	3.00	4.00	5.00	
1. 00	Land	600, 013	٥		0	0	1. 00
2.00		1	U	0	0	0	
3.00	Land Improvements	2, 301, 596	772 0/4	0	772.074	0	2.00
	Buildings and Fixtures	38, 997, 628	773, 864	0	773, 864	0	3. 00
4.00	Building Improvements	7, 095	1 120 774	0	1 120 774	214 0(0	4. 00
5.00	Fi xed Equi pment	23, 848, 989	1, 130, 774	0	1, 130, 774	214, 060	
6.00	Movable Equipment	7, 528	0	0	0	0	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	65, 762, 849	1, 904, 638	0	1, 904, 638	214, 060	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10. 00	Total (line 8 minus line 9)	65, 762, 849	1, 904, 638	0	1, 904, 638	214, 060	10. 00
		Endi ng Bal ance	Fully				
			Depreciated				
			Assets				
	DART I ANALYGIC OF QUANGES IN CARLTAL ACCE	6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						4 00
1.00	Land	600, 013	0				1. 00
2.00	Land Improvements	2, 301, 596	0				2. 00
3.00	Buildings and Fixtures	39, 771, 492	0				3. 00
4.00	Building Improvements	7, 095	0				4. 00
5.00	Fixed Equipment	24, 765, 703	0				5. 00
6.00	Movable Equipment	7, 528	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	67, 453, 427	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	67, 453, 427	0				10. 00

Heal th	Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 14-0161	Peri od:	Worksheet A-7	
					From 10/01/2022 To 09/30/2023		nared·
					10 077 007 2020	2/21/2024 2:0	1 pm
			Sl	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
						instructions)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORL	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FLXT	1, 377, 738	0	1	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 077, 780	0	)	0 0	0	2. 00
3.00	Total (sum of lines 1-2)	2, 455, 518	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	1, 377, 738				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 077, 780				2. 00
3.00	Total (sum of lines 1-2)	o	2, 455, 518	1			3. 00
				•			•

Heal th	n Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 10/01/2022 To 09/30/2023	Date/Time Pre	pared:
		COMI	 PUTATION OF RAT	TINS	ALLOCATION OF	2/21/2024 2: 0° OTHER CAPITAL	I pm
		COM	TOTALION OF ICA	1103	ALLOCATION OF	OTHER CALLIAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col			
		4.00	0.00	2)	4.00	F 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	1. 00	2.00	3.00	4. 00	5. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	42, 080, 182		42, 080, 18	2 0. 629440	41, 228	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24, 773, 230		24, 773, 23			2.00
3.00	Total (sum of lines 1-2)	66, 853, 412	l .	66, 853, 41			3.00
0.00	Trotal (Sam of Trillos 1 2)		TION OF OTHER (			F CAPITAL	0.00
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART III DECONOLITATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CE			// 0/	0 1 220 020	0	1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FLXT CAP REL COSTS-MVBLE EQUIP	25, 740 15, 153		66, 96 39, 42			1. 00 2. 00
3. 00	Total (sum of lines 1-2)	40, 893		106, 39			3.00
3.00	Total (suil of Titles 1-2)	40, 673		JMMARY OF CAPI		U	3.00
			30	DIVINANT OF CALL	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
	DART III DECONOLITATION OF CARLTY COOTS OF	11. 00	12. 00	13. 00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS 0	41 220	25.74		1 204 004	1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXI	0	41, 228 24, 272			1, 304, 996 2, 086, 233	1. 00 2. 00
3.00	Total (sum of lines 1-2)		65, 500				
3.00	Total (Sum Of Titles 1-2)	1	1 05, 500	1 40, 09	J <sub> </sub> 0	3, 371, 229	3.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 14-0161 

Expense Classification on Worksheet A						Го 09/30/2023	Date/Time Prep 2/21/2024 2:0	
Cost Center Description   Sesis/Costs (2)   Amount   Cost Center   Line # (Not) A-7 Set					Expense Classification on	Worksheet A	2/21/2024 2.0	Гріп
1.00   Investment Income								
1.00   Investment Income								
1.00   Investment Income								
1.00   Investment Income								
Triving   Triv		Cost Center Description						
COSIS-BLIC & FITX (Chapter 2)   CAP REL COSTS-MANELE EQUIP   2 00   0 2 00   0 3 0	1 00		1. 00					
Investment Income = CAP RTL   COSTS-MUNIE FOULP   2.00   0.2.00   0.2.00   0.3.00   0.4.00   0.5.00	1.00			0	CAP REL COSTS-BLDG & FIXI	1.00	0	1. 00
3. 00   Investment Finceme - other (chapter 2)   0   0   0   0   0   0   0   0   0	2.00			0	CAP REL COSTS-MVBLE FOULP	2.00	0	2. 00
Chapter 2)  (Chapter 2)  (Chapter 3)  (Chapter 4)  (Chapter 4)  (Chapter 5)  (Chapter 7)  (Chapter 7)  (Chapter 2)  (Chapter 7)  (Chapter 8)  (Chapter 7)  (Chapter 7)  (Chapter 7)  (Chapter 7)  (Chapter 8)  (Chapter 8)  (Chapter 8)  (Chapter 8)  (Chapter 8)  (Chapter 8)  (Chapter 9)  (Chapter 8)  (Chapter 9)  (Chapter 9)  (Chapter 1)  (Chapter 2)  (Chapter 1)  (Chapter 2)  (Chapter 1)  (Chapter 1)  (Chapt				_				
1.00   Contract (Indighter 1)   Contract (Indighter 2)   Contracts (Indighter 3)   Contracts (	3.00			0		0.00	0	3. 00
discounts (Chapter 8)	4 00			0		0.00		4 00
Refunds and robates or expenses (chapter 8)	4.00			Ü		0.00	٩	4.00
Sental of provider space by   0   0.00   0.60   0.00   0.70   0.00   0.70   0.00   0.70   0.00   0.70   0.00   0.70   0.00   0.70   0.00   0.70   0.00   0.00   0.70   0.00   0.70   0.00   0.70   0.00   0.70   0.00   0.70   0.00   0.70   0.00   0.70   0.70   0.00   0.70   0	5.00			0		0.00	О	5.00
Suppliers (chapter 8)								
Telephone services (pay stations excluded) (chapter 21)   Stations excluded) (chapter 22)   Stations excluded) (chapter 23)   Stations excluded) (chapter 24)   Stations exclu	6. 00			0		0.00	0	6. 00
Stations excluded) (chapter 21)	7 00			0		0.00	0	7 00
1-devision and radio service (Chapter 21)	7.00			· ·		0.00		7. 00
(chapter 21) 10.00 Provider-based physician A-8-2 -4,100,972 10.00 Provider-based physician A-8-2 -4,100,972 11.00 Sale of Scrap, waste, etc. (Chapter 23) 12.00 Chapter 23) 13.00 Chapter 23) 14.00 Cafeteria-employees and guests B -143,060 CAFETERIA 11.00 014.00 14.00 Cafeteria-employees and guests B -143,060 CAFETERIA 11.00 015.00 15.00 Renta of quarters to employee and others 16.00 Sale of nedical records and abstracts 18.00 Sale of nedical records and B -80 MEDICAL RECORDS & LIBRARY 16.00 018.00 17.00 patients 18.00 Sale of nedical records and B -80 MEDICAL RECORDS & LIBRARY 16.00 018.00 19.00 Catalogue 10.00 00 00 00 00 00 00 00 00 00 00 00 00								
Parking   of (chapter 21)   A-8-2   -4,100,972   -30   0.00   0	8. 00		A	-33, 636	ADMINISTRATIVE & GENERAL	5. 00	0	8. 00
10.00   Provider-based physician   A-8-2   -4,100,972   0   10.00   0   11.00   12.00   12.00   12.00   12.00   12.00   13.00   13.00   13.00   14.0	9 00			0		0.00	0	9 00
adjustment   10.0   Sale of Scrap, waste, etc.   0   0.00   0.11.00   0.00   0.11.00   0.00   0.11.00   0.12.00   0.12.00   0.12.00   0.12.00   0.12.00   0.12.00   0.13.00   0.14.00   0.14.00   0.14.00   0.14.00   0.14.00   0.14.00   0.14.00   0.14.00   0.14.00   0.14.00   0.14.00   0.14.00   0.14.00   0.14.00   0.14.00   0.14.00   0.14.00   0.15.00			A-8-2	-4, 100, 972		0.00	· ·	
Chapter 23)   Chapter 23)   Chapter 24)   Chapter 28								
12.00   Related organization   12.00   Transactions (Chapter 10)   13.00   Laundry and I linen service   0   0   0   0   0   13.00   15.00	11. 00			0		0.00	0	11. 00
transactions (chapter 10)	12 00		Λ_Q_1	_208_628			0	12 00
13.00   Laundry and I linen service   0   0   0   13.00   15	12.00		A-0-1	-270, 020			Ĭ	12.00
15.00   Rental of quarters to employee and others   0   0.00   0   15.00   0   15.00   0   16.00   0   16.00   0   16.00   0   16.00   0   17.00   0   17.00   0   17.00   0   18.00   0   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   0   18.00   0   18.00   0   18.00   0   18.00   0   18.00   0   0   18.00   0   18.00   0   19.00   0   19.00   0   19.00   0   0   19.00   0	13.00			0		0.00	0	13.00
and others				-143, 060	CAFETERI A		_	
16.00   Sale of medical and surgical supplies to other than patients   0   0.00   0.	15. 00			0		0.00	0	15. 00
Supplies to other than   Datients	16 00			0		0.00	0	16 00
17. 00   Sale of drugs to other than patients   0   0.00	10.00			0		0.00	Ĭ	10.00
patients								
18.00   Sale of medical records and abstracts   19.00   20.0	17. 00			0		0.00	0	17. 00
abstracts	18 00	1.	B	-80	MEDICAL RECORDS & LIBRARY	16 00	0	18 00
education (tuition, fees, books, etc.)   20.00   Vending machines   B	10.00			00	WEDI ONE RECORDS & ELBRART	10.00	Ĭ	10.00
Dooks, etc.)   Vending machines   B   Continues   B   Continues   B   Continues   B   Continues   Co	19. 00			0		0.00	O	19.00
20.00   Vending machines   B   -6.162/CAFETERIA   11.00   0.20.00								
21.00   Income from imposition of interest, finance or penalty charges (chapter 21)   Interest, finance or penalty charges (chapter 21)   Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments   A-8-3   ORESPIRATORY THERAPY   A-8-3   ORESPIRATO	20.00		R	-6 162	CAFETERIA	11 00	0	20.00
Interest, finance or penalty charges (chapter 21)   22.00   Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments   23.00   Adjustment for respiratory therapy costs in excess of   Iimitation (chapter 14)   24.00   Adjustment for physical therapy costs in excess of   Iimitation (chapter 14)   25.00   Depreciation - CAP REL   A   162,477 CAP REL COSTS-BLDG & FIXT   1.00   9 26.00							-	
1		interest, finance or penalty						
overpayments and borrowings to repay Medicare overpayments  23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)  24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)  25.00 Utilization review - physicians' compensation (chapter 21)  26.00 Depreciation - CAP REL A 162,477 CAP REL COSTS-BLDG & FIXT 1.00 9 26.00 COSTS-BLDG & FIXT 1.00 9 27.00 CAP REL COSTS-BLDG & FIXT 1.00 9 27.00 9 27.00 CAP REL COSTS-BLDG & FIXT 1.00 9 27.00 9 27.00 CAP REL COSTS-BLDG & FIXT 1.00 9 27.00 9 27.00 CAP REL COSTS-BLDG & FIXT 1.00 9 27.00 9 27.00 Physicians' assistant 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.0							_	
Page   Medicare overpayments   A-8-3   ORESPIRATORY THERAPY	22. 00			0		0.00	0	22. 00
23.00   Adjustment for respiratory therapy costs in excess of limitation (chapter 14)   Adjustment for physical therapy costs in excess of limitation (chapter 14)   Adjustment for physical therapy costs in excess of limitation (chapter 14)   Adjustment for physical therapy costs in excess of limitation (chapter 14)   O*** Cost Center Deleted ***   114.00   25.00								
I imitation (chapter 14)	23.00		A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)  25.00 Utilization review - physicians' compensation (chapter 21)  26.00 Depreciation - CAP REL COSTS-BLDG & FIXT  27.00 Depreciation - CAP REL A 162,477 CAP REL COSTS-BLDG & FIXT  28.00 Non-physician Anesthetist A 197,200 CAP REL COSTS-MVBLE EQUIP 2.00 9 27.00 COSTS-MVBLE EQUIP 2.00 0 0.0								
therapy costs in excess of limitation (chapter 14)  25.00 Utilization review - physicians' compensation (chapter 21)  26.00 Depreciation - CAP REL	24 00		Λοο	^	DHVSICAL THEDADV	44 00		24 00
1 imitation (chapter 14)   Utilization review -	∠4. UU		H-0-3	0	THISICAL INERAPT	00.00		∠4. UU
physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		limitation (chapter 14)						
Chapter 21)   Depreciation - CAP REL   A   162,477 CAP REL COSTS-BLDG & FIXT   1.00   9 26.00	25. 00			0	*** Cost Center Deleted ***	114.00		25. 00
26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 9 26. 00 COSTS-BLDG & FIXT 1.00 9 26. 00 COSTS-BLDG & FIXT 1.00 9 26. 00 COSTS-BLDG & FIXT 1.00 9 27. 00 9 27. 00 COSTS-BLDG & FIXT 1.00 9 27. 00 9 27. 00 COSTS-BLDG & FIXT 1.00 9 27. 00 COSTS-BLDG & FIXT 1.00 9 27. 00 9 27. 00 Physicians and sexists and 1.00 Physicians and 1.								
COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist A -542, 118 NONPHYSICIAN ANESTHETISTS 19. 00 29. 00 Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest  A 197, 200 CAP REL COSTS-MVBLE EQUIP 2. 00 9 27. 00 28. 00 9 27. 00 28. 00 0 00 0 00 0 00 0 29. 00 0 00 0 00 0 29. 00 0 00 0 30. 00	26. 00		A	162. 477	CAP REL COSTS-BLDG & FLXT	1.00	9	26, 00
COSTS-MVBLE EQUIP  28.00 Non-physician Anesthetist A -542, 118 NONPHYSICIAN ANESTHETISTS 19.00 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest  A -542, 118 NONPHYSICIAN ANESTHETISTS 19.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	_5.00		'	.52, 111		1.30	[	_2. 00
28.00 Non-physician Anesthetist A -542, 118 NONPHYSICIAN ANESTHETISTS 19.00 29.00 29.00 Physicians' assistant 0.00 0 29.00 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest	27. 00		A	197, 200	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest	20 00			E40 110	NONDHYSI CLANLANESTHETI STS	10.00		20 00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest  A-8-3  OCCUPATIONAL THERAPY  67.00  30.00			A	-54∠, I18 ∩	INCINELLE SI CLAIN AINES HELLS 15		۸	
therapy costs in excess of   i mit tati on (chapter 14)			A-8-3	0	OCCUPATIONAL THERAPY			
30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest  OADULTS & PEDIATRICS 30. 00  SPEECH PATHOLOGY 68. 00 31. 00 0 0 0 0 0 32. 00		therapy costs in excess of		_				
instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest	20.00			=	ADULTO A DEDLATRICO	22.55		20.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest  A-8-3 OSPEECH PATHOLOGY 68.00 31.00 0.00 0.00 0.00 0.00 0.00	30. 99			0	NADULIS & PEDIATRICS	30.00		30. 99
pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest	31. 00		A-8-3	n	SPEECH PATHOLOGY	68.00		31. 00
32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest		pathology costs in excess of		0		33.30		50
Depreciation and Interest	00							00.5-
	32. 00			0		0.00	이	32. 00
	33. 00		В	-346	DI ETARY	10.00	n	33. 00
		,	- 1	3.0	1		١	

Provider CCN: 14-0161 Peri od: Worksheet A-8 From 10/01/2022 To 09/30/2023 Date/Time Prepared:

					09/30/2023	Date/Time Prep 2/21/2024 2:0	
				Expense Classification on	Worksheet A	2/21/2024 2.0	ı piii
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	·	1.00	2.00	3.00	4. 00	5. 00	
34.00	LOBBYING DUES	А	-18, 804	ADMINISTRATIVE & GENERAL	5. 00	0	34. 00
35.00	EMPLOYEE HEALTH	A	-9, 269	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
36.00	MEDICAL TRANSPORTATION	В	-32, 042	EMERGENCY	91.00	0	36.00
	SERVI CES						
37.00	LAB NON PATIENT CARE	В	-805	LABORATORY	60.00	0	37.00
38. 00	CARDI AC REHAB	В	-6, 950	CARDIAC REHABILITATION	76. 97	0	38. 00
39. 00	CRNA PART B BENEFITS	A	-85, 716	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39. 00
39. 01	EMPLOYEE BENEFIT PART B -	A	-149, 385	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39. 01
	SALARI ED						
40.00	HOSPITAL ADMIN - FARM INCOME	В	-37, 000	ADMINISTRATIVE & GENERAL	5. 00	0	40.00
41.00	RENTAL INCOME AND OTHER	В	-13, 900	ADMINISTRATIVE & GENERAL	5. 00	0	41.00
42.00	PENSION COST	A	141, 108	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42.00
43.00	OTHER REVENUE - RHC	В	-8, 481	RURAL HEALTH CLINIC -	88. 00	0	43.00
				STREATOR			
44.00	DI ABETES SERVI CES	В		DI ABETES SERVI CES	76. 00	0	44.00
45.00	OTHER REVENUE - PT	В	-62, 691	PHYSI CAL THERAPY	66. 00	0	45. 00
46.00	MEDICALD ASSESSMENT TAX	A	-2, 761, 004	ADMINISTRATIVE & GENERAL	5. 00	0	46. 00
	EXPENSE						
47.00	REVENUE CYCLE ADMINISTRATION	В		ADMINISTRATIVE & GENERAL	5. 00	0	47.00
49.00	RECRUI TI NG	A	-2, 257	ADMINISTRATIVE & GENERAL	5. 00	0	49. 00
49. 01	RECRUI TI NG	A	-17, 888	ADULTS & PEDIATRICS	30.00	0	49. 01
49. 02	RECRUI TI NG	A	-400	ELECTROCARDI OLOGY	69. 00	0	49. 02
49. 03	RECRUI TI NG	A		LABORATORY	60.00	0	49. 03
49. 04	RECRUI TI NG	A	-1, 000	EMERGENCY	91.00	0	49. 04
49. 05	RECRUI TI NG	A	-2, 400	RURAL HEALTH CLINIC -	88.00	0	49. 05
				STREATOR			
49.06	RECRUI TI NG	A	-9, 561	RURAL HEALTH CLINIC -	88. 07	0	49. 06
				REYNOLDS			
49. 07	MARKETING & ADVERTISING	A		ADULTS & PEDIATRICS	30. 00	0	49. 07
49. 08	OUTSIDE TRAINING SESSION	A		EMERGENCY	91. 00	0	49. 08
49. 09	MALPRACTICE INSURANCE	A	-23, 100	ADMINISTRATIVE & GENERAL	5. 00	0	49. 09
49. 10	STREATOR RHC- MISSING SALARIES	A	220, 202	RURAL HEALTH CLINIC -	88. 00	0	49. 10
				STREATOR			
49. 11	PONTIAC RHC- MISSING SALARIES	A	103, 505	RURAL HEALTH CLINIC -	88. 01	0	49. 11
				PONTI AC			
49. 12	DWIGHT RHC- MISSING SALARIES	Α		RURAL HEALTH CLINIC - DWIGHT	88. 03	0	49. 12
49. 13	FAIRBURY RHC- MISSING SALARIES	A	33, 723	RURAL HEALTH CLINIC -	88. 04	0	49. 13
				FAI RBURY			
49. 14	RHC MISSING BENEFITS	A	69, 910	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	49. 14
49. 15	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	49. 15
	(3)						
49. 16	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	49. 16
	(3)		_			_	
49. 17	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 17
40.55	(3)		=			_	40.10
49. 18	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	49. 18
40.40	(3)		_		0.00		40 40
49. 19	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	49. 19
40.00	(3)		_		2 22	_	40.00
49. 20	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	49. 20
50. 00	(3) TOTAL (sum of lines 1 thru 49)		7 400 000				EO 00
SU. UU	(Transfer to Worksheet A,		-7, 423, 329				50. 00
	column 6, line 200.)						
	COTAINITO, TITLE 200.)			0110 0 1 15 1			L

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0161

Peri od: Worksheet A-8-1 From 10/01/2022

OTTTOL	00313			Го 09/30/2023	Date/Time Pre 2/21/2024 2:0	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	. p
				Allowable Cost	Included in	
				,	Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	MINISTRY CHG - BLDG	311, 241	613, 428	1.00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	MINISTRY CHG - EQUIPMENT	771, 828	0	2.00
3.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY CHG - POOLED EB	351, 700	351, 700	3.00
3. 01	5. 00	ADMINISTRATIVE & GENERAL	MINISTRY CHG - POOLED A&G	3, 133, 577	6, 650, 724	3. 01
3.02	6. 00	MAINTENANCE & REPAIRS	MINISTRY CHG - POOLED ENGINE	182, 397	182, 397	3. 02
3.03	66. 00	PHYSI CAL THERAPY	MINISTRY CHG - POOLED REHAB	41, 091	37, 672	3. 03
3.04	67. 00	OCCUPATIONAL THERAPY	MINISTRY CHG - POOLED REHAB	10, 530	9, 654	3.04
3.05	68. 00	SPEECH PATHOLOGY	MINISTRY CHG - POOLED REHAB	5, 850	5, 364	3. 05
3.07	73. 00	DRUGS CHARGED TO PATIENTS	MINISTRY CHG - POOLED PHARMA	75, 016	75, 016	3. 07
3.08	5. 00	ADMINISTRATIVE & GENERAL	MINISTRY CHG - MINISTRY ALLO	987, 081	987, 081	3. 08
3.09	5. 00	ADMINISTRATIVE & GENERAL	MINISTRY CHG - FUNCTIONAL RE	4, 192, 646	2, 770, 261	3.09
3. 10	16. 00	MEDICAL RECORDS & LIBRARY	MINISTRY CHG - FUNCTIONAL ME	191, 751	123, 896	3. 10
4.00	13. 00	NURSING ADMINISTRATION	MINISTRY CHG - FUNCTIONAL NU	900, 944	0	4.00
4. 01	17. 00	SOCIAL SERVICE	MINISTRY CHG - FUNCTIONAL CA	640, 666	619, 260	4. 01
4. 02	5. 00	ADMINISTRATIVE & GENERAL	MINISTRY CHARGES - CARE HUB	390, 463	O	4. 02
4.04	6. 00	MAINTENANCE & REPAIRS	PCI HTM - ENGINEERING	421, 528	441, 920	4.04
4. 05	54. 00	RADI OLOGY-DI AGNOSTI C	PCI HTM - IMAGING	604, 173	633, 400	4. 05
4.06	60.00	LABORATORY	PCI HTM - LABORATORY	116, 382	122, 012	4.06
4. 07	5. 00	ADMINISTRATIVE & GENERAL	SFI / PCI CREDENTIALING	48, 687	48, 687	4. 07
4.08	54. 00	RADI OLOGY-DI AGNOSTI C	SFI / PCI EQUIP TECH	3, 209	5, 399	4. 08
4. 09	7. 00	OPERATION OF PLANT	SFI / PCI BIO MED	1, 268	1, 570	4. 09
4. 10	5. 00	ADMINISTRATIVE & GENERAL	MANAGEMENT SVCS- OSFMSG	1, 274, 601	1, 274, 601	4. 10
4. 11	5. 00	ADMINISTRATIVE & GENERAL	PURCHASED SVCS- ST GABRIEL	515, 809	517, 024	4. 11
4. 12	0.00			o	O	4. 12
4. 13	0.00			o	O	4. 13
4. 14	0.00			o	O	4. 14
4. 15	0.00			o	0	4. 15
4. 16	0.00			0	O	4. 16
5.00	TOTALS (sum of lines 1-4).			15, 172, 438	15, 471, 066	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					
* Tho	amounts on lines 1 4 (and sub	ecripte as appropriato) are t	transformed in detail to Works	shoot A column	6 lines as	

\* 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.

1105 1101	been posted to norksheet 71,	cordinas i dia, or 2, the diada	it dironabio sii	oura be indicated in corumn i	or time part.	
				Related Organization(s) and/	or Home Office	
	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 RELAT	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 ci ilibai	Sement ander the Aviii.					
6.00	В	OSF HEALTHCARE SYSTEM	100.00	OSF HEALTHCARE	100.00	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) 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.

OTTTOL	00010				To 09/30/2023	Date/Time Pro 2/21/2024 2:0	epared:
	Net	Wkst. A-7 Ref.				2,21,202121	, p
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			ENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED OF	RGANIZATIONS OR (	CLAI MED	
	HOME OFFICE CO						
1.00	-302, 187						1. 00
2.00	771, 828	9					2. 00
3.00	0	1 -1					3. 00
3. 01	-3, 517, 147	0					3. 01
3.02	0	0					3. 02
3.03	3, 419	0					3. 03
3.04	876						3. 04
3.05	486	0					3. 05
3.07	0	0					3. 07
3.08	0	0					3. 08
3.09	1, 422, 385	0					3. 09
3. 10	67, 855	11					3. 10
4.00	900, 944	11					4. 00
4.01	21, 406	0					4. 01
4.02	390, 463	o					4. 02
4.04	-20, 392	o					4. 04
4.05	-29, 227						4. 05
4.06	-5, 630	o					4. 06
4.07	0						4. 07
4.08	-2, 190	o					4. 08
4.09	-302	o					4. 09
4. 10	l 0	0					4. 10
4. 11	-1, 215	0					4. 11
4. 12	0						4. 12
4. 13	0	0					4. 13
4. 14	0	0					4. 14
4. 15	0	0					4. 15
4. 16	0	1					4. 16
5.00	-298, 628						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 RELAT	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	CATHOLIC SYSTEM	6.00
7.00		7.00
8. 00 9. 00		8.00
9.00		9.00
10. 00		10.00
100.00		100.00

- (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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0161

Peri od: Worksheet A-8-2 From 10/01/2022

09/30/2023 Date/Time Prepared: 2/21/2024 2:01 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er ider Component Remuneration Component Component Hours 7.00 1. 00 2.00 3. 00 4.00 5. 00 6. 00 1.00 5. 00 ADMINISTRATIVE & GENERAL 211, 500 1.00 32, 340 32, 340 0 2.00 13. 00 NURSI NG ADMI NI STRATI ON 30, 595 30, 595 0 0 2.00 3.00 30. 00 ADULTS & PEDIATRICS 1, 803, 974 1, 803, 974 197, 500 0 3.00 4.00 53. 00 ANESTHESI OLOGY 991, 680 877, 298 114, 382 239, 400 1, 084 4.00 60. 00 LABORATORY 5.00 1, 338 1, 338 0 260, 300 0 5.00 69. 00 ELECTROCARDI OLOGY 6.00 1,700 1, 700 260, 300 0 6.00 0 7.00 91. 00 EMERGENCY 1, 353, 727 1, 353, 727 0 211, 500 7.00 0 8.00 0.00 8.00 0 0 9.00 0.00 9.00 10.00 0.00 0 10.00 4, 215, 354 4, 100, 972 114, 382 1,084 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of 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 5. 00 ADMINISTRATIVE & GENERAL 1. 00 1.00 0 0 2.00 13. 00 NURSING ADMINISTRATION 0 0 0 0 2.00 3.00 30. 00 ADULTS & PEDIATRICS 0 0 0 3.00 0 0 4.00 53. 00 ANESTHESI OLOGY 6, 238 0000000 4.00 124, 764 60. 00 LABORATORY 5.00 O 0 5.00 69. 00 ELECTROCARDI OLOGY 6.00 0 0 0 6.00 7.00 91. 00 EMERGENCY 0 0 0 0 7.00 0 0 0.00 8.00 0 0 8.00 0.00 9.00 0 0 9.00 10.00 0.00 0 10.00 200 00 200.00

200.00			124, 764	6, 238	0	0	0 200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	
		I denti fi er	Component	Limit	Di sal I owance		
			Share of col.				
			14				
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	0	0	0	32, 340	1.00
2.00	13. 00	NURSING ADMINISTRATION	0	0	0	30, 595	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	1, 803, 974	3.00
4.00	53. 00	ANESTHESI OLOGY	0	124, 764	0	877, 298	4.00
5.00	60.00	LABORATORY	0	0	0	1, 338	5. 00
6.00	69. 00	ELECTROCARDI OLOGY	0	0	0	1, 700	6.00
7.00	91. 00	EMERGENCY	0	0	0	1, 353, 727	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	124, 764	0	4, 100, 972	200.00
	•	•	: -	•		•	·

	ALLOCATION - GENERAL SERVICE COSTS	SATIVI SAWES	Provider Co	CN: 14-0161 P F T	eriod: rom 10/01/2022 o 09/30/2023	Worksheet B Part I Date/Time Pre 2/21/2024 2:0	pared:
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	CAPITAL REI	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	·
		col . 7)	1 00	2.00	4.00	4.0	
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	4. 00	4A	
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 304, 996	1, 304, 996				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 086, 233		2, 086, 233			2.00
4. 00 5. 00	00500 ADMINISTRATIVE & GENERAL	8, 987, 502 10, 052, 238				11, 631, 407	4. 00 5. 00
6.00	00600 MAINTENANCE & REPAIRS	433, 435		1		522, 284	1
7.00	00700 OPERATION OF PLANT	1, 565, 798		1		1, 835, 909	7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	166, 663 798, 739		1	, , , , , ,	176, 103 1, 028, 256	
10. 00	01000 DI ETARY	191, 058				241, 583	
11. 00	01100 CAFETERI A	396, 486		1		525, 522	
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CE & SUPPLY	1, 985, 763 373, 171	2, 405 0	1		2, 353, 109 407, 581	
16. 00	01600 MEDICAL RECORDS & LIBRARY	192, 013	_	_	1	203, 132	
17. 00	01700 SOCIAL SERVICE	640, 666	0	0		640, 666	17. 00
19. 00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	3, 880, 328	80, 452	75, 461	986, 231	5, 022, 472	30.00
31. 00	03100 INTENSIVE CARE UNIT	676, 382	7, 578	54, 294	190, 604	928, 858	1
43. 00	04300 NURSERY	251, 682	5, 510	839	72, 128	330, 159	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1, 728, 705	106, 341	238, 299	356, 560	2, 429, 905	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	428, 657	9, 387			562, 320	1
53. 00	05300 ANESTHESI OLOGY	337, 341		1 .,		441, 266	
54. 00 54. 10	05400  RADI OLOGY-DI AGNOSTI C   03630  ULTRA SOUND	1, 198, 455 302, 245				1, 445, 487 438, 575	
54. 20	03440 MAMMOGRAPHY	123, 262		1		204, 902	
56. 00	05600 RADI OI SOTOPE	202, 145	400	549		203, 235	
57. 00	05700 CT SCAN	473, 360				686, 504	1
58. 00 60. 00	05800   MRI	238, 135 2, 122, 595				362, 713 2, 485, 547	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	138, 342		1		138, 342	1
64. 00	06400 I NTRAVENOUS THERAPY	222, 560		0		282, 402	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	620, 489 910, 746		1		781, 217 1, 253, 723	
67. 00	06700 OCCUPATI ONAL THERAPY	288, 184				387, 458	
68. 00	06800 SPEECH PATHOLOGY	160, 131	8, 805	2, 583	46, 167	217, 686	
69. 00 70. 00	06900  ELECTROCARDI OLOGY   07000  ELECTROENCEPHALOGRAPHY	292, 384 226, 603		1		422, 054 282, 530	
70.00		295, 121	18, 255			313, 376	
72. 00		348, 095	0	0	0	348, 095	
73.00		3, 800, 975	6, 954			3, 991, 429	73. 00 76. 00
76. 00 76. 97	03950  DI ABETES SERVI CES   07697  CARDI AC REHABI LI TATI ON	129, 624 92, 506	855 11, 126	1	38, 718 29, 377	169, 197 142, 209	76.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77. 00
78. 00		0	0	0	0	0	78. 00
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC - STREATOR	4, 756, 493	123, 629	0	999, 072	5, 879, 194	88. 00
88. 01	08801 RURAL HEALTH CLINIC - PONTIAC	2, 414, 611	27, 355	1		3, 019, 418	1
88. 02	08802 RURAL HEALTH CLINIC - CULLOM	292, 140				365, 890	
88. 03 88. 04	08803   RURAL HEALTH CLINIC - DWIGHT   08804   RURAL HEALTH CLINIC - FAIRBURY	659, 316 841, 862	0 41, 593	,	111, 190 157, 876	798, 357 1, 043, 370	88. 03 88. 04
88. 05	08805 RURAL HEALTH CLINIC - MINONK	501, 745		1		621, 646	1
88. 06	08806 RURAL HEALTH CLINIC - FLANAGAN	378, 642		954	80, 250	477, 372	88. 06
88. 07	08807 RURAL HEALTH CLINIC - REYNOLDS	1, 454, 017	17 510	7, 251		1, 775, 167	1
88. 08 88. 09	08808 RURAL HEALTH CLINIC - EL PASO   08809 RURAL HEALTH CLINIC - CLINTON	702, 775 1, 262, 374	17, 519 20, 064	1		891, 401 1, 567, 689	1
90. 00	09000 CLINIC	84, 146	6, 933		22, 754	113, 833	
91.00	09100 EMERGENCY	2, 823, 012	47, 446	32, 570	689, 472	3, 592, 500	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					0	92.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS			I			
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	64, 834, 946	1, 068, 170	2, 084, 554	8, 374, 111	63, 983, 050	J118. 00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	40, 122	15, 921	0	6, 060	62, 103	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	2, 982, 790	214, 126	1, 679	599, 783	3, 798, 378	192. 00
	1 19201 CARDIAC PHASE III 2 19202 FUND DEVELOPMENT	1, 189 70, 757		l .		1, 653 84, 620	192. 01 192. 02
- 72.0	-	10,737	0,007		7, 170	04, 020	1,,,,,,,,,

Health Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Peri od:	Worksheet B	
				From 10/01/2022 To 09/30/2023	Part I Date/Time Pre	narodi
				10 09/30/2023	2/21/2024 2:0	
		CAPI TAL REI	ATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP		Subtotal	
	for Cost			BENEFITS		
	Allocation			DEPARTMENT		
	(from Wkst A					
	col . 7)	1 00	2.00	4.00	4.0	
100 00 10000 PULLIONARY FUNCTION	0	1.00	2.00	4.00	4A	100.00
192. 03 19203 PULMONARY FUNCTION	0	0		0		192. 03
192. 04 19204 RESEARCH	0	0		0	0	192. 04
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers		0		0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	67, 929, 804	1, 304, 996	2, 086, 23	3 8, 987, 502	67, 929, 804	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2022 Part I
To 09/30/2023 Date/Time Prepared: 2/21/2024 2:01 pm

					09/30/2023	2/21/2024 2:0	
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL 5.00	6. 00	7. 00	LINEN SERVICE 8.00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	11, 631, 407					5.00
6. 00	00600 MAI NTENANCE & REPAI RS	107, 905	630, 189				6. 00
7.00	00700 OPERATION OF PLANT	379, 304	37, 521				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	36, 383	0	_	212, 486		8. 00
9.00	00900 HOUSEKEEPI NG	212, 441	5, 526		0	1, 267, 228	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	49, 912 108, 574	2, 146 6, 350		0	4, 632	10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	486, 159	1, 435		0	13, 706 3, 097	13.00
14. 00	01400 CENTRAL SERVICE & SUPPLY	84, 207	0, 100		Ö	0,077	14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	41, 968	6, 635	25, 219	0	14, 320	16. 00
17. 00	01700 SOCIAL SERVICE	132, 364	0	0	0	0	17. 00
19. 00		0	0	0	0	0	19. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1, 037, 658	48, 008	182, 479	47, 414	103, 616	30.00
31. 00	1 1	191, 905	4, 522		10, 874	9, 760	31.00
43. 00	04300 NURSERY	68, 212	3, 288		2, 286	7, 097	43. 00
	ANCILLARY SERVICE COST CENTERS			,	,	, -	
50.00	05000 OPERATING ROOM	502, 026	63, 457		31, 992	136, 960	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	116, 177	5, 602	·	3, 895	12, 090	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	91, 167 298, 642	20. 017	0 76,086	28, 947	0 43, 203	53. 00 54. 00
54. 00	03630 ULTRA SOUND	90, 611	1, 410		20, 947	3, 043	54. 10
54. 20	03440 MAMMOGRAPHY	42, 333	0, 110		Ö	0,010	54. 20
56. 00	05600 RADI OI SOTOPE	41, 989	238	906	0	515	56. 00
57. 00	05700 CT SCAN	141, 834	2, 933		0	6, 329	57. 00
58. 00	05800 MRI	74, 938	4, 740		0	10, 230	58. 00
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	513, 521 28, 582	10, 442	39, 689	0	22, 536 0	60. 00 63. 00
64. 00	06400   NTRAVENOUS THERAPY	58, 345	0		0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	161, 402	2, 594	9, 859	Ö	5, 598	65. 00
66. 00	06600 PHYSI CAL THERAPY	259, 023	32, 304		4, 546	69, 721	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	80, 050	9, 454	35, 936	0	20, 405	67. 00
68. 00	06800 SPEECH PATHOLOGY	44, 975	5, 254		0	11, 340	68. 00
69. 00	06900 ELECTROCARDI OLOGY	87, 198	1, 130	4, 293	0	2, 438	69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	58, 372 64, 744	10, 893	1	0	0 23, 511	70. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	71, 917	10, 073	0	0	23, 311	72.00
73. 00	1 1	824, 641	4, 150	15, 774	0	8, 957	73. 00
76. 00	03950 DI ABETES SERVI CES	34, 957	510		0	1, 102	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	29, 381	6, 639		0	14, 329	76. 97
77. 00 78. 00	07700   ALLOGENEI C HSCT ACQUISITION   07800   CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	77. 00 78. 00
76.00	OUTPATIENT SERVICE COST CENTERS	l ol		<u> </u>	U	0	76.00
88. 00		1, 214, 648	73, 773	280, 413	0	159, 225	88. 00
88. 01	08801 RURAL HEALTH CLINIC - PONTIAC	623, 821	16, 323		46	35, 231	1
88. 02	08802 RURAL HEALTH CLINIC - CULLOM	75, 594	5, 819	22, 118	0	12, 559	88. 02
88. 03	08803 RURAL HEALTH CLINIC - DWIGHT	164, 943	0	0	515	0	88. 03
88. 04 88. 05	08804 RURAL HEALTH CLINIC - FAIRBURY 08805 RURAL HEALTH CLINIC - MINONK	215, 563	24, 820 5, 597		353		88. 04 88. 05
88. 05 88. 06	08806 RURAL HEALTH CLINIC - MINONK	128, 434 98, 626	5, 597 10, 458		8	12, 081 22, 572	88.05
88. 07	08807 RURAL HEALTH CLINIC - REYNOLDS	366, 755	10, 430	0	0	22, 372	88. 07
88. 08	08808 RURAL HEALTH CLINIC - EL PASO	184, 166	10, 454	39, 736	0	22, 563	88. 08
88. 09	08809 RURAL HEALTH CLINIC - CLINTON	323, 889	11, 973		0	25, 841	88. 09
90. 00		23, 518	4, 137		0	8, 930	90.00
91. 00	09100 EMERGENCY	742, 221	28, 313	107, 618	79, 678	61, 108	•
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
102. 0	10200 OPIOID TREATMENT PROGRAM	O	C	0	0	0	102. 00
.02.0	SPECIAL PURPOSE COST CENTERS	<u> </u>		,	<u> </u>		102.00
118.0	SUBTOTALS (SUM OF LINES 1 through 117)	10, 815, 995	488, 865	1, 715, 567	210, 554	962, 214	118. 00
	NONREI MBURSABLE COST CENTERS						
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12, 831	9, 500		0	20, 505	
	D19200 PHYSICIANS' PRIVATE OFFICES 119201 CARDIAC PHASE III	784, 756 342	127, 779 67		1, 932 0		192. 00 192. 01
	2 19202 FUND DEVELOPMENT	17, 483	3, 978		n		192. 01
	3 19203 PULMONARY FUNCTION	0	3, 770	0	ol		192. 02
	4 19204 RESEARCH	0	0	0	o		192. 04
200.0							200. 00
201. 0		0	0	0	010 401		201. 00
202. 0	TOTAL (sum lines 118 through 201)	11, 631, 407	630, 189	2, 252, 734	212, 486	1, 267, 228	1202.00

					2/21/2024 2:0	1 pm
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CE &	MEDICAL RECORDS &	
	10.00	11. 00	13.00	SUPPLY 14. 00	16. 00	
GENERAL SERVICE COST CENTERS	10.00	111.00	10.00	111.00	10.00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						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   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	306, 430					10. 00
11. 00   01100   CAFETERI A	0	678, 290				11. 00
13. 00 O1300 NURSING ADMINISTRATION	0	30, 569				13. 00
14. 00 01400 CENTRAL SERVI CE & SUPPLY	0	7, 812	0	499, 600	201 274	14.00
16.00   01600   MEDICAL RECORDS & LIBRARY 17.00   01700   SOCIAL SERVICE	0	0		O O	291, 274 0	16. 00 17. 00
19. 00   01700 SOCIAL SERVICE  19. 00   01900   NONPHYSI CI AN ANESTHETI STS	0	0		0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		,	<u> </u>		17.00
30. 00 03000 ADULTS & PEDI ATRI CS	227, 543	124, 253	1, 311, 250	48, 603	17, 146	30. 00
31.00 03100 INTENSIVE CARE UNIT	60, 635	19, 191	202, 573	9, 312	2, 882	31.00
43. 00 04300 NURSERY	2, 711	8, 007	84, 520	0	433	43. 00
ANCILLARY SERVICE COST CENTERS	40.040	00.444	105 100	47 550	04.054	F0 00
50.00   05000   0PERATING ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	10, 919 4, 622	38, 414	405, 488	17, 558	21, 351 740	50.00
53. 00   05200   DELI VERT   ROOM & LABOR   ROOM	4, 622	13, 777	0	5, 403	2, 919	52. 00 53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0	23, 275		1, 653	9, 277	54. 00
54. 10   03630   ULTRA SOUND	o	9, 887		2, 469	7, 217	54. 10
54. 20   03440   MAMMOGRAPHY	0	5, 219		901	3, 745	54. 20
56. 00   05600   RADI OI SOTOPE	0	0	0	282	4, 648	56. 00
57. 00   05700   CT   SCAN	0	8, 947		15, 990	33, 629	57. 00
58. 00   05800   MRI	0	8, 428		5, 042	9, 739	58. 00
60. 00   06000   LABORATORY	0	55, 011		12, 502	52, 694	60.00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS. 64. 00   06400   INTRAVENOUS THERAPY	0	6, 710	1	5, 036	943 1, 230	63. 00 64. 00
65. 00   06500   RESPI RATORY   THERAPY	0	18, 024		23, 405	4, 276	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	35, 140		1, 873	5, 512	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	9, 628		244	2, 405	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	6, 062	2	0	927	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	11, 119		2, 157	9, 932	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	5, 187	1	1, 069	1, 678	70.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS	0	0	0	121, 549 95, 255	914 2, 326	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	16, 889	1	2, 903	31, 081	73. 00
76. 00 03950 DI ABETES SERVI CES	0	4, 214	1	0	165	76. 00
76. 97 07697 CARDIAC REHABILITATION	0	5, 025		227	671	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	٥		0	10 502	10,004	00 00
88. 00   08800   RURAL HEALTH CLINIC - STREATOR 88. 01   08801   RURAL HEALTH CLINIC - PONTIAC	0	56, 276		18, 592 10, 150	10, 006 6, 590	88. 00 88. 01
88. 02 08802 RURAL HEALTH CLINIC - CULLOM	0	00, 270	o o	2, 671	789	88. 02
88.03 08803 RURAL HEALTH CLINIC - DWIGHT	0	O	0	2, 597	1, 397	88. 03
88.04 08804 RURAL HEALTH CLINIC - FAIRBURY	0	0	0	3, 171	1, 620	88. 04
88. 05   08805   RURAL HEALTH CLINIC - MINONK	0	0	0	7, 807	1, 375	88. 05
88. 06 08806 RURAL HEALTH CLINIC - FLANAGAN	0	0	0	1, 751	843	88. 06
88. 07   08807 RURAL HEALTH CLINIC - REYNOLDS	0	0	0	7, 561	3, 669	88. 07
88. 08   08808 RURAL HEALTH CLINIC - EL PASO 88. 09   08809 RURAL HEALTH CLINIC - CLINTON	0	0		4, 423 9, 006	1, 674 3, 781	88. 08 88. 09
90. 00   09000   CLINIC	0	4, 020		155	206	90. 00
91. 00   09100   EMERGENCY	0	78, 773		56, 071	30, 844	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	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS	20/ 420	/00.057	2 070 022	407 200	201 274	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	306, 430	609, 857	2, 879, 823	497, 388	291, 274	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	584	. 0	170	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	66, 455		2, 042		192. 00
192. 01 19201 CARDI AC PHASE III	o	65	1	0		192. 01
192. 02 19202 FUND DEVELOPMENT	0	1, 329		О	0	192. 02
192. 03 19203 PULMONARY FUNCTION	0	0	0	0		192. 03
192. 04 19204 RESEARCH	0	0	0	0	0	192. 04
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0		0	0	200. 00 201. 00
201.00   Negative Cost Centers	0	С	ή 0	· η	0	201.00

Health Financial Systems	SAINT JAMES HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co	CN: 14-0161	Peri od:	Worksheet B		
				From 10/01/2022			
				To 09/30/2023			
					2/21/2024 2:0	1 pm	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL		
			ADMI NI STRATI O	N SERVICE &	RECORDS &		
				SUPPLY	LI BRARY		
	10.00	11. 00	13.00	14. 00	16.00		
202.00 TOTAL (sum lines 118 through 201)	306, 430	678, 290	2, 879, 82	3 499, 600	291, 274	202. 00	

	Financial Systems	SATINI JAMES				u or form CMS	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der Co		Period: From 10/01/2022 To 09/30/2023		pared:
						2/21/2024 2:0	
	Cost Center Description	SOCIAL SERVICE		Subtotal	Intern &	Total	
			ANESTHETI STS		Residents Cost		
					& Post Stepdown		
					Adj ustments		
		17. 00	19. 00	24. 00	25. 00	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 6. 00	OO5OO  ADMINISTRATIVE & GENERAL   OO6OO  MAINTENANCE & REPAIRS						5. 00 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	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVI CE & SUPPLY						14.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	772 020					16.00
17. 00 19. 00	01700   SOCIAL SERVICE   01900   NONPHYSICIAN ANESTHETISTS	773, 030 0	0				17. 00 19. 00
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		0				19.00
30.00	03000 ADULTS & PEDI ATRI CS	550, 328	0	8, 720, 77	0 0	8, 720, 770	30. 00
31.00	03100 INTENSIVE CARE UNIT	185, 006					
43.00	04300 NURSERY	37, 696	0	556, 90	7 0	556, 907	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0				
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0				
54. 00	05300  ANESTHESI OLOGY   05400  RADI OLOGY-DI AGNOSTI C	0	0			554, 532 1, 946, 587	
54. 10	03630 ULTRA SOUND	0	0			558, 571	
54. 20	03440 MAMMOGRAPHY		0			257, 100	
56. 00	05600 RADI OI SOTOPE	0	0				
57.00	05700 CT SCAN	0	0	907, 31	3 0	907, 313	57. 00
58. 00	05800 MRI	0	0	493, 84	6 0	493, 846	58. 00
60.00	06000 LABORATORY	0	0				
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			167, 867	
64.00	06400 I NTRAVENOUS THERAPY	0	0	,		353, 723	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0			1, 006, 375 1, 784, 629	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0				
68. 00	06800 SPEECH PATHOLOGY	0	0				
69.00	06900 ELECTROCARDI OLOGY	0	0	540, 32	1 0	540, 321	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			348, 836	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				
	07300 DRUGS CHARGED TO PATIENTS	0	_				
	03950 DI ABETES SERVI CES 07697 CARDI AC REHABI LI TATI ON	0	0				
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	1	0		1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0		
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - STREATOR	0	0				88. 00
88. 01	08801 RURAL HEALTH CLINIC - PONTIAC	0	0			3, 829, 900	
88. 02	08802 RURAL HEALTH CLINIC - CULLOM	0	0	485, 44		485, 440	
88. 03 88. 04	08803   RURAL HEALTH CLINIC - DWIGHT   08804   RURAL HEALTH CLINIC - FAIRBURY	0	0	967, 80 1, 436, 80		967, 809 1, 436, 806	
88. 05	08805 RURAL HEALTH CLINIC - MINONK	0	0	798, 22		798, 223	
88. 06	08806 RURAL HEALTH CLINIC - FLANAGAN	0	0	651, 37		651, 374	
88. 07	08807 RURAL HEALTH CLINIC - REYNOLDS	0	0	2, 153, 15		2, 153, 152	ı
88. 08	08808 RURAL HEALTH CLINIC - EL PASO	0	0	1, 154, 41		1, 154, 417	88. 08
88. 09	08809 RURAL HEALTH CLINIC - CLINTON	0	0	1, 987, 68		1, 987, 687	1
90. 00	09000 CLI NI C	0	0	170, 52		170, 525	
91.00	09100 EMERGENCY	0	0	5, 608, 63		5, 608, 634	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				0		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)	773, 030	0	62, 111, 55	6 0	62, 111, 556	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				
	19200   PHYSICIANS' PRIVATE OFFICES   19201   CARDIAC PHASE III		0			5, 542, 800	192. 00 192. 01
	19201 CARDIAC PHASE TTT 19202 FUND DEVELOPMENT		0	2, 52 131, 11		2, 525 131, 119	
	19203 PULMONARY FUNCTION	0	0		0 0		192. 02
	19204 RESEARCH	0	0		0		192. 04

Health Financial Systems	SAINT JAMES	SAINT JAMES HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co	CN: 14-0161	Peri od:	Worksheet B			
				From 10/01/2022 To 09/30/2023		narod:		
				10 09/30/2023	2/21/2024 2:0	11 pm		
Cost Center Description	SOCIAL SERVICE	NONPHYSI CI AN	Subtotal	Intern &	Total			
		ANESTHETI STS		Residents Cost				
				& Post				
				Stepdown				
				Adjustments				
	17. 00	19. 00	24.00	25. 00	26. 00			
200.00 Cross Foot Adjustments		0		0	0	200. 00		
201.00 Negative Cost Centers	0	0		0	0	201. 00		
202.00   TOTAL (sum lines 118 through 201)	773, 030	0	67, 929, 80	04 0	67, 929, 804	202. 00		

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: | 2/21/2024 2:01 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS SAINT JAMES HOSPITAL Provider CCN: 14-0161

Carl Center Description							2/21/2024 2:0	1 pm
Company   Comp				CAPI TAL REI	LATED COSTS			
Company   Comp		Cost Center Description	Directly	BIDG & FIXT	MVRLE FOLLE	Subtotal	EMPLOYEE	
DEPRINE   SERVICE COST CENTERS   Sel PRES COSTS   1.00   2.00   2.00   2.00   4.00   1.00   2.00		cost center bescription		DEDG & TIXT	WVBLL LQUIF	Subtotal		
CEMERAL SERVICE COST CENTERS								
DEFENDED SERVICE COST CENTERS								
0.000   0.000   CAP REL COSTS-BLIG & FIXT		CENEDAL SEDVICE COST CENTEDS	0	1.00	2.00	2A	4. 00	
2.00 DIOCODE CAP REL COSTS - WINTEL EDUIP   0	1 00							1 00
0.000   0.0000   AMMIN INSTRATIVE A. ENI PERM IS   0.000   0								ł
0.000 00.000 IM MTEANACE & REPAIRS 0 8.79 1.4.08 10.190 0 6.00 0 7.00 00.000 IAMBRY A LINEA SERVICE OF SERVICE SUPPLY 0 1.00 0			0	0	0	0	0	4. 00
7.00   007000   007001   00   FRANTI W   FRANT		1	30, 136	1				•
0.00   0.000   D. J. J. J. S. P.			9 692	l			_	•
9.00   0.9900   MUSSECREP INS			0,002	1				•
11.00   01100   CAFETERIA   0   10,442   1,937   12,479   0   11,00   13,00   130   01300   MINSTING ADMINISTRATION   0   2,405   45,48   47,753   0   13,00   130   01300   01400   CENTRAL SERVICE & SURPHY   0   0   0   0   0   0   0   14,00   14			0	9, 261	13, 667	22, 928	0	1
13.00   01300   NURSI NO ADMINISTRATION   0   2.405   45,348   47,753   013.00   16.00   01000   NURSI NO ADMINISTRATION   0   0   0   0   0   16.00   01000   NURSI NO ADMINISTRATION   0   0   0   0   0   0   17.00   01700   NURSI NO ADMINISTRATION   0   0   0   0   0   0   19.00   10000   NURSI NO ADMINISTRATION   0   0   0   0   0   0   19.00   10000   NURSI NO ADMINISTRATION   0   0   0   0   0   0   19.00   10000   NURSI NO ADMINISTRATION   0   0   0   0   0   0   19.00   03000   ADMINISTRATION   0   0   0   0   0   0   19.00   03000   ADMINISTRATION   0   0   0   0   0   19.00   03000   NURSI NO ADMINISTRATION   0   0   0   0   0   19.00   03000   NURSI NO ADMINISTRATION   0   0   0   0   0   19.00   03000   NURSI NO ADMINISTRATION   0   0   0   0   0   19.00   03000   ORBATINES NO ADMINISTRATION   0   0   0   0   0   0   19.00   03000   ORBATINES NO ADMINISTRATION   0   0   0   0   0   0   0   19.00   03000   ORBATINES NO ADMINISTRATION   0   0   0   0   0   0   0   0   0			0	l			_	•
14.00 0   0400  CFMTRAL SERVICE & SUPPLY   0   0   0   0   14.00   17.00 0   1700  DICLAL RECORDS & LIBRARY   0   11,1119   0   11,1119   0   17.00 0   1700  DICLAL RECORDS & LIBRARY   0   11,1119   0   11,1119   0   17.00 0   1700  DICLAL RECORDS & LIBRARY   0   11,1119   0   0   17.00   17.00 0   1700  DICLAL RECORDS & LIBRARY   0   0   0   0   0   0   0   17.00 0   1700  DICLAL RECORDS & LIBRARY   0   0   0   0   0   0   0   17.00 0   1700  DICLAL RECORDS & LIBRARY   0   0   0   0   0   0   0   18.00 0   1700  DICLAL RECORDS & LIBRARY & DICLAL RECORDS & DICL			0	l			_	•
16. 00   01400  MEDICAL RECORDS & LIBRARY   0   11,119   0   11,119   0   16. 00   17. 00   170.			0	2, 405	45, 348		_	•
17. 00   01700   SOCIAL SERVICE   00   0   0   0   0   0   0   0   0			0	11, 119	0	-	_	•
INPATT INT ROUTINE SERVICE COST CENTERS   34,014   80,452   75,461   189,927   03 0.0 0   31 0.0 0   31 0.0 0   31 0.0 0   31 0.0 0   31 0.0 0   31 0.0 0   31 0.0 0   31 0.0 0   31 0.0 0   31 0.0 0   31 0.0 0   31 0.0 0   31 0.0 0   31 0.0 0   31 0.0 0   31 0.0 0   32 0.0			0		1		0	•
30.00   3000   ADULTS & PEDIATRICS   34, 014   30, 452   75, 461   189, 927   0 30.00   31.00   31.00   0300   INTENSIVE COST CENTERS   51, 204   0 43.00   33.00	19. 00		0	0	0	0	0	19. 00
31.00   03000   INTERSIVE CARE UNIT	20.00		24 014	00.453	75 4/1	100 027	0	20.00
0   0.3500   NURSERY   0   5   5.10   8.39   6   3.49   0   43.00			1	1		·		•
50.00		1	1	l				•
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   9,387   1,429   10,816   0   52.00								
53.00   05300   ANESTHESI OLOGY   0   0   39,087   39,087   053.00			6, 998	1		·		•
54. 00   06400   RADI OLOCY-DI AGNOSTI C   0   33, 545   42, 123   75, 668   0   54, 00		1	0	1				ł
54.10   03630   ULTRA SOUND   0   2,563   46,533   48,896   0   54,10			0	1				•
56. 00   05600   RADIO ISOTOPE   0   400   549   949   0   56. 00   58. 00   05800   MRI   0   7. 943   51. 564   59. 507   0   58. 00   05800   MRI   0   7. 943   51. 564   59. 507   0   58. 00   06. 00   0600   ABORATORY   31. 175   17. 498   28. 889   76. 76.2   0   60. 00   06. 00   06. 00   06. 00   06. 00   0   0   0   0   0   0   0   0   0			0	l				ł
57.00   GS700   CT SCAN			0	1			_	•
58.00   OSBOD   MRI   O   7.943   51.564   59.507   O   68.00			0	l .				
0.0   0.0			0	l			_	1
63.00   06300   06400   STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   0   0			31, 175	l		·		•
55 00   06500   RESPI RATORY THERAPY   32,904   4,346   5,538   42,788   0   65,00		1	0	1			0	•
66 00   06600   PHYSI CAL THERAPY   0   54, 134			0	0	-	0		1
67.00   06700   06700   06700   06700   068.00   06800   06800   06800   06800   069			32, 904	l			_	•
68. 00   06.000   06.000   06.000   06.000   06.000   06.000   06.000   06.000   06.000   06.000   06.000   06.000   06.000   06.000   06.000   07.000   0			0	l			_	•
69. 00   06900			0	l			_	•
171.00   07100   MDI CAL SUPPLIES CHARGED TO PATIENT   0   18, 255   0   0.71.00   0.72.00   0			0	l			0	•
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0 0 0 0 0 0 0 72.00			72, 600	ł		·	_	•
73. 00   07300   DRUGS CHARGED TO PATIENTS   45   6,954   7,171   14,170   0   73. 00   76. 00   03950   DI ABETES SERVI CES   0   855   0   855   0   76. 00   76. 97   77. 00   07697   CARDIA C. REHABI LITATION   0   0   0   0   0   0   0   0   0		1 I	0		1		_	•
The first color   The first			45	١		_	_	•
77. 00   07700   ALLOGENEIC HSCT ACQUISITION   0   0   0   0   0   0   77. 00   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   0   0   78. 00   00TPATIENT SERVICE COST CENTERS  88. 00   08800   RURAL HEALTH CLINIC - STREATOR   9,518   123,629   0   133,147   0   88. 00   88. 01   08801   RURAL HEALTH CLINIC - PONTIAC   5,025   27,355   1,241   33,621   0   88. 01   88. 02   08802   RURAL HEALTH CLINIC - PONTIAC   763   9,751   1,131   11,645   0   88. 02   88. 03   08803   RURAL HEALTH CLINIC - DWIGHT   141,811   0   27,851   169,662   0   88. 03   88. 04   08804   RURAL HEALTH CLINIC - FAIRBURY   1,463   41,593   2,039   45,095   0   88. 03   88. 05   08805   RURAL HEALTH CLINIC - FAIRBURY   1,463   41,593   2,039   45,095   0   88. 05   88. 06   08806   RURAL HEALTH CLINIC - FINNONK   1,246   9,380   1,928   12,554   0   88. 05   88. 06   08806   RURAL HEALTH CLINIC - FLANAGAN   1,067   17,526   954   19,547   0   88. 06   88. 07   08807   RURAL HEALTH CLINIC - REYNOLDS   143,471   0   7,251   150,722   0   88. 07   88. 09   08809   RURAL HEALTH CLINIC - REYNOLDS   143,471   0   7,251   150,722   0   88. 07   88. 09   08809   RURAL HEALTH CLINIC - CLINTON   3,286   20,064   1,630   24,980   0   88. 09   90. 00   09000   CLINIC   0   0   6,933   0   6,933   0   90. 00   91. 00   09100   EMERGENCY   6,962   47,446   32,570   86,978   0   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART OTHER REI MBURSABLE COST CENTERS			0	1				1
78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   0   78. 00		1 1	j	1				
OUTPATIENT SERVICE COST CENTERS   Service			1					
88. 00   08800   RURAL HEALTH CLINIC - STREATOR   9, 518   123, 629   0   133, 147   0   88. 00   88. 01   08801   RURAL HEALTH CLINIC - PONTIAC   5, 025   27, 355   1, 241   33, 621   0   88. 01   88. 02   08802   RURAL HEALTH CLINIC - CULLOM   763   9, 751   1, 131   11, 645   0   88. 02   88. 03   08803   RURAL HEALTH CLINIC - DWIGHT   141, 811   0   27, 851   169, 662   0   88. 03   88. 04   08804   RURAL HEALTH CLINIC - FAI RBURY   1, 463   41, 593   2, 039   45, 095   0   88. 04   88. 05   08805   RURAL HEALTH CLINIC - FAI RBURY   1, 463   41, 593   2, 039   45, 095   0   88. 04   88. 05   08806   RURAL HEALTH CLINIC - FILANAGAN   1, 067   17, 526   954   19, 547   0   88. 06   88. 07   08807   RURAL HEALTH CLINIC - FLANAGAN   1, 067   17, 526   954   19, 547   0   88. 06   88. 08   08808   RURAL HEALTH CLINIC - REYNOLDS   143, 471   0   7, 251   150, 722   0   88. 07   88. 09   08809   RURAL HEALTH CLINIC - EL PASO   -51, 852   17, 519   5, 071   -29, 262   0   88. 08   88. 09   08809   RURAL HEALTH CLINIC - CLINTON   3, 286   20, 064   1, 630   24, 980   0   88. 08   89. 09   09000   09000   CLINIC   0   0   6, 933   0   90. 00   0   0   0   0   0   0   0   0	78.00		0	0	U	Ü	0	78.00
88. 02   08802   RURAL HEALTH CLINIC - CULLOM   763   9,751   1,131   11,645   0 88. 02   88. 03   08803   RURAL HEALTH CLINIC - DWI GHT   141,811   0 27,851   169,662   0 88. 03   88. 04   08804   RURAL HEALTH CLINIC - FAIRBURY   1,463   41,593   2,039   45,095   0 88. 04   88. 05   08805   RURAL HEALTH CLINIC - MI NONK   1,246   9,380   1,928   12,554   0 88. 05   88. 06   08806   RURAL HEALTH CLINIC - FLANAGAN   1,067   17,526   954   19,547   0 88. 06   88. 07   08807   RURAL HEALTH CLINIC - REYNOLDS   143,471   0 7,251   150,722   0 88. 07   88. 08   08808   RURAL HEALTH CLINIC - EL PASO   -51,852   17,519   5,071   -29,262   0 88. 08   88. 09   08809   RURAL HEALTH CLINIC - CLINTON   3,286   20,064   1,630   24,980   0 88. 09   89. 00   09000   CLINIC   0 6,933   0 6,933   0 90.00   91. 00   09100   EMERGENCY   6,962   47,446   32,570   86,978   0 91.00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0 102.00   0THER REIMBURSABLE COST CENTERS   1800   15,921   0 102.00   102. 00   10200   OPI OI DI TREATMENT PROGRAM   0   0   0   0   0   0   0   SPECIAL PURPOSE COST CENTERS   1800   15,921   0   15,921   0   190.00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFICES   96,645   214,126   1,679   312,450   0   192. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFICES   96,645   214,126   1,679   312,450   0   192. 00   192. 01   19201   CARDI AC PHASE II I   0   112   0   112   0   192. 01   192. 02   19202   FUND DEVELOPMENT   0   6,667   0   6,667   0   0   0   0   0   0   0   0   0	88. 00		9, 518	123, 629	0	133, 147	0	88. 00
88. 03  08803 RURAL HEALTH CLINIC - DWIGHT	88. 01		5, 025				0	1
88. 04 08804 RURAL HEALTH CLINIC - FAIRBURY 1, 463 41, 593 2, 039 45, 095 0 88. 04 88. 05 08805 RURAL HEALTH CLINIC - MINONK 1, 246 9, 380 1, 928 12, 554 0 88. 05 88. 06 08806 RURAL HEALTH CLINIC - FLANAGAN 1, 067 17, 526 954 19, 547 0 88. 05 88. 07 08807 RURAL HEALTH CLINIC - REYNOLDS 143, 471 0 7, 251 150, 722 0 88. 07 88. 08 08808 RURAL HEALTH CLINIC - EL PASO -51, 852 17, 519 5, 071 -29, 262 0 88. 08 88. 09 08809 RURAL HEALTH CLINIC - CLINTON 3, 286 20, 064 1, 630 24, 980 0 88. 09 90. 00 09000 CLINIC 0 0 6, 933 0 6, 933 0 90. 00 91. 00 09100 EMERGENCY 6, 962 47, 446 32, 570 86, 978 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	l				
88. 05			1					1
88. 06			1	l				1
88. 08				l				1
88. 09			1					1
90. 00		1	1	l			_	•
91. 00			1					1
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0   92. 00   0THER REI MBURSABLE COST CENTERS   0   0   0   0   0   0   102. 00   0   102. 00   0   0   0   0   0   0   0   0   0			· -	l	1			•
102. 00				,	52, 51.5		_	1
SPECIAL PURPOSE COST CENTERS   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   480, 463   1, 068, 170   2, 084, 554   3, 633, 187   0   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   15, 921   0   15, 921   0   192. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFICES   96, 645   214, 126   1, 679   312, 450   0   192. 00   192. 01   192. 01   19201   CARDI AC PHASE I I I   0   112   0   192. 01   192. 02   19202   FUND DEVELOPMENT   0   6, 667   0   6, 667   0   192. 02   192. 02   19202   1			1		,			
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 480, 463 1, 068, 170 2, 084, 554 3, 633, 187 0 118. 00  NONREI MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 15, 921 0 15, 921 0 190. 00  192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 96, 645 214, 126 1, 679 312, 450 0 192. 00  192. 01 19201 CARDI AC PHASE I I I 0 112 0 192. 01  192. 02 19202 FUND DEVELOPMENT 0 6, 667 0 192. 02	102.00		0	0	0	0	0	102. 00
NONREI MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 15, 921 0 15, 921 0 190. 00  192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 96, 645 214, 126 1, 679 312, 450 0 192. 00  192. 01 19201 CARDI AC PHASE I I I 0 112 0 192. 01  192. 02 19202 FUND DEVELOPMENT 0 6, 667 0 192. 02	118 00		480 463	1 068 170	2 084 554	3 633 197	0	118 00
190. 00     19000 GFT, FLOWER, COFFEE SHOP & CANTEEN     0     15, 921     0     15, 921     0     190. 00       192. 00     19200 PHYSI CLANS' PRI VATE OFFICES     96, 645     214, 126     1, 679     312, 450     0     192. 00       192. 01     19201 CARDI AC PHASE III     0     112     0     112     0     192. 01       192. 02     19202 FUND DEVELOPMENT     0     6, 667     0     6, 667     0     192. 02	. 10. 00		1 700, 403	1,000,170	2,004,004	5, 000, 107	0	1. 13. 00
192. 01   19201   CARDI AC PHASE I I I   0   112   0   192. 01   192. 02   19202   FUND DEVELOPMENT   0   6, 667   0   6, 667   0   192. 02		19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	-	l				
192. 02   19202   FUND DEVELOPMENT 0 6, 667 0 6, 667 0   192. 02			96, 645	l				
			0	ł				
<u> </u>				l				
		· · ·			1	- 1		·

Health Financial Systems	SAINT JAMES HOSPITAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0161		Peri od: From 10/01/2022	Worksheet B Part II		
					Date/Time Prepared: 2/21/2024 2:01 pm		
		CAPI TAL REI	LATED COSTS				
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT		
	0	1.00	2.00	2A	4. 00		
192. 04 19204 RESEARCH	0	0		0 0	0	192. 04	
200.00 Cross Foot Adjustments				0		200. 00	
201.00 Negative Cost Centers		0		0	0	201. 00	
202.00   TOTAL (sum lines 118 through 201)	577, 108	1, 304, 996	2, 086, 23	3, 968, 337	0	202. 00	

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2022 Part II
To 09/30/2023 Date/Time Prepared: 2/21/2024 2:01 pm

		ADMINI CTDATI VE	MAINTENANGE	ODEDATION OF	09/30/2023	2/21/2024 2:0	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	OFNEDAL CEDIUSE COST OFNEDO	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT						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	1, 262, 883	21 015				5. 00
6. 00 7. 00	OO6OO   MAINTENANCE & REPAIRS   OO7OO   OPERATION OF PLANT	11, 716 41, 183	21, 915 1, 305				6. 00 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	3, 950	0	0	3, 950		8. 00
9. 00	00900 HOUSEKEEPI NG	23, 066	192		0	47, 982	9. 00
10.00	01000 DI ETARY	5, 419	75		0	175	10.00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	11, 789 52, 785	221 50	2, 064 466	0	519 117	11. 00 13. 00
14. 00	01400 CENTRAL SERVI CE & SUPPLY	9, 143	0	0	o	0	14. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	4, 557	231	2, 156	0	542	16. 00
17. 00	01700 SOCIAL SERVICE	14, 371	0	0	0	0	17. 00
19. 00	01900   NONPHYSICIAN ANESTHETISTS   NPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	19. 00
30.00	03000 ADULTS & PEDI ATRI CS	112, 664	1, 669	15, 603	881	3, 923	30. 00
31. 00	03100 INTENSIVE CARE UNIT	20, 836	157	1, 470	202	370	•
43. 00	04300 NURSERY	7, 406	114	1, 069	42	269	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS    O5000   OPERATING ROOM	54, 508	2, 207	20, 624	595	5, 186	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	12, 614	195		72	458	ı
53.00	05300 ANESTHESI OLOGY	9, 898	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	32, 425	696	6, 506	538	1, 636	54.00
54. 10 54. 20	03630   ULTRA SOUND   03440   MAMMOGRAPHY	9, 838 4, 596	49 0	458 0	0	115 0	54. 10 54. 20
56. 00	05600 RADI OI SOTOPE	4, 559	8	77	Ö	19	56.00
57. 00	05700 CT SCAN	15, 400	102		0	240	57. 00
58.00	05800 MRI	8, 136	165		0	387	58. 00
60. 00 63. 00	06000   LABORATORY   06300   BLOOD STORING, PROCESSING & TRANS.	55, 756 3, 103	363 0	3, 394	0	853 0	60. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	6, 335	0	o o	o	0	64. 00
65.00	06500 RESPI RATORY THERAPY	17, 524	90	843	0	212	65. 00
66.00	06600 PHYSI CAL THERAPY	28, 124	1, 123		85	2, 640	•
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	8, 691 4, 883	329 183		0	773 429	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	9, 468	39	· ·	0	92	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	6, 338	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 030	379	3, 540	0	890	71. 00
72. 00 73. 00	07200   IMPL. DEV. CHARGED TO PATIENTS   07300   DRUGS CHARGED TO PATIENTS	7, 808 89, 536	0 144	0 1, 349	0	0 339	72. 00 73. 00
76. 00	03950 DI ABETES SERVI CES	3, 795	18		0	42	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	3, 190	231	2, 158	0	543	ı
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77. 00
78. 00	07800   CAR T-CELL IMMUNOTHERAPY   OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	78. 00
88. 00		131, 879	2, 565	23, 977	0	6, 029	88. 00
88. 01	08801 RURAL HEALTH CLINIC - PONTIAC	67, 732	568		1	1, 334	1
88. 02	08802 RURAL HEALTH CLINIC - CULLOM	8, 208	202		0	476	88. 02
88. 03 88. 04	08803 RURAL HEALTH CLINIC - DWIGHT   08804 RURAL HEALTH CLINIC - FAIRBURY	17, 909 23, 405	0 863	-	10 7	0 2, 028	88. 03 88. 04
88. 05	08805 RURAL HEALTH CLINIC - MINONK	13, 945	195		ó	457	88. 05
88. 06	08806 RURAL HEALTH CLINIC - FLANAGAN	10, 708	364		0	855	1
88. 07	08807 RURAL HEALTH CLINIC - REYNOLDS	39, 821	0	_	0	0	88. 07
88. 08 88. 09	08808 RURAL HEALTH CLINIC - EL PASO 08809 RURAL HEALTH CLINIC - CLINTON	19, 996 35, 166	364 416	3, 398 3, 891	0	854 978	88. 08 88. 09
90. 00	09000 CLINIC	2, 554	144		0	338	90.00
91.00	09100 EMERGENCY	80, 587	985	· ·	1, 481	2, 314	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
102.00	OTHER REIMBURSABLE COST CENTERS	O	0		O	0	102. 00
102.00	10200   OPIOLD TREATMENT PROGRAM   SPECIAL PURPOSE COST CENTERS	l o	0	0	U	0	102.00
118.00		1, 174, 350	17, 001	146, 691	3, 914	36, 432	118. 00
	NONREI MBURSABLE COST CENTERS	,					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 393	330		0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES  19201 CARDIAC PHASE III	85, 205 37	4, 444 2	41, 527 22	36 0		192. 00 192. 01
	19202 FUND DEVELOPMENT	1, 898	138		ol		192. 01
192. 03	19203 PULMONARY FUNCTION	o	0	0	o	0	192. 03
	19204 RESEARCH	0	0	0	0	0	192. 04
200. 00 201. 00		0	^		0	_	200. 00 201. 00
201.00		1, 262, 883	21, 915	192, 621	3, 950		201.00
	· · · · · · · · · · · · · · · · · · ·						

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: | Date/Time

			10	09/30/2023	Date/lime Pre   2/21/2024 2:0	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	
			ADMINISTRATION	SERVICE & SUPPLY	RECORDS & LI BRARY	
	10. 00	11. 00	13. 00	14. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						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 6. 00   00600 MAINTENANCE & REPAIRS						5. 00 6. 00
7.00   OO700   OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000 DI ETARY	15, 390					10.00
11. 00   01100   CAFETERI A	0	27, 072				11. 00
13.00 01300 NURSING ADMINISTRATION	0	1, 220	102, 391			13. 00
14.00 01400 CENTRAL SERVICE & SUPPLY	0	312	0	9, 455		14. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	0	0	0	0	18, 605	16.00
17. 00   01700   SOCI AL   SERVI CE	0	0	0	0	0	17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	0	0	l O	U	0	19.00
30. 00 03000 ADULTS & PEDIATRICS	11, 429	4, 959	46, 621	920	1, 092	30.00
31. 00   03100   NTENSI VE CARE UNI T	3, 045	766		176	184	31.00
43. 00   04300   NURSERY	136	320		0	28	43. 00
ANCILLARY SERVICE COST CENTERS				'		
50. 00 05000 OPERATING ROOM	548	1, 533	14, 417	332	1, 360	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	232	0	- 1	0	47	52. 00
53. 00   05300   ANESTHESI OLOGY	0	550		102	186	53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0	929		31	591	54.00
54. 10   03630   ULTRA SOUND	0	395		47	460	54. 10
54. 20   03440   MAMMOGRAPHY 56. 00   05600   RADI OI SOTOPE	0	208 0	0	17	239	54. 20
56. 00   05600   RADI 01 SOTOPE 57. 00   05700   CT   SCAN	0	357	0	303	296 2, 143	56. 00 57. 00
58. 00   05800 MRI	0	336		95	621	58.00
60. 00   06000 LABORATORY	Ö	2, 196		237	3, 404	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	ő	2, 170	Ö	0	60	63.00
64. 00 06400 I NTRAVENOUS THERAPY	O	268		95	78	64. 00
65. 00 06500 RESPI RATORY THERAPY	О	719		443	272	65. 00
66. 00 06600 PHYSI CAL THERAPY	O	1, 403	0	35	351	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	384	0	5	153	
68. 00 06800 SPEECH PATHOLOGY	0	242	0	0	59	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	444	0	41	633	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	207	0	20	107	70.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT 72.00   07200   MPL. DEV. CHARGED TO PATIENTS	0	0	0	2, 301 1, 803	58 148	71.00
73.00 07300 DRUGS CHARGED TO PATTENTS	0	674	0	55	1, 980	
76. 00   03950   DI ABETES   SERVI CES	0	168	1, 582	0	1, 700	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	Ö	201	0	4	43	76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	O	0		o	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 - STREATOR	0	0	-	352	638	1
88. 01   08801 RURAL HEALTH CLINIC - PONTIAC	0	2, 246	0	192	420	1
88. 02   08802   RURAL HEALTH CLINIC - CULLOM	0	0	0	51	50	88. 02
88. 03   08803   RURAL HEALTH CLINIC - DWIGHT 88. 04   08804   RURAL HEALTH CLINIC - FAIRBURY	0	0	0	49	89 103	88. 03 88. 04
88. 04   08804 RURAL HEALTH CLINIC - FAIRBURY 88. 05   08805 RURAL HEALTH CLINIC - MINONK	0	0	0	60 148	88	88. 05
88. 06   08806   RURAL HEALTH CLINIC - FLANAGAN	0	0	0	33	54	
88. 07   08807 RURAL HEALTH CLINIC - REYNOLDS	0	0	0	143	234	88. 07
88. 08   08808 RURAL HEALTH CLINIC - EL PASO	o	0	Ö	84	107	88. 08
88.09 08809 RURAL HEALTH CLINIC - CLINTON	O	0	0	170	241	88. 09
90. 00   09000   CLI NI C	O	160	0	3	13	90.00
91. 00   09100   EMERGENCY	0	3, 144	29, 564	1, 061	1, 965	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	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS	15 200	24 241	102 201	0.412	10 (05	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	15, 390	24, 341	102, 391	9, 413	18, 605	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23	0	3	Ω	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	2, 652		39		192. 00
192. 01 19201 CARDI AC PHASE III	o	3	ا	ő		192. 01
192. 02 19202 FUND DEVELOPMENT	ol	53		ol		192. 02
192. 03 19203 PULMONARY FUNCTION	o	0	o	o		192. 03
192. 04 19204 RESEARCH	O	0	0	0	0	192. 04
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00

Health Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Peri od:	Worksheet B	
				From 10/01/2022		
				To 09/30/2023	Date/Time Pre	
					2/21/2024 2:0	1 pm
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	
			ADMI NI STRATI O	N SERVICE &	RECORDS &	
				SUPPLY	LI BRARY	
	10.00	11. 00	13. 00	14.00	16.00	
202.00 TOTAL (sum lines 118 through 201)	15, 390	27, 072	102, 39	9, 455	18, 605	202. 00

	THIRTIAL SYSTEMS	SATIVI SAMES	Provider CO	F	Period: From 10/01/2022 To 09/30/2023	Worksheet B Part II Date/Time Pre 2/21/2024 2:0	pared:
	Cost Center Description	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	j jiii
		17. 00	19. 00	24. 00	25.00	26. 00	
1. 00 2. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT  00200 CAP REL COSTS-MVBLE EQUIP						1.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00 7. 00 8. 00	OO6OO MAI NTENANCE & REPAI RS   OO7OO   OPERATI ON OF PLANT   OO8OO   LAUNDRY & LI NEN SERVI CE						6. 00 7. 00 8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00 13. 00 14. 00	01100   CAFETERI A   01300   NURSI NG   ADMI NI STRATI ON   01400   CENTRAL   SERVI CE   & SUPPLY						11. 00 13. 00 14. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	14, 371					16. 00 17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	0	0				19. 00
30. 00 31. 00	03000   ADULTS & PEDI ATRI CS   03100   INTENSI VE CARE UNIT	10, 231 3, 439		399, 919 100, 868		399, 919 100, 868	1
43. 00	1 1	701		19, 439			
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0		452, 948 26, 255		452, 948 26, 255	1
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	1	49, 823 119, 020	0	49, 823 119, 020	53. 00
54. 10	03630 ULTRA SOUND	Ō		60, 258	0	60, 258	54. 10
54. 20 56. 00	03440   MAMMOGRAPHY   05600   RADI OI SOTOPE	0	1	52, 272 5, 913		52, 272 5, 913	1
57. 00	05700 CT SCAN	0		162, 915	0	162, 915	57. 00
58. 00 60. 00	05800   MRI   06000   LABORATORY	0		70, 787 142, 965		70, 787 142, 965	
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0		3, 163 6, 77 <i>6</i>		3, 163 6, 776	1
65.00	06500 RESPI RATORY THERAPY	ő	1	62, 891	0	62, 891	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	1	112, 419 30, 584		112, 419 30, 584	•
68. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0		18, 892	0	18, 892	68. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		55, 218 97, 219		97, 219	69. 00 70. 00
71. 00 72. 00	O7100   MEDICAL SUPPLIES CHARGED TO PATIENT   O7200   IMPL. DEV. CHARGED TO PATIENTS	0		32, 453 9, 759			71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	ő	1	108, 247	0	108, 247	73. 00
76. 00 76. 97	03950   DI ABETES   SERVI CES   07697   CARDI AC   REHABI LI TATI ON	0		6, 636 26, 696			76. 00 76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0			0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS				0	0	78. 00
88. 00 88. 01	O8800   RURAL HEALTH CLINIC - STREATOR   O8801   RURAL HEALTH CLINIC - PONTIAC	0	ł i	298, 587 111, 419		298, 587 111, 419	1
88. 02	08802 RURAL HEALTH CLINIC - CULLOM	0	1	22, 523	0	22, 523	88. 02
88. 03 88. 04	08803   RURAL HEALTH CLINIC - DWIGHT   08804   RURAL HEALTH CLINIC - FAIRBURY	0	1	187, 719 79, 628		187, 719 79, 628	1
88. 05 88. 06	08805 RURAL HEALTH CLINIC - MINONK 08806 RURAL HEALTH CLINIC - FLANAGAN	0		29, 20 <i>6</i> 34, 960		29, 206 34, 960	1
88. 07	08807 RURAL HEALTH CLINIC - REYNOLDS	0		190, 920	0	190, 920	88. 07
88. 08 88. 09	08808 RURAL HEALTH CLINIC - EL PASO 08809 RURAL HEALTH CLINIC - CLINTON	0		-4, 459 65, 842		-4, 459 65, 842	1
90.00	09000 CLI NI C	0		11, 490	0	11, 490	90.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		217, 281	0	217, 281	91.00
102.00	OTHER REIMBURSABLE COST CENTERS 10200 OPI OI D TREATMENT PROGRAM	0		(	0	0	102. 00
118. 00	SPECIAL PURPOSE COST CENTERS	14, 371	0				
190. 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		21, 534			190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES 19201 CARDIAC PHASE III	0	1	456, 797 181	0	456, 797	1
192. 02	19202 FUND DEVELOPMENT	0		10, 374	0	10, 374	192. 02
	19203   PULMONARY FUNCTION   19204   RESEARCH	0	ł ·	(			192. 03 192. 04
			'				

Health Financial Systems	SAINT JAMES HOSPITAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co	CN: 14-0161	Peri od:	Worksheet B		
				From 10/01/2022 To 09/30/2023		pared:	
					2/21/2024 2:0	1 pm	
Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN	Subtotal	Intern &	Total		
		ANESTHETI STS		Residents Cost			
				& Post			
				Stepdown			
				Adjustments			
	17. 00	19. 00	24. 00	25. 00	26.00		
200.00 Cross Foot Adjustments		0		0 0	0	200.00	
201.00 Negative Cost Centers	0	0		0	0	201. 00	
202.00 TOTAL (sum lines 118 through 201)	14, 371	0	3, 968, 33	0	3, 968, 337	202. 00	

COST ALLOCATION - STATISTICAL BASIS		Provider C		Peri od: From 10/01/2022	Worksheet B-1	
	CADITAL DEL	LATED COSTS		To 09/30/2023	Date/Time Pre 2/21/2024 2:0	
Cost Center Description	BLDG & FIXT	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	1. 00	2.00	4. 00	5A	5. 00	
GENERAL SERVICE COST CENTERS	40/ 454				I	1 00
1. 00   00100   CAP REL COSTS-BLDG & FLXT 2. 00   00200   CAP REL COSTS-MVBLE EQUIP	186, 151	2, 046, 810				1. 00 2. 00
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT	0		1	6		4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	34, 255					5. 00
6.00   00600   MAINTENANCE & REPAIRS   7.00   00700   OPERATION OF PLANT	1, 254 8, 969				522, 284 1, 835, 909	1
8. 00   00800 LAUNDRY & LINEN SERVICE	0, 707		31, 12		176, 103	1
9. 00   00900   HOUSEKEEPI NG	1, 321		681, 19	0 0	1, 028, 256	9. 00
10. 00   01000   DI ETARY	513	1			241, 583	1
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON	1, 518 343				525, 522 2, 353, 109	
14. 00 01400 CENTRAL SERVICE & SUPPLY	0		113, 45		407, 581	1
16. 00 01600 MEDICAL RECORDS & LIBRARY	1, 586	i .		0	203, 132	1
17. 00   01700   SOCIAL SERVICE 19. 00   01900   NONPHYSICIAN ANESTHETISTS	0			0 0	640, 666 0	1
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	, <u> </u>	I	0 0	0	19.00
30. 00 03000 ADULTS & PEDIATRICS	11, 476					•
31. 00   03100   NTENSI VE CARE UNI T	1, 081					•
43. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	786	823	237, 83	0 0	330, 159	43.00
50. 00   05000   OPERATI NG   ROOM	15, 169	233, 796	1, 175, 69	1 0	2, 429, 905	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 339					•
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	0 4, 785	1,			441, 266 1, 445, 487	•
54. 10   03630   ULTRA SOUND	337				438, 575	•
54. 20   03440   MAMMOGRAPHY	0	46, 320			204, 902	•
56. 00   05600   RADI OI SOTOPE	57	1	1		203, 235	1
57. 00   05700   CT   SCAN 58. 00   05800   MRI	701 1, 133				686, 504 362, 713	
60. 00   06000   LABORATORY	2, 496		1		2, 485, 547	1
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0			0 0	138, 342	1
64. 00   06400   I NTRAVENOUS THERAPY 65. 00   06500   RESPI RATORY THERAPY	620	1	197, 31 497, 38		282, 402 781, 217	1
66. 00   06600   PHYSI CAL THERAPY	7,722				1, 253, 723	1
67. 00 06700 OCCUPATI ONAL THERAPY	2, 260		270, 70	3 0	387, 458	67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 256				217, 686	1
69. 00   06900  ELECTROCARDI OLOGY 70. 00   07000  ELECTROENCEPHALOGRAPHY	270	41, 443 17, 608			422, 054 282, 530	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 604	1	1	0 0	313, 376	1
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	1		0 0	,	
73. 00   07300   DRUGS CHARGED TO PATIENTS 76. 00   03950   DI ABETES SERVI CES	992 122		581, 41 127, 66			•
76. 00 03930 DIABETES SERVICES 76. 97 07697 CARDIAC REHABILITATION	1, 587				169, 197 142, 209	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	1	0 0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	) 0		0 0	0	78. 00
0UTPATIENT SERVICE COST CENTERS  88. 00   08800   RURAL   HEALTH   CLINIC - STREATOR	17, 635	i 0	3, 294, 23	2 0	5, 879, 194	88. 00
88. 01   08801   RURAL HEALTH CLINIC - PONTIAC	3, 902	<b> </b>			3, 019, 418	•
88. 02 08802 RURAL HEALTH CLINIC - CULLOM	1, 391				365, 890	
88. 03   08803   RURAL HEALTH CLINIC - DWIGHT 88. 04   08804   RURAL HEALTH CLINIC - FAIRBURY	5, 933				798, 357 1, 043, 370	•
88. 05   08805 RURAL HEALTH CLINIC - MINONK	1, 338	l .			621, 646	1
88.06 08806 RURAL HEALTH CLINIC - FLANAGAN	2, 500	936	264, 61	1 0	477, 372	88. 06
88. 07 08807 RURAL HEALTH CLINIC - REYNOLDS	0				1, 775, 167	1
88.08   08808   RURAL HEALTH CLINIC - EL PASO 88.09   08809   RURAL HEALTH CLINIC - CLINTON	2, 499 2, 862				891, 401 1, 567, 689	1
90. 00   09000   CLI NI C	989		75, 02		113, 833	
91. 00 09100 EMERGENCY	6, 768	31, 955	2, 273, 40	8 0	3, 592, 500	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	T 0	0	1	0 0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	152, 369	2, 045, 163	27, 612, 07	2 -11, 631, 407	52, 351, 643	118.00
NONREI MBURSABLE COST CENTERS  190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN	2, 271		19, 98	1 0	62 103	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	30, 544				3, 798, 378	192. 00
192.01 19201 CARDIAC PHASE III	16	0	1, 16			192. 01
192. 02 19202 FUND DEVELOPMENT	951	0	23, 72	6 0	84, 620	192. 02

Health Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od: From 10/01/2022	Worksheet B-1	
				To 09/30/2023	Date/Time Prep 2/21/2024 2:0	
	CAPITAL REL	LATED COSTS				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	

						2/21/2024 2:0	ı pm
		CAPITAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	
				DEPARTMENT (GROSS SALARI ES)		(ACCUM. COST)	
		1.00	2. 00	4.00	5A	5. 00	
192.03	19203 PULMONARY FUNCTION	0	0	0	0	0	192. 03
192. 04	19204 RESEARCH	0	0	0	0	0	192. 04
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 304, 996	2, 086, 233	8, 987, 502		11, 631, 407	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	7. 010416	1. 019261	0. 303277		0. 206603	203. 00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		1, 262, 883	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000000		0. 022432	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0161

Peri od: Worksheet B-1 From 10/01/2022 To 09/30/2023 Date/Ti me Prepared:

2/21/2024 2:01 pm Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY REPAI RS PLANT LINEN SERVICE (SQUARE FEET) (MEALS SERVED) (SQUARE FEET) (SQUARE FEET) (POUNDS OF 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 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 150, 642 6.00 00700 OPERATION OF PLANT 7.00 7.00 8,969 141, 673 00800 LAUNDRY & LINEN SERVICE 8.00 186, 374 8.00 9.00 00900 HOUSEKEEPI NG 1, 321 1, 321 140, 352 9.00 01000 DI ETARY 513 513 513 16, 839 10.00 10.00 0 1, 518 01100 CAFETERI A 0 11.00 1,518 1,518 Λ 11.00 01300 NURSING ADMINISTRATION 13.00 343 343 0 343 0 13.00 14.00 01400 CENTRAL SERVICE & SUPPLY 0 0 14.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 1.586 1.586 1.586 0 16.00 01700 SOCIAL SERVICE 0 17.00 0 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 12, 504 30.00 03000 ADULTS & PEDIATRICS 41, 587 30.00 11 476 11 476 11 476 31.00 03100 INTENSIVE CARE UNIT 1,081 1,081 9, 538 1,081 3, 332 31.00 43.00 04300 NURSERY 786 2,005 786 149 43.00 786 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50 00 28 061 50 00 15, 169 15, 169 15, 169 600 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 339 1, 339 3, 416 1, 339 254 52.00 05300 ANESTHESI OLOGY 53.00 53.00 0 54 00 05400 RADI OLOGY-DI AGNOSTI C 4.785 4, 785 25, 390 4.785 54 00 0 54.10 03630 ULTRA SOUND 337 337 0 337 0 54.10 03440 MAMMOGRAPHY 0 0 54.20 54.20 56.00 05600 RADI OI SOTOPE 57 57 0 57 0 56.00 57 00 05700 CT SCAN 701 701 0 701 57 00 0 58.00 05800 MRI 1.133 1, 133 0 1, 133 0 58.00 06000 LABORATORY 0 60.00 60.00 2.496 2, 496 2.496 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 63.00 06400 INTRAVENOUS THERAPY 0 0 0 64.00 C 0 64.00 65.00 06500 RESPIRATORY THERAPY 620 620 0 620 0 65.00 06600 PHYSI CAL THERAPY 66.00 7.722 7,722 3, 987 7.722 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 2.260 2, 260 0 67.00 2, 260 0 06800 SPEECH PATHOLOGY 0 68.00 1, 256 1, 256 1, 256 0 68.00 69.00 06900 ELECTROCARDI OLOGY 270 270 270 0 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 2,604 71.00 0 71.00 2,604 2, 604 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 992 992 0 992 0 73.00 76.00 03950 DI ABETES SERVI CES 122 122 0 122 0 76.00 07697 CARDIAC REHABILITATION 0 76.97 1,587 1, 587 1,587 0 76.97 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 C 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC - STREATOR 17.635 17, 635 0 17.635 0 08801 RURAL HEALTH CLINIC - PONTIAC 3,902 40 3, 902 0 88.01 3, 902 88.01 08802 RURAL HEALTH CLINIC - CULLOM 08803 RURAL HEALTH CLINIC - DWIGHT 88.02 1, 391 1, 391 0 1, 391 0 88.02 88.03 452 0 88.03 88.04 08804 RURAL HEALTH CLINIC - FAIRBURY 5.933 5, 933 310 5.933 0 88.04 88.05 08805 RURAL HEALTH CLINIC - MINONK 1,338 1, 338 1, 338 0 88.05 08806 RURAL HEALTH CLINIC - FLANAGAN 0 2,500 2,500 2.500 0 88.06 88.06 08807 RURAL HEALTH CLINIC - REYNOLDS 88.07 0 0 88 07 08808 RURAL HEALTH CLINIC - EL PASO 88.08 2,499 2, 499 0 2, 499 0 88.08 08809 RURAL HEALTH CLINIC - CLINTON 88.09 2,862 2, 862 0 2,862 0 88.09 09000 CLI NI C 90.00 90.00 989 989 0 989 0 09100 EMERGENCY 91.00 6, 768 6, 768 69, 886 6, 768 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 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) 116, 860 107, 891 184, 679 106, 570 16, 839 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 2 271 2 271 2 271 C 192.00 19200 PHYSICIANS' PRIVATE OFFICES 30, 544 30, 544 1,695 30, 544 0 192.00 192. 01 19201 CARDI AC PHASE III 0 192. 01 16 16 16 192. 02 19202 FUND DEVELOPMENT 951 951 0 951 0 192. 02 0 192. 03 19203 PULMONARY FUNCTION 0 192.03 0 C 0 192. 04 19204 RESEARCH 0 0 0 0 192. 04 200.00 Cross Foot Adjustments 200.00

Health Financial Systems	SAINT JAMES	HOSPITAL	In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C	Peri od: From 10/01/2022	Worksheet B-1	
			To 09/30/2023	Date/Time Prep 2/21/2024 2:0	
Cost Center Description	MAINTENANCE &	OPERATION OF	 HOUSEKEEPI NG		

				'	0 77 007 2020	2/21/2024 2:0	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF			
				LAUNDRY)			
		6. 00	7. 00	8. 00	9. 00	10.00	
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	630, 189	2, 252, 734	212, 486	1, 267, 228	306, 430	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	4. 183355	15. 900941	1. 140105	9. 028927	18. 197636	203. 00
204.00	Cost to be allocated (per Wkst. B,	21, 915	192, 621	3, 950	47, 982	15, 390	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 145477	1. 359617	0. 021194	0. 341869	0. 913950	205. 00
	[11]						
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)						

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0161 Peri od: Worksheet B-1 From 10/01/2022 09/30/2023 Date/Time Prepared: 2/21/2024 2:01 pm Cost Center Description CAFETERI A NURSI NG CENTRAL MEDI CAL SOCIAL SERVICE SERVICE & (FTE'S) ADMI NI STRATI ON RECORDS & **SUPPLY** LI BRARY (TOTAL PATI (COSTED (FTE'S) (GROSS ENT DAYS) REQUIS.) CHARGES) 17.00 11.00 13.00 14.00 16.00 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 20, 924 11.00 13.00 01300 NURSING ADMINISTRATION 943 8.416 13.00 14.00 01400 CENTRAL SERVICE & SUPPLY 241 1, 825, 723 14.00 01600 MEDICAL RECORDS & LIBRARY 257, 871, 630 16 00 16.00 0 C C 17.00 01700 SOCIAL SERVICE 0 0 4, 450 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3,833 3,832 177, 614 15, 173, 351 3, 168 30.00 03100 INTENSIVE CARE UNIT 592 592 34, 028 2, 550, 111 1,065 31.00 31.00 383, 520 43.00 04300 NURSERY 247 247 217 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 185 1, 185 64, 162 18, 894, 658 0 50.00 654, 637 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 53.00 05300 ANESTHESI OLOGY 425 0 19, 746 2, 582, 890 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 8, 209, 836 54 00 718 Ω 6.040 0 54 00 54.10 03630 ULTRA SOUND 305 0 9,023 6, 387, 023 0 54.10 03440 MAMMOGRAPHY 54.20 161 3, 294 3, 314, 180 0 54.20 05600 RADI OI SOTOPE 56, 00 0 1.031 4. 113. 029 0 56, 00 0 05700 CT SCAN 0 29, 759, 951 57.00 276 58.434 0 57.00 58.00 05800 MRI 260 0 18, 424 8, 618, 243 0 58.00 06000 LABORATORY 60.00 1,697 45, 687 46, 738, 865 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 834.699 0 63.00 0 06400 INTRAVENOUS THERAPY 64.00 207 0 18.403 1,088,554 0 64.00 06500 RESPIRATORY THERAPY 85, 529 3, 783, 678 65.00 556 0 65.00 06600 PHYSI CAL THERAPY 66.00 1,084 6,845 4, 877, 915 0 66.00 06700 OCCUPATIONAL THERAPY 2, 128, 521 67.00 67.00 297 0 890 0 06800 SPEECH PATHOLOGY 68.00 187 0 820, 698 0 68.00 69.00 06900 ELECTROCARDI OLOGY 343 7.883 8, 789, 085 0 69.00 07000 ELECTROENCEPHALOGRAPHY 3, 908 1, 485, 137 70.00 70.00 160 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT Λ 444. 190 809, 077 71.00 0 Λ 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 348, 096 2, 058, 819 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 521 10,608 27, 505, 390 0 73.00 03950 DI ABETES SERVI CES 76.00 76.00 130 130 C 145, 712 0 76.97 07697 CARDIAC REHABILITATION 155 C 828 593, 467 0 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 C 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC - STREATOR 0 67, 942 8, 854, 856 0 88.00 0 08801 RURAL HEALTH CLINIC - PONTIAC 88.01 1,736 0 37, 092 5, 831, 731 0 88.01 08802 RURAL HEALTH CLINIC - CULLOM 88.02 0 9.760 698, 436 88.02 0 0 9, 492 88.03 08803 RURAL HEALTH CLINIC - DWIGHT 0 0 1, 236, 278 0 88.03 88.04 08804 RURAL HEALTH CLINIC - FAIRBURY 0 0 11,589 1, 433, 997 0 88.04 08805 RURAL HEALTH CLINIC - MINONK 0 1, 217, 170 88.05 28, 530 0 88.05 08806 RURAL HEALTH CLINIC - FLANAGAN 0 Ω 6 398 88 06 88 06 746, 387 0 08807 RURAL HEALTH CLINIC - REYNOLDS 0 88.07 C 27, 629 3, 246, 945 0 88.07 08808 RURAL HEALTH CLINIC - EL PASO 0 1, 481, 525 88.08 88.08 16, 164 0 3, 346, 009 88.09 08809 RURAL HEALTH CLINIC - CLINTON 0 C 32, 910 88.09 0 90 00 09000 CLINIC 181 976 90 00 124 565 0 91.00 09100 EMERGENCY 2,430 2, 430 204, 905 27, 295, 274 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 0 102. 00 0 0 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 8, 416 1, 817, 639 4, 450 118. 00 18, 813 257, 871, 630 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 18 622 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 2.050 7, 462 0 192. 01 19201 CARDI AC PHASE III 0 0 0 192. 01 2 192. 02 19202 FUND DEVELOPMENT 0 0 192. 02 41 0 192. 03 19203 PULMONARY FUNCTION 0 0 0 0 192. 03 192. 04 19204 RESEARCH 0 0 0 192.04

Health Financial Systems	SAINT JAMES	HOSPITAL		In Lie	eu of Form CMS-2	552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der 0		Peri od: From 10/01/2022	Worksheet B-1	
				To 09/30/2023	Date/Time Prep 2/21/2024 2:01	
Cost Center Description	CAFETERI A (FTF' S)	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICE &	MEDI CAL RECORDS &	SOCIAL SERVICE	

				Ι΄	0 077 007 2020	2/21/2024 2:0	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	SOCIAL SERVICE	
		(FTE' S)	ADMI NI STRATI ON	SERVICE &	RECORDS &		
				SUPPLY	LI BRARY	(TOTAL PATI	
			(FTE'S)	(COSTED	(GROSS	ENT DAYS)	
				REQUI S. )	CHARGES)		
		11. 00	13.00	14. 00	16.00	17. 00	
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	678, 290	2, 879, 823	499, 600	291, 274	773, 030	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	32. 416842	342. 184292	0. 273645	0. 001130	173. 714607	203. 00
204.00	Cost to be allocated (per Wkst. B,	27, 072	102, 391	9, 455	18, 605	14, 371	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	1. 293825	12. 166231	0. 005179	0.000072	3. 229438	205. 00
	11)						
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

SAINT JAMES HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0161

Period: Worksheet B-1

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0161 From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/21/2024 2:01 pm Cost Center Description NONPHYSI CI AN **ANESTHETI STS** (ASSI GNED TIME) 19.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICE & SUPPLY 14.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 43.00 04300 NURSERY 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 50 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 000000000000000000000000 52.00 05300 ANESTHESI OLOGY 53.00 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 54 00 54.10 03630 ULTRA SOUND 54.10 54. 20 03440 MAMMOGRAPHY 54. 20 56.00 05600 RADI OI SOTOPE 56.00 05700 CT SCAN 57 00 57 00 58.00 05800 MRI 58.00 06000 LABORATORY 60.00 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 64.00 06400 INTRAVENOUS THERAPY 64 00 65.00 06500 RESPIRATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 76.00 03950 DI ABETES SERVI CES 76.00 76. 97 07697 CARDIAC REHABILITATION 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC - STREATOR 88 00 08801 RURAL HEALTH CLINIC - PONTIAC 88.01 00000000000 88.01 08802 RURAL HEALTH CLINIC - CULLOM 08803 RURAL HEALTH CLINIC - DWIGHT 88.02 88.02 88.03 88.03 88.04 08804 RURAL HEALTH CLINIC - FAIRBURY 88.04 88.05 08805 RURAL HEALTH CLINIC - MINONK 88.05 08806 RURAL HEALTH CLINIC - FLANAGAN 88.06 88.06 08807 RURAL HEALTH CLINIC - REYNOLDS 88.07 88 07 08808 RURAL HEALTH CLINIC - EL PASO 88.08 88.08 08809 RURAL HEALTH CLINIC - CLINTON 88.09 88.09 09000 CLI NI C 90.00 90.00 09100 EMERGENCY 91.00 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 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.00 0 0 0 192. 01 19201 CARDI AC PHASE III 192. 01 192. 02 19202 FUND DEVELOPMENT 192. 02 192. 03 19203 PULMONARY FUNCTION 192. 03 192. 04 19204 RESEARCH 0 192.04 200.00 Cross Foot Adjustments 200.00

COST ALLOCATION - STATISTICAL BASIS  Provider CCN: 14-0161  Period: From 10/01/2022 To 09/30/2023  Date/Time Prepared: 2/21/2024 2: 01 pm  Cost Center Description  NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME) 19.00  Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, Part I)  Period: From 10/01/2022 To 09/30/2023  Date/Time Prepared: 2/21/2024 2: 01 pm  201.00 202.00	Heal th Fi	nancial Systems	SAINT JAMES HOSPITAL			In Lieu of Form CMS-2552-10			
To 09/30/2023   Date/Time Prepared: 2/21/2024 2:01 pm	COST ALL	OCATION - STATISTICAL BASIS		Provi der CCN:	14-0161		Worksheet B-1		
ANESTHETISTS (ASSIGNED TIME) 19.00  201.00   Negative Cost Centers 202.00   Cost to be allocated (per Wkst. B, 0)  202.00   Negative Cost Centers 202.00   Ost to be allocated (per Wkst. B, 0)									
CASSIGNED   TI ME)   19.00     Negative Cost Centers   201.00   Cost to be allocated (per Wkst. B,   0   202.00		Cost Center Description	NONPHYSI CI AN						
TIME)   19.00     Negative Cost Centers   201.00   Cost to be allocated (per Wkst. B, 0   202.00									
19.00   Negative Cost Centers   201.00   Cost to be allocated (per Wkst. B,   0   202.00			,						
201.00   Negative Cost Centers   201.00   202.00   Cost to be allocated (per Wkst. B,   0   202.00			TIME)						
202.00 Cost to be allocated (per Wkst. B, 0			19. 00						
	201.00	Negative Cost Centers						201. 00	
Part I)	202.00	Cost to be allocated (per Wkst. B,	0					202. 00	
		Part I)							
203.00   Unit cost multiplier (Wkst. B, Part I)   0.000000   203.00	203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000					203. 00	
204.00   Cost to be allocated (per Wkst. B,   0   204.00	204.00	Cost to be allocated (per Wkst. B,	0					204. 00	
Part II)		Part II)							
205.00 Unit cost multiplier (Wkst. B, Part   0.000000   205.00	205.00	Unit cost multiplier (Wkst. B, Part	0. 000000					205. 00	
		11)							
206.00 NAHE adjustment amount to be allocated 206.00	206.00	NAHE adjustment amount to be allocated						206. 00	
(per Wkst. B-2)		(per Wkst. B-2)							
207.00 NAHE unit cost multiplier (Wkst. D, 207.00	207.00	NAHE unit cost multiplier (Wkst. D,						207. 00	
Parts III and IV)		Parts III and IV)							

Date/Time Prepared: 09/30/2023 2/21/2024 2:01 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 8, 720, 770 8, 720, 770 8, 720, 770 03100 INTENSIVE CARE UNIT 1, 642, 707 1, 642, 707 0 1, 642, 707 31.00 31.00 43.00 04300 NURSERY 556, 907 556, 907 0 556, 907 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 899, 271 3, 899, 271 3, 899, 271 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 726, 737 726, 737 0 726, 737 52.00 0 53.00 05300 ANESTHESI OLOGY 554, 532 554, 532 554, 532 53.00 1, 946, 587 54.00 05400 RADI OLOGY-DI AGNOSTI C 1.946.587 1, 946, 587 54.00 0 54.10 03630 ULTRA SOUND 558, 571 558, 571 558, 571 54.10 54. 20 03440 MAMMOGRAPHY 257, 100 257, 100 0 0 0 257, 100 54. 20 05600 RADI OI SOTOPE 251, 813 56.00 251, 813 251, 813 56.00 05700 CT SCAN 907.313 907.313 907, 313 57.00 57 00 58.00 05800 MRI 493, 846 493, 846 493, 846 58.00 06000 LABORATORY 3, 191, 942 60.00 3, 191, 942 3, 191, 942 0 0 0 0 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 167.867 167, 867 63 00 167 867 63 00 06400 INTRAVENOUS THERAPY 64.00 353, 723 353, 723 353, 723 64.00 06500 RESPIRATORY THERAPY 1,006,375 1,006,375 1,006,375 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 1, 784, 629 1, 784, 629 1, 784, 629 66.00 06700 OCCUPATIONAL THERAPY 67 00 Ω 545, 580 545, 580 67 00 545 580 68.00 06800 SPEECH PATHOLOGY 306, 216 306, 216 306, 216 68.00 69.00 06900 ELECTROCARDI OLOGY 540, 321 540, 321 0 0 0 0 0 0 540, 321 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 348 836 348 836 348 836 70 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 576, 393 576, 393 576, 393 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 517, 593 517, 593 517, 593 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 4, 895, 824 4, 895, 824 4, 895, 824 73.00 03950 DIABETES SERVICES 76 00 256, 569 256, 569 76 00 256, 569 76.97 07697 CARDIAC REHABILITATION 223, 716 223, 716 223, 716 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 C 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC - STREATOR 7, 635, 851 7, 635, 851 0 7, 635, 851 88.00 08801 RURAL HEALTH CLINIC - PONTIAC 3, 829, 900 3, 829, 900 0 3, 829, 900 88.01 88.01 0 88.02 08802 RURAL HEALTH CLINIC - CULLOM 485.440 485, 440 485, 440 88.02 |08803| RURAL HEALTH CLINIC - DWIGHT 967, 809 967, 809 88.03 967, 809 88 03 0 88.04 08804 RURAL HEALTH CLINIC - FAIRBURY 1, 436, 806 1, 436, 806 1, 436, 806 88.04 88 05 08805 RURAL HEALTH CLINIC - MINONK 798, 223 798, 223 0 798, 223 88 05 08806 RURAL HEALTH CLINIC - FLANAGAN 651, 374 88.06 651.374 651.374 88.06 08807 RURAL HEALTH CLINIC - REYNOLDS 2, 153, 152 88.07 2, 153, 152 2, 153, 152 88 07 88.08 08808 RURAL HEALTH CLINIC - EL PASO 1, 154, 417 1, 154, 417 0 0 1, 154, 417 88.08 88.09 08809 RURAL HEALTH CLINIC - CLINTON 1, 987, 687 1, 987, 687 1, 987, 687 88.09 09000 CLINIC 170, 525 90.00 170, 525 170, 525 90.00 91.00 09100 EMERGENCY 5, 608, 634 5, 608, 634 5, 608, 634 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2, 913, 034 2, 913, 034 2, 913, 034 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 102 00 200.00 Subtotal (see instructions) 65, 024, 590 65, 024, 590 65, 024, 590 200. 00 0 201.00 Less Observation Beds 2, 913, 034 2, 913, 034 2, 913, 034 201. 00

62, 111, 556

0

62, 111, 556

o

62, 111, 556 202. 00

202.00

From 10/01/2022 Part I Date/Time Prepared: 09/30/2023 2/21/2024 2:01 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 9, 670, 932 9, 670, 932 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 2, 550, 111 2, 550, 111 31.00 383, 520 04300 NURSERY 43.00 43.00 383, 520 ANCILLARY SERVICE COST CENTERS 16, 319, 245 50.00 50.00 2, 575, 413 18, 894, 658 0.206369 0.000000 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 607, 065 47, 572 654, 637 1.110137 0.000000 52.00 53 00 05300 ANESTHESI OLOGY 491, 205 2, 091, 685 2, 582, 890 0.214694 0.000000 53 00 05400 RADI OLOGY-DI AGNOSTI C 7, 466, 060 0. 237104 743.776 8, 209, 836 0.000000 54.00 54.00 03630 ULTRA SOUND 5, 990, 551 0.000000 54.10 396, 472 6, 387, 023 0.087454 54 10 54.20 03440 MAMMOGRAPHY 1,717 3, 312, 463 3, 314, 180 0.077576 0.000000 54.20 56.00 05600 RADI OI SOTOPE 260, 398 3, 852, 631 4, 113, 029 0.061223 0.000000 56.00 25, 978, 975 29, 759, 951 05700 CT SCAN 0.030488 0.000000 57.00 3, 780, 976 57.00 58.00 05800 MRI 632, 236 7, 986, 007 8, 618, 243 0.057302 0.000000 58.00 06000 LABORATORY 7, 278, 705 39, 460, 160 46, 738, 865 0.068293 0.000000 60.00 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 246, 674 588, 025 834, 699 0.201111 0.000000 63.00 06400 INTRAVENOUS THERAPY 1.087.834 1.088.554 0.324948 64.00 720 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 2, 379, 628 1, 404, 050 3, 783, 678 0. 265978 0.000000 65.00 06600 PHYSI CAL THERAPY 4, 344, 648 4, 877, 915 0. 365859 0.000000 66.00 533, 267 66.00 06700 OCCUPATIONAL THERAPY 352, 270 2, 128, 521 0. 256319 0.000000 67.00 1, 776, 251 67.00 121, 959 06800 SPEECH PATHOLOGY 68.00 698, 739 820, 698 0.373117 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 1, 354, 556 7, 434, 529 8, 789, 085 0.061476 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 485, 137 1, 485, 137 0. 234885 0.000000 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 342 258 466, 819 809.077 0 712408 0 000000 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 722, 827 1, 335, 992 2, 058, 819 0.251403 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 5, 580, 562 21, 924, 828 27, 505, 390 0.177995 0.000000 73.00 73.00 76.00 03950 DI ABETES SERVI CES 145, 712 145, 712 1.760795 0.000000 76.00 0 76.97 07697 CARDIAC REHABILITATION 0.000000 22,060 571, 407 593, 467 0.376965 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0.000000 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC - STREATOR 08801 RURAL HEALTH CLINIC - PONTIAC 88.00 0 8, 854, 856 8, 854, 856 88.00 88. 01 0 5, 831, 731 5, 831, 731 88.01 88.02 08802 RURAL HEALTH CLINIC - CULLOM 0 0 0 698, 436 698, 436 88.02 08803 RURAL HEALTH CLINIC - DWIGHT 1, 236, 278 88 03 1, 236, 278 88 03 88.04 08804 RURAL HEALTH CLINIC - FAIRBURY 1, 433, 997 1, 433, 997 88.04 08805 RURAL HEALTH CLINIC - MINONK 1, 217, 170 1, 217, 170 88.05 88.05 88.06 08806 RURAL HEALTH CLINIC - FLANAGAN 0 0 746, 387 746. 387 88.06 08807 RURAL HEALTH CLINIC - REYNOLDS 3, 246, 945 3, 246, 945 88 07 88 07 88.08 08808 RURAL HEALTH CLINIC - EL PASO 1, 481, 525 1, 481, 525 88.08 88.09 08809 RURAL HEALTH CLINIC - CLINTON 0 3, 346, 009 3, 346, 009 88.09 09000 CLI NI C 0. 937074 90.00 181. 976 181.976 0.000000 90.00 0 91.00 91.00 09100 EMERGENCY 3, 542, 563 23, 752, 711 27, 295, 274 0 205480 0.000000 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 893, 858 3, 608, 561 5, 502, 419 0.529410 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPLOLD TREATMENT PROGRAM 102.00 211, 405, 902 257, 871, 630 200.00 Subtotal (see instructions) 46, 465, 728 200. 00 201.00 Less Observation Beds 201.00

46, 465, 728

211, 405, 902

257, 871, 630

202.00

202.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0161

Period:
From 10/01/2022
To 09/30/2023

Bate/Time Prepared:

2/21/2024 2:01 pm Title XVIII Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0. 206369 52.00 05200 DELIVERY ROOM & LABOR ROOM 1. 110137 52.00 05300 ANESTHESI OLOGY 0.214694 53 00 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 237104 54.00 54.10 03630 ULTRA SOUND 0.087454 54.10 54. 20 03440 MAMMOGRAPHY 0.077576 54 20 05600 RADI 0I S0T0PE 56.00 0.061223 56.00 57.00 05700 CT SCAN 0.030488 57.00 58.00 05800 MRI 0.057302 58.00 06000 LABORATORY 0.068293 60.00 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 201111 63.00 06400 I NTRAVENOUS THERAPY 0. 324948 64.00 64.00 06500 RESPIRATORY THERAPY 0. 265978 65.00 65.00 06600 PHYSI CAL THERAPY 0. 365859 66.00 66 00 67.00 06700 OCCUPATIONAL THERAPY 0. 256319 67.00 06800 SPEECH PATHOLOGY 68.00 0.373117 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 0.061476 70.00 07000 ELECTROENCEPHALOGRAPHY 0. 234885 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.712408 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 251403 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 177995 73.00 73.00 76.00 03950 DI ABETES SERVI CES 1.760795 76.00 76. 97 07697 CARDIAC REHABILITATION 0. 376965 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC - STREATOR 08801 RURAL HEALTH CLINIC - PONTIAC 88.00 88.00 88 01 88 01 08802 RURAL HEALTH CLINIC - CULLOM 88.02 88.02 08803 RURAL HEALTH CLINIC - DWIGHT 88. 03 88.03 88.04 08804 RURAL HEALTH CLINIC - FAIRBURY 88.04 08805 RURAL HEALTH CLINIC - MINONK 08806 RURAL HEALTH CLINIC - FLANAGAN 88.05 88.05 88.06 88.06 08807 RURAL HEALTH CLINIC - REYNOLDS 88.07 88.07 08808 RURAL HEALTH CLINIC - EL PASO 08809 RURAL HEALTH CLINIC - CLINTON 88 08 88 08 88.09 88.09 90.00 09000 CLI NI C 0. 937074 90.00 91.00 09100 EMERGENCY 0. 205480 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 529410 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 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

From 10/01/2022 Part I Date/Time Prepared: 09/30/2023 2/21/2024 2:01 pm Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 8, 720, 770 8, 720, 770 8, 720, 770 03100 INTENSIVE CARE UNIT 1, 642, 707 1, 642, 707 0 1, 642, 707 31.00 31.00 43.00 04300 NURSERY 556, 907 556, 907 0 556, 907 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 899, 271 3, 899, 271 3, 899, 271 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 726, 737 726, 737 0 726, 737 52.00 0 53.00 05300 ANESTHESI OLOGY 554, 532 554, 532 554, 532 53.00 1, 946, 587 54.00 05400 RADI OLOGY-DI AGNOSTI C 1.946.587 1, 946, 587 54.00 0 54.10 03630 ULTRA SOUND 558, 571 558, 571 558, 571 54.10 54. 20 03440 MAMMOGRAPHY 257, 100 257, 100 0 0 0 257, 100 54. 20 05600 RADI OI SOTOPE 251, 813 56.00 251, 813 251, 813 56.00 05700 CT SCAN 907.313 907.313 907, 313 57.00 57 00 58.00 05800 MRI 493, 846 493, 846 493, 846 58.00 06000 LABORATORY 3, 191, 942 60.00 3, 191, 942 3, 191, 942 0 0 0 0 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 167.867 167, 867 63 00 167 867 63 00 06400 INTRAVENOUS THERAPY 64.00 353, 723 353, 723 353, 723 64.00 06500 RESPIRATORY THERAPY 1,006,375 1,006,375 1,006,375 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 1, 784, 629 1, 784, 629 1, 784, 629 66.00 06700 OCCUPATIONAL THERAPY 67 00 Ω 545, 580 545, 580 67 00 545 580 68.00 06800 SPEECH PATHOLOGY 306, 216 306, 216 306, 216 68.00 69.00 06900 ELECTROCARDI OLOGY 540, 321 540, 321 0 0 0 0 0 0 540, 321 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 348 836 348 836 348 836 70 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 576, 393 576, 393 576, 393 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 517, 593 517, 593 517, 593 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 4, 895, 824 4, 895, 824 4, 895, 824 73.00 76 00 03950 DI ABETES SERVICES 256, 569 256, 569 76 00 256, 569 76.97 07697 CARDIAC REHABILITATION 223, 716 223, 716 223, 716 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 C 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC - STREATOR 7, 635, 851 7, 635, 851 0 7, 635, 851 88.00 08801 RURAL HEALTH CLINIC - PONTIAC 3, 829, 900 3, 829, 900 0 3, 829, 900 88.01 88.01 0 88.02 08802 RURAL HEALTH CLINIC - CULLOM 485.440 485, 440 485, 440 88.02 |08803| RURAL HEALTH CLINIC - DWIGHT 967, 809 967, 809 88.03 967, 809 88 03 0 88.04 08804 RURAL HEALTH CLINIC - FAIRBURY 1, 436, 806 1, 436, 806 1, 436, 806 88.04 88 05 08805 RURAL HEALTH CLINIC - MINONK 798, 223 798, 223 0 798, 223 88 05 08806 RURAL HEALTH CLINIC - FLANAGAN 651, 374 88.06 651.374 651.374 88.06 08807 RURAL HEALTH CLINIC - REYNOLDS 2, 153, 152 88.07 2, 153, 152 2, 153, 152 88 07 88.08 08808 RURAL HEALTH CLINIC - EL PASO 1, 154, 417 1, 154, 417 0 0 1, 154, 417 88.08 88.09 08809 RURAL HEALTH CLINIC - CLINTON 1, 987, 687 1, 987, 687 1, 987, 687 88.09 09000 CLINIC 170, 525 90.00 170, 525 170, 525 90.00 91.00 09100 EMERGENCY 5, 608, 634 5, 608, 634 5, 608, 634 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2, 913, 034 2, 913, 034 2, 913, 034 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 102 00

65, 024, 590

2, 913, 034

62, 111, 556

65, 024, 590

2, 913, 034

62, 111, 556

0

65, 024, 590 200. 00

2, 913, 034 201. 00

62, 111, 556 202. 00

0

o

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

From 10/01/2022 Part I Date/Time Prepared: 09/30/2023 2/21/2024 2:01 pm Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 9, 670, 932 9, 670, 932 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 2, 550, 111 2, 550, 111 31.00 04300 NURSERY 43.00 43.00 383, 520 383, 520 ANCILLARY SERVICE COST CENTERS 50.00 50.00 2, 575, 413 16, 319, 245 18, 894, 658 0.206369 0.000000 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 607, 065 47, 572 654, 637 1.110137 0.000000 52.00 53 00 05300 ANESTHESI OLOGY 491, 205 2, 091, 685 2, 582, 890 0.214694 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 7, 466, 060 0. 237104 743.776 8, 209, 836 0.000000 54.00 54.00 03630 ULTRA SOUND 5, 990, 551 0.000000 54.10 396, 472 6, 387, 023 0.087454 54 10 54.20 03440 MAMMOGRAPHY 1,717 3, 312, 463 3, 314, 180 0.077576 0.000000 54.20 56.00 05600 RADI OI SOTOPE 260, 398 3, 852, 631 4, 113, 029 0.061223 0.000000 56.00 25, 978, 975 29, 759, 951 05700 CT SCAN 0.030488 57.00 3, 780, 976 0.000000 57.00 58.00 05800 MRI 632, 236 7, 986, 007 8, 618, 243 0.057302 0.000000 58.00 06000 LABORATORY 7, 278, 705 39, 460, 160 46, 738, 865 0.068293 0.000000 60.00 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 246, 674 588, 025 834, 699 0.201111 0.000000 63.00 06400 INTRAVENOUS THERAPY 1.087.834 1.088.554 0.324948 64.00 720 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 2, 379, 628 1, 404, 050 3, 783, 678 0. 265978 0.000000 65.00 06600 PHYSI CAL THERAPY 4, 344, 648 4, 877, 915 0. 365859 66.00 533, 267 0.000000 66.00 06700 OCCUPATIONAL THERAPY 352, 270 2, 128, 521 0. 256319 0.000000 67.00 1, 776, 251 67.00 06800 SPEECH PATHOLOGY 121, 959 68.00 698, 739 820, 698 0.373117 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 1, 354, 556 7, 434, 529 8, 789, 085 0.061476 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 485, 137 1, 485, 137 0. 234885 0.000000 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 342 258 466, 819 809 077 0 712408 0 000000 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 722, 827 1, 335, 992 2, 058, 819 0.251403 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 5, 580, 562 21, 924, 828 27, 505, 390 0.177995 0.000000 73.00 73.00 76.00 03950 DI ABETES SERVI CES 145, 712 145, 712 1.760795 0.000000 76.00 76.97 07697 CARDIAC REHABILITATION 22,060 571, 407 593, 467 0.376965 0.000000 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0.000000 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC - STREATOR 08801 RURAL HEALTH CLINIC - PONTIAC 88.00 0 8, 854, 856 8, 854, 856 0.862335 0.000000 88.00 88.01 0 5, 831, 731 5, 831, 731 0.656735 0.000000 88.01 88.02 08802 RURAL HEALTH CLINIC - CULLOM 0 0 0 698, 436 698, 436 0.695039 0.000000 88.02 08803 RURAL HEALTH CLINIC - DWIGHT 0 782841 88 03 1, 236, 278 1, 236, 278 0.000000 88 03 0.000000 88.04 08804 RURAL HEALTH CLINIC - FAIRBURY 1, 433, 997 1, 433, 997 1.001959 88.04 08805 RURAL HEALTH CLINIC - MINONK 1, 217, 170 1, 217, 170 0.655802 0.000000 88.05 88.05 0 88.06 08806 RURAL HEALTH CLINIC - FLANAGAN 746, 387 746. 387 0.872703 0.000000 88.06 08807 RURAL HEALTH CLINIC - REYNOLDS 3, 246, 945 88 07 3, 246, 945 0.663132 0.000000 88 07 0 88.08 08808 RURAL HEALTH CLINIC - EL PASO 1, 481, 525 1, 481, 525 0.779209 0.000000 88.08 88.09 08809 RURAL HEALTH CLINIC - CLINTON 0 3, 346, 009 3, 346, 009 0.594047 0.000000 88.09 09000 CLI NI C 181, 976 0. 937074 90.00 181. 976 0.000000 90.00 0 91.00 09100 EMERGENCY 3, 542, 563 23, 752, 711 27, 295, 274 0.205480 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 893, 858 3, 608, 561 5, 502, 419 0.529410 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPLOLD TREATMENT PROGRAM 102.00 211, 405, 902 257, 871, 630 200.00 Subtotal (see instructions) 46, 465, 728 200. 00 201.00 Less Observation Beds 201.00

46, 465, 728

211, 405, 902

257, 871, 630

202.00

202.00

Heal th Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

SAINT JAMES HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 14-0161
From 10/01/2022
To 09/30/2023 Date/Time Prepared:

			10 09/30/2023	Date/II me Prepared:   2/21/2024 2:01 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient	THE XIX	nospi tui	3331
oost contor boson per on	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>			
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 I NTENSI VE CARE UNI T				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
50. 00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 10   03630   ULTRA SOUND	0. 000000			54. 10
54. 20 03440 MAMMOGRAPHY	0. 000000			54. 20
56. 00 05600 RADI OI SOTOPE	0. 000000			56. 00
57. 00 05700 CT SCAN	0. 000000			57. 00
58. 00   05800   MRI	0. 000000			58. 00
60. 00   06000   LABORATORY	0. 000000			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATIONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 00   03950   DI ABETES   SERVI CES	0. 000000			76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
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				
88.00 08800 RURAL HEALTH CLINIC - STREATOR	0. 000000			88. 00
88. 01   08801   RURAL HEALTH CLINIC - PONTIAC	0. 000000			88. 01
88. 02 08802 RURAL HEALTH CLINIC - CULLOM	0. 000000			88. 02
88. 03 08803 RURAL HEALTH CLINIC - DWIGHT	0. 000000			88. 03
88. 04   08804   RURAL HEALTH CLINIC - FAIRBURY	0. 000000			88. 04
88. 05   08805   RURAL HEALTH CLINIC - MINONK	0. 000000			88. 05
88. 06   08806   RURAL HEALTH CLINIC - FLANAGAN	0. 000000			88. 06
88. 07   08807 RURAL HEALTH CLINIC - REYNOLDS	0. 000000			88. 07
88. 08   08808 RURAL HEALTH CLINIC - EL PASO	0. 000000			88. 08
88. 09   08809   RURAL HEALTH CLINIC - CLINTON	0. 000000			88. 09
90. 00   09000   CLI NI C	0.000000			90.00
91. 00   09100   EMERGENCY	0.000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				400.00
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

Health Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 10/01/2022 To 09/30/2023		narod:
				10 09/30/2023	2/21/2024 2:0	pareu. 1 pm
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	399, 919	0	399, 91	9 4, 757	84. 07	30. 00
31.00   INTENSIVE CARE UNIT	100, 868		100, 86	1, 065	94. 71	31. 00
43. 00 NURSERY	19, 439		19, 43	9 217	89. 58	43.00
200.00 Total (lines 30 through 199)	520, 226		520, 22	6, 039		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 531		1			30. 00
31.00   INTENSIVE CARE UNIT	362	34, 285				31. 00
43. 00 NURSERY	0	0				43. 00
200.00 Total (lines 30 through 199)	1, 893	162, 996				200. 00

Health Financial Systems	SAINT JAMES	HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Period: From 10/01/2022 Fo 09/30/2023	Worksheet D Part II Date/Time Pre 2/21/2024 2:0	pared: 1 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col .	Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	150.040	10.004.50		0.000.00		
50. 00 05000 OPERATING ROOM	452, 948				22, 583	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	26, 255				-	52.00
53. 00   05300   ANESTHESI OLOGY	49, 823					1
54. 00   05400   RADI OLOGY-DI AGNOSTI C	119, 020				4, 949	
54. 10   03630   ULTRA SOUND	60, 258			1	1	1
54. 20   03440   MAMMOGRAPHY	52, 272				-	54. 20
56. 00   05600   RADI 0I SOTOPE	5, 913				228	
57. 00   05700   CT   SCAN	162, 915					
58. 00   05800   MRI	70, 787					
60. 00   06000   LABORATORY	142, 965					
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	3, 163					
64. 00   06400   I NTRAVENOUS THERAPY	6, 776		l		0	64. 00
65. 00 06500 RESPI RATORY THERAPY	62, 891		•			
66. 00 06600 PHYSI CAL THERAPY	112, 419					
67. 00   06700   OCCUPATI ONAL THERAPY	30, 584				2, 078	
68. 00   06800   SPEECH PATHOLOGY	18, 892		•		1, 413	
69. 00   06900   ELECTROCARDI OLOGY	55, 218		•	1	4, 415	
70. 00 07000 ELECTROENCEPHALOGRAPHY	97, 219				_	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	32, 453					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 759		•	1		
73.00 07300 DRUGS CHARGED TO PATIENTS	108, 247			1	9, 423	
76. 00   03950   DI ABETES   SERVI CES	6, 636	145, 712	0. 04554:	2 0	0	76. 00
76. 97   07697   CARDI AC   REHABI LI TATI ON	26, 696	593, 467	•	1	595	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0					77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 00000	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	1	1				
88.00 08800 RURAL HEALTH CLINIC - STREATOR	298, 587		1			
88. 01 08801 RURAL HEALTH CLINIC - PONTIAC	111, 419					88. 01
88.02 08802 RURAL HEALTH CLINIC - CULLOM	22, 523					88. 02
88.03 08803 RURAL HEALTH CLINIC - DWIGHT	187, 719		1		-	88. 03
88. 04   08804   RURAL HEALTH CLINIC - FAIRBURY	79, 628					88. 04
88.05 08805 RURAL HEALTH CLINIC - MINONK	29, 206					88. 05
88.06 08806 RURAL HEALTH CLINIC - FLANAGAN	34, 960					88. 06
88. 07 08807 RURAL HEALTH CLINIC - REYNOLDS	190, 920				1	88. 07
88.08   08808   RURAL HEALTH CLINIC - EL PASO	-4, 459				-	88. 08
88.09 08809 RURAL HEALTH CLINIC - CLINTON	65, 842					88. 09
90. 00 09000 CLI NI C	11, 490					90. 00
91. 00   09100   EMERGENCY	217, 281					1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	133, 586			1	22, 514	
200.00   Total (lines 50 through 199)	3, 092, 811	245, 267, 067	Ί	14, 615, 559	136, 535	200. 00

Health Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST			Period: From 10/01/2022 To 09/30/2023	Worksheet D Part III Date/Time Pre 2/21/2024 2:0	
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
· ·	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown	3	Adjustments		Education Cost	
	Adjustments					
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	O	0		0	0	30.00
31. 00 03100 INTENSIVE CARE UNIT	o	0		0	0	31. 00
43. 00   04300   NURSERY		0		0	0	
200.00 Total (lines 30 through 199)		0				200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200.00
oost content bescription	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	bays	0 . 601. 6)	l rogram bays	
	,	minus col. 4)				
	4.00	5.00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
30. 00   03000 ADULTS & PEDIATRICS	O	0	4, 75	7 0.00	1, 531	30.00
31. 00   03100   NTENSI VE CARE UNI T		0	1, 06			
43. 00   04300   NURSERY		0	21			
200.00 Total (lines 30 through 199)		0				200.00
Cost Center Description	Inpati ent		0,03	7	1,093	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
						30.00
30. 00   03000   ADULTS & PEDI ATRI CS	0					
31. 00   03100   INTENSI VE CARE UNIT	0					31.00
43. 00   04300   NURSERY	0					43.00
200.00   Total (lines 30 through 199)	0					200. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 10/01/2022 | Part IV | To 09/30/2023 | Date/Time Prepared: | Date/Time THROUGH COSTS

					10 07/30/202	2/21/2024 2:0	
			Ti tl e	e XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	Program	Program	Post-Stepdowr	i	
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	_			_1		
50. 00	05000 OPERATI NG ROOM	0		I .		0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C	1	0	0	
53.00	05300 ANESTHESI OLOGY	0	C	2	0	0	
54. 00	O5400  RADI OLOGY - DI AGNOSTI C	0		2	0	0	
54. 10	03630 ULTRA SOUND	0		2	0	0	54. 10
54. 20	03440 MAMMOGRAPHY	0		(	0	0 0	54. 20
56. 00 57. 00	05600	0		(	0	0 0	56.00
58.00	05700  CT   SCAN	0		()	0		57. 00 58. 00
60.00	06000 LABORATORY	0		()	0		1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0		1
64. 00	06400 I NTRAVENOUS THERAPY	0			0		
65. 00	06500 RESPIRATORY THERAPY	0			0		
66. 00	06600 PHYSI CAL THERAPY	0			0		1
67. 00	06700 OCCUPATI ONAL THERAPY	0	7		0		
68. 00	06800 SPEECH PATHOLOGY	0			0	ol o	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	Ĭ		0	ol o	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	ĺ		0	ol o	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	l c		0	ol o	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	l c		0	ol o	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	l c		0	ol o	73. 00
76. 00	03950 DI ABETES SERVI CES	0	l c		0	ol o	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	C		0	ol o	76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	C		0	o o	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	C		0	o o	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - STREATOR	0	C	)	0	0 0	88. 00
88. 01	08801 RURAL HEALTH CLINIC - PONTIAC	0	C	)	0	0 0	88. 01
88. 02	08802 RURAL HEALTH CLINIC - CULLOM	0	C	)	0	0 0	88. 02
88. 03	08803 RURAL HEALTH CLINIC - DWIGHT	0	C		0	0 0	88. 03
88. 04	08804 RURAL HEALTH CLINIC - FAIRBURY	0	C	)	0	0 0	88. 04
88. 05	08805 RURAL HEALTH CLINIC - MINONK	0	C	)	0	0	
88. 06	08806 RURAL HEALTH CLINIC - FLANAGAN	0	C	)	0	0	
88. 07	08807 RURAL HEALTH CLINIC - REYNOLDS	0	C		0	0	
88. 08	08808 RURAL HEALTH CLINIC - EL PASO	0	[ C	]	U	0	
88. 09	08809 RURAL HEALTH CLINIC - CLINTON	0	C	2	0	0	
90.00	09000 CLINIC	0			U	0	
91.00	09100 EMERGENCY	0		'	U	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			J	0	0	
200.00	Total (lines 50 through 199)	0	[ C	יו	0	0 0	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-0161 Peri od: Worksheet D From 10/01/2022 To 09/30/2023 THROUGH COSTS Part IV Date/Time Prepared: 2/21/2024 2:01 pm Title XVIII Hospi tal Ratio of Cost Cost Center Description All Other Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of (col. 5 ÷ col Part I, col. 4) 8) col s. 2. 3. 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 18, 894, 658 0.00000050.00 0000000000000000000000000 05200 DELIVERY ROOM & LABOR ROOM 0 0 654, 637 0.000000 52.00 52.00 53.00 05300 ANESTHESI OLOGY 0 0 2, 582, 890 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 8, 209, 836 0.000000 54 00 54 00 0 54.10 03630 ULTRA SOUND 0 6, 387, 023 0.000000 54.10 54. 20 03440 MAMMOGRAPHY 3, 314, 180 0.000000 54.20 56.00 05600 RADI OI SOTOPE 0 0 4. 113. 029 0.000000 56 00 05700 CT SCAN 0 0 57.00 29, 759, 951 0.000000 57.00 58.00 05800 MRI 8, 618, 243 0.000000 58.00 0 46, 738, 865 60.00 06000 LABORATORY 0 0.000000 60.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 0 834, 699 0.000000 63.00 63 00 64.00 06400 I NTRAVENOUS THERAPY 0 1, 088, 554 0.000000 64.00 06500 RESPIRATORY THERAPY 0 3, 783, 678 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 0 4, 877, 915 0.000000 66.00 66,00 06700 OCCUPATIONAL THERAPY 0 67.00 0 2, 128, 521 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 820, 698 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 8, 789, 085 69.00 07000 ELECTROENCEPHALOGRAPHY 0 0 1, 485, 137 0.000000 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 809.077 71.00 0.000000 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 058, 819 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 27, 505, 390 73.00 0.000000 73.00 03950 DI ABETES SERVICES 0 76.00 0 145.712 0.000000 76.00 0 07697 CARDIAC REHABILITATION 0 76.97 593, 467 0.000000 76.97 0 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0.000000 77.00 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0 0 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC - STREATOR 0 0 8, 854, 856 0.000000 88.00 0.000000 08801 RURAL HEALTH CLINIC - PONTIAC 5, 831, 731 0000000000000 88.01 08802 RURAL HEALTH CLINIC - CULLOM 08803 RURAL HEALTH CLINIC - DWIGHT 0 0 88.02 698, 436 0.000000 88.02 0 0 1, 236, 278 88 03 0.000000 88 03 88.04 08804 RURAL HEALTH CLINIC - FAIRBURY 0 1, 433, 997 0.000000 88.04 08805 RURAL HEALTH CLINIC - MINONK 0 88. 05 0 1, 217, 170 0.000000 88.05 08806 RURAL HEALTH CLINIC - FLANAGAN 0 0 746, 387 0.000000 88.06 88.06

0

0

0

0

0

3, 246, 945

1, 481, 525

3, 346, 009

27, 295, 274

245, 267, 067

5, 502, 419

181, 976

0

0

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

88.07

88.08

88.09

90 00

91.00

92.00

200.00

08807 RURAL HEALTH CLINIC - REYNOLDS

08808 RURAL HEALTH CLINIC - EL PASO

08809 RURAL HEALTH CLINIC - CLINTON

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

88.07

88. 09

90 00

91.00

200.00

09000 CLI NI C

09100 EMERGENCY

Health Financial Systems SAINT JAMES HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-0161 THROUGH COSTS

THROUGH GGSTS			To	09/30/2023	Date/Time Prep 2/21/2024 2:0	
		Title	xVIII	Hospi tal	PPS	ı piii
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS	1					
50. 00   05000   OPERATI NG ROOM	0. 000000	942, 042		3, 237, 671	0	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	-	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	151, 109		366, 594	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	341, 382		1, 731, 262	0	54. 00
54.10  03630 ULTRA SOUND	0. 000000	172, 120	0	1, 039, 384	0	54. 10
54. 20   03440   MAMMOGRAPHY	0. 000000	0	0	0	0	54. 20
56. 00   05600   RADI 0I SOTOPE	0. 000000	158, 787	0	1, 250, 376	0	56. 00
57.00  05700 CT SCAN	0. 000000	1, 620, 414	0	13, 890, 362	0	57. 00
58. 00  05800 MRI	0. 000000	327, 544	0	1, 708, 739	0	58. 00
60. 00  06000  LABORATORY	0. 000000	3, 078, 872	0	3, 013, 872	0	60.00
63.00   06300   BLOOD STORING, PROCESSING & TRANS.	0. 000000	62, 844	0	94, 252	0	63.00
64. 00   06400   I NTRAVENOUS THERAPY	0. 000000	0	0	435, 137	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	1, 045, 036	0	422, 704	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	241, 046	0	18, 485	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	144, 592	0	228	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	61, 402	0	5, 088	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	702, 635	0	2, 552, 693	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	0	o	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	99, 707	l o	10, 531	ol	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	404, 839	l o	244, 459	ol	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 394, 729		328, 846	0	73. 00
76. 00   03950 DI ABETES   SERVI CES	0. 000000	0	0	o	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	13, 221	0	176, 599	0	76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	o	0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	o	ol	0	78. 00
OUTPATIENT SERVICE COST CENTERS			1	- 1		
88.00 08800 RURAL HEALTH CLINIC - STREATOR	0. 000000	0	0	0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC - PONTIAC	0. 000000	0	0	o	0	88. 01
88.02 08802 RURAL HEALTH CLINIC - CULLOM	0. 000000	0	0	ol	0	88. 02
88.03 08803 RURAL HEALTH CLINIC - DWIGHT	0. 000000	0	0	ol	0	88. 03
88.04 08804 RURAL HEALTH CLINIC - FAIRBURY	0. 000000	0	l o	ol	0	88. 04
88. 05   08805 RURAL HEALTH CLINIC - MINONK	0. 000000	0	0	ol	0	88. 05
88.06 08806 RURAL HEALTH CLINIC - FLANAGAN	0. 000000	0	0	o	0	88. 06
88. 07   08807 RURAL HEALTH CLINIC - REYNOLDS	0. 000000	0	0	o	0	88. 07
88. 08   08808 RURAL HEALTH CLINIC - EL PASO	0. 000000	0	0	ol	0	88. 08
88. 09 08809 RURAL HEALTH CLINIC - CLINTON	0. 000000	0	0	ol	0	88. 09
90. 00   09000   CLI NI C	0. 000000	0	0	35, 825	0	90.00
91. 00   09100   EMERGENCY	0. 000000	1, 725, 901	0	4, 142, 502	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	927, 337	-	529, 695	0	92. 00
200.00 Total (lines 50 through 199)	3. 000000	14, 615, 559		35, 235, 304		200. 00
200.00     10tal (11100 00 till ough 177)	1	. 1, 010, 007	1	00, 200, 004	٥١	_50.00

From 10/01/2022   Part V   To 09/30/2023   Date/Time Prepare	
Charges Costs	
Cost Center Description Cost to Charge PPS Reimbursed Cost Cost PPS Services	
Ratio From   Services (see   Reimbursed   Reimbursed   (see inst.)	
Part I, col. 9 Subject To Subject To	
Ded. & Coins. Ded. & Coins.	
(see inst.)	
1.00 2.00 3.00 4.00 5.00	
ANCI LLARY SERVI CE COST CENTERS	
50. 00   05000   OPERATING ROOM   0. 206369   3, 237, 671   0   0   668, 155   50	0.00
	2.00
	3.00
	4. 00
	4. 10
	4. 20
	6.00
	7. 00
	8. 00
	0.00
	3. 00
	4. 00
	5. 00
	6. 00
	7. 00
	8. 00
	9. 00
	0. 00
	1. 00
	2. 00
	3.00
	6.00
	6. 97
	7.00
78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0. 000000   0   0   0   78   00TPATIENT SERVICE COST CENTERS	8. 00
	8. 00
	88. 01
	88. 02
	8. 03
	88. 04
	88. 05
	8. 06
	88. 07
	8. 08
	8. 09
	0.00
	1. 00
	2. 00
200.00 Subtotal (see instructions) 35, 235, 304 435 28, 742 3, 849, 722 200	
	1. 00
Only Charges	
202.00   Net Charges (line 200 - line 201)   35, 235, 304   435   28, 742   3, 849, 722 202	2. 00

Peri od: Worksheet D From 10/01/2022 Part V To 09/30/2023 Date/Ti me Prepared:

					2/21/2024 2:0	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subj ect To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	1			
ANCILLARY SERVICE COST CENTERS	0.00	7.00	l			
50. 00 05000 OPERATING ROOM	0	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	Ö	1			52. 00
53. 00   05300   ANESTHESI OLOGY	0	Ö	1			53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C		0	•			54.00
54. 10   03630   ULTRA SOUND		0	l .			54. 10
	0		•			
54. 20   03440   MAMMOGRAPHY	0	0	•			54. 20
56. 00   05600   RADI OI SOTOPE	0	0	•			56. 00
57. 00   05700   CT   SCAN	0	876	1			57. 00
58. 00   05800   MRI	0	0	•			58. 00
60. 00   06000   LABORATORY	30	0				60.00
63.00   06300   BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0				64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0	1			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0	1			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		Ö				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0	1			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0	•			73.00
· · · · · · · · · · · · · · · · · · ·	0	0				1
76. 00   03950   DI ABETES   SERVI CES	0	_				76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0				76. 97
77. 00 07700 ALLOGENEI C HSCT ACQUISITION	0	0	1			77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
OUTPATIENT SERVICE COST CENTERS		1	1			
88.00 08800 RURAL HEALTH CLINIC - STREATOR						88. 00
88. 01   08801   RURAL HEALTH CLINIC - PONTIAC						88. 01
88.02 08802 RURAL HEALTH CLINIC - CULLOM						88. 02
88. 03   08803   RURAL HEALTH CLINIC - DWIGHT						88. 03
88. 04   08804 RURAL HEALTH CLINIC - FAIRBURY						88. 04
88.05 08805 RURAL HEALTH CLINIC - MINONK						88. 05
88.06 08806 RURAL HEALTH CLINIC - FLANAGAN						88. 06
88. 07   08807 RURAL HEALTH CLINIC - REYNOLDS						88. 07
88. 08   08808 RURAL HEALTH CLINIC - EL PASO						88. 08
88. 09   08809 RURAL HEALTH CLINIC - CLINTON						88. 09
90. 00   09000   CLINIC		0				90.00
91. 00   09100   EMERGENCY		0	1			91.00
· · · · · · · · · · · · · · · · · · ·	0	0	1			92.00
	_	_	1			
200.00 Subtotal (see instructions)	30		1			200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges	20	07/				202 00
202.00   Net Charges (line 200 - line 201)	30	876	1			202. 00

Health Financial Systems	SAINT JAMES HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0161	Peri od: From 10/01/2022	Worksheet D-1
			Date/Time Prepared: 2/21/2024 2:01 pm
	Title XVIII	Hospi tal	PPS

		Title XVIII	Hospi tal	2/21/2024 2: 0 PPS	1 pm
	Cost Center Description		·	1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			4, 983	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-berivate room days (excluding swing-bed and observation bed days)		vate room days,	4, 757 0	2. 00 3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		3, 168	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roof reporting period		31 of the cost	0, 100	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December :	31 of the cost	226	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	l of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	1, 531	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nly (including private ro	oom days) after	106	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period		e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	0. 00	18. 00		
19. 00					19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period	after December 31 of t	ne cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions			8, 720, 770	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decembe 5 x line 17)	·		0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)		, , , ,	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	·		0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December $3 \times 1$ ine 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		0 8, 720, 770	26. 00 27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	l and observation had ab-	argos)	0	28. 00
29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	a and observation bed cha	ii ges)	0	29.00
30. 00	Semi -pri vate room charges (excluding swing bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 =	- line 28)		0. 000000	31. 00
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	33. 00
34.00	Average per diem private room charge differential (line 32 mir		(i ons)	0.00	34. 00 35. 00
35. 00 36. 00	Average per diem private room cost differential (line 34 x lir Private room cost differential adjustment (line 3 x line 35)	le 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	ferential (line	8, 720, 770	37.00
200	27 minus line 36)	, p			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		T	1, 833. 25	38. 00
38.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			2, 806, 706	38.00
40. 00	Medically necessary private room cost applicable to the Progra			0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		2, 806, 706	41. 00

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der (		Period: From 10/01/2022	Worksheet D-1	
					o 09/30/2023	Date/Time Pre 2/21/2024 2:0	
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 -	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4.00	<u>4)</u> 5. 00	
42. 00	NURSERY (title V & XIX only)	0		0.00		0	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	1 (40 707	1.0/	1 540 45	2/2	FF0 2/7	42.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT	1, 642, 707	1, 06	1, 542. 45	362	558, 367	43. 00 44. 00
	BURN INTENSIVE CARE UNIT						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	st. D-3, col. 3	3, line 200)			2, 542, 579	48. 00
48. 01	Program inpatient cellular therapy acquisiti	on cost (Worksh	neet D-6, Part		column 1)	0	48. 01
49. 00	Total Program inpatient costs (sum of lines	41 through 48.(	01)(see instru	ctions)		5, 907, 652	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp.	atient routine	services (fro	m Wkst D sum	of Parts I and	162, 996	50.00
00.00	III)	atront routino	301 11 003 (11 0	m witst. D, sum	or rares r and	102, 770	00.00
51.00	Pass through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D, su	m of Parts II	136, 535	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				299, 531	52. 00
	Total Program inpatient operating cost exclu		elated, non-ph	ysician anesthe	etist, and	5, 608, 121	
	medical education costs (line 49 minus line	52) '			·		
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	E4 00
	Target amount per discharge					0 0. 00	
55. 01	Permanent adjustment amount per discharge					0.00	
55. 02	Adjustment amount per discharge (contractor					0.00	
	Target amount (line 54 x sum of lines 55, 55			E/ I	·	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (	ithe so minus i	The 53)	0	
	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n the cost rep	orting period e	endi ng 1996,	0.00	•
	updated and compounded by the market basket)	0.00	/ 0 00				
60. 00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						60.00
61.00	Continuous improvement bonus payment (if line	0	61.00				
	55.01, or line 59, or line 60, enter the les						
	53) are less than expected costs (lines $54 \times 10^{-2}$ enter zero. (see instructions)	60), or 1 % of	f the target a	mount (line 56)	, otherwise		
62. 00	Relief payment (see instructions)					0	62.00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine cos	to through Doc	mbor 21 of th	o cost reportin	a pariod (Saa	0	64. 00
04.00	instructions) (title XVIII only)	ts through bece	elliber 31 of th	e cost reportir	ig perrou (see	O	04.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 of the	cost reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	no costs (lino	64 plus lino	45) (+i +l o VVIII	only): for	0	66. 00
00.00	CAH, see instructions	ne costs (Title	04 prus rine	os)(title xviii	on y), roi	O	00.00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost rep	orting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after [	December 31 of	the cost renor	ting period	0	68. 00
00.00	(line 13 x line 20)	e costs arter t	becember 31 of	the cost repor	ting period	O	00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70.00
	Adjusted general inpatient routine service of	-					71.00
	Program routine service cost (line 9 x line			,			72.00
	Medically necessary private room cost applications						73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient			•	urt II column		74. 00 75. 00
, 5. 50	26, line 45)		20010 (11011				. 5. 65
	Per diem capital-related costs (line 75 ÷ li						76. 00
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
	Aggregate charges to beneficiaries for exces		orovi der recor	ds)			79.00
80.00	Total Program routine service costs for comp	arison to the o		*	ıs line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi		1)				81.00
~ / ()()	Inpatient routine service cost limitation (I		* .				82. 00 83. 00
	reasonable inbatient routine service costs in						
83. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		,				84. 00
83. 00 84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation	structions) (see instructio	ons)				84. 00 85. 00
83. 00 84. 00	Program inpatient ancillary services (see in	structions) (see instructio of lines 83 th	ons)				84. 00

1, 589 87. 00 1, 833. 25 88. 00 2, 913, 034 89. 00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems	SAINT JAMES	HOSPI TAL		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	Date/Time Prep 2/21/2024 2:0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x 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	399, 919	8, 720, 770	0. 04585	8 2, 913, 034	133, 586	90.00
91.00 Nursing Program cost	0	8, 720, 770	0.00000	0 2, 913, 034	0	91.00
92.00 Allied health cost	0	8, 720, 770	0.00000	0 2, 913, 034	0	92.00
93.00 All other Medical Education	0	8, 720, 770	0. 00000	0 2, 913, 034	0	93. 00

Health Financial Systems	SAINT JAMES HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider Co	CN: 14-0161	Peri od:	Worksheet D-3	
			From 10/01/2022	5 . (7) 5	
			To 09/30/2023		
	Ti +Lo	: XVIII	Hospi tal	2/21/2024 2: 0 PPS	трш
Cost Conton Doscription					
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS			2, 977, 364		30.00
31. 00   03100   NTENSI VE CARE UNI T			1, 768, 060		31.00
43. 00   04300   NURSERY			1, 700, 000		43.00
					43.00
ANCI LLARY SERVI CE COST CENTERS		0. 20636	942, 042	194, 408	FO 00
50. 00 05000 OPERATING ROOM		l .			1
52. 00   05200   DELIVERY ROOM & LABOR ROOM		1. 11013		0	
53. 00 05300 ANESTHESI OLOGY		0. 21469			
54. 00   05400   RADI OLOGY - DI AGNOSTI C		0. 23710	·	80, 943	1
54. 10   03630   ULTRA SOUND		0. 08745		15, 053	
54. 20   03440   MAMMOGRAPHY		0. 07757		0	
56. 00   05600   RADI OI SOTOPE		0. 06122		9, 721	1
57. 00   05700   CT   SCAN		0. 03048	1, 620, 414	49, 403	
58. 00   05800   MRI		0.05730	2 327, 544	18, 769	58. 00
60. 00   06000   LABORATORY		0. 06829	3, 078, 872	210, 265	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 20111	1 62, 844	12, 639	63.00
64. 00 06400 INTRAVENOUS THERAPY		0. 32494		0	1
65. 00 06500 RESPIRATORY THERAPY		0. 26597		277, 957	
66. 00 06600 PHYSI CAL THERAPY		0. 36585			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 25631		37, 062	
68. 00 06800 SPEECH PATHOLOGY		0. 37311			1
69. 00   06900   ELECTROCARDI OLOGY		0. 06147		43, 195	1
70. 00 07000 ELECTROEARDT OLOGT		0. 23488		43, 173	1
					1
		0. 71240		71, 032	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 25140		101, 778	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 17799			
76. 00 03950 DI ABETES SERVI CES		1. 76079		0	1
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 37696	·	4, 984	1
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000		0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS		0.0000			00.00
88. 00 08800 RURAL HEALTH CLINIC - STREATOR		0.00000		0	1
88. 01   08801 RURAL HEALTH CLINIC - PONTIAC		0.00000		0	
88. 02 08802 RURAL HEALTH CLINIC - CULLOM		0.00000		0	
88.03 08803 RURAL HEALTH CLINIC - DWIGHT		0. 00000		0	
88.04 08804 RURAL HEALTH CLINIC - FAIRBURY		0.00000		0	
88.05 08805 RURAL HEALTH CLINIC - MINONK		0.00000	0	0	
88.06 08806 RURAL HEALTH CLINIC - FLANAGAN		0.00000	0	0	88. 06
88.07 08807 RURAL HEALTH CLINIC - REYNOLDS		0.00000	0	0	88. 07
88.08   08808 RURAL HEALTH CLINIC - EL PASO		0. 00000	0	0	88. 08
88.09 08809 RURAL HEALTH CLINIC - CLINTON		0.00000	0	0	88. 09
90. 00   09000   CLI NI C		0. 93707		0	90.00
91. 00   09100   EMERGENCY		0. 20548		354, 638	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 52941		490, 941	
200.00 Total (sum of lines 50 through 94 and 96 t	hrough 98)		14, 615, 559		1
201.00 Less PBP Clinic Laboratory Services-Progra	9 ,		0.1,010,007	2, 5.2, 5, 7	201.00
202.00 Net charges (line 200 minus line 201)	2 3 S.I.S. 955 (11116 01)		14, 615, 559		202. 00
202.00     Not charges (11116 200 millions 11116 201)		ı	14,015,557	I	1202.00

Health Financial Systems SAINT JAME	S HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CO	CN: 14-0161	Peri od:	Worksheet D-3	
			From 10/01/2022		
	Component	CCN: 14-U161	To 09/30/2023		
	Ti tl o	xVIII S	Swing Beds - SNF	2/21/2024 2: 0 PPS	т ріп
Cost Center Description	II tie	Ratio of Cost		Inpati ent	
oust defiter bescription		To Charges	Program	Program Costs	
		l 10 onar ges		(col. 1 x col.	
			3	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		•			
30. 00 03000 ADULTS & PEDI ATRI CS					30. 00
31.00 03100 INTENSIVE CARE UNIT					31.00
43. 00   04300   NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 20636	9 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		1. 11013	7 0	0	52.00
53. 00   05300   ANESTHESI OLOGY		0. 21469	4 0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 23710	4, 476	1, 061	54.00
54. 10   03630   ULTRA SOUND		0.08745		204	54. 10
54. 20 03440 MAMMOGRAPHY		0. 07757		0	54. 20
56. 00 05600 RADI 0I SOTOPE		0.06122		0	56. 00
57. 00   05700 CT SCAN		0. 03048		0	57. 00
58. 00   05800   MRI		0. 05730		245	1
60. 00   06000   LABORATORY		0. 06829		806	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 20111		0	63.00
64. 00   06400   I NTRAVENOUS THERAPY		0. 32494		Ö	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 26597		1, 551	65. 00
66. 00   06600   PHYSI CAL THERAPY		0. 36585		13, 143	1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 25631		9, 441	
68. 00   06800   SPEECH PATHOLOGY		0. 37311		0, 441	68.00
69. 00   06900   ELECT FATHOLOGY		0. 06147		23	
70. 00   07000   ELECTROENCEPHALOGRAPHY		0. 23488		0	70.00
71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 71240		-	
72. 00   07200   MPL. DEV. CHARGED TO PATTENT		0. 71240		1, 740	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 17799		4, 072	
76. 00   03950   DI ABETES   SERVI CES		1. 76079		4,072	76.00
76. 97   07697   CARDI AC   REHABI LI TATI ON		0. 37696		0	76. 97
77. 00 07700 ALLOGENEI CHSCT ACQUI SI TI ON		0. 00000		-	77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY		0.00000			1
OUTPATIENT SERVICE COST CENTERS		0.00000	J	0	76.00
88. 00   08800   RURAL HEALTH CLINIC - STREATOR		0.00000	<u>1</u>	0	88. 00
88. 01   08801 RURAL HEALTH CLINIC - PONTIAC		0.00000		Ö	88. 01
88. 02   08802 RURAL HEALTH CLINIC - CULLOM		0.00000		0	88. 02
88. 03   08803   RURAL HEALTH CLINIC - DWIGHT		0.00000		0	88. 03
88. 04   08804 RURAL HEALTH CLINIC - FAIRBURY		0.00000		0	88. 04
88. 05   08805   RURAL HEALTH CLINIC - MINONK		0.00000		0	88. 05
88.06   08806 RURAL HEALTH CLINIC - FLANAGAN		0.00000		0	88. 06
88. 07   08807 RURAL HEALTH CLINIC - REYNOLDS		0.00000		0	88. 07
88. 08   08808 RURAL HEALTH CLINIC - RETNOLDS				0	88. 08
88. 09 08809 RURAL HEALTH CLINIC - EL PASO		0. 00000 0. 00000		0	88. 09
90. 00   09000   CLINIC   CLINIC - CLINION		0. 93707		0	90.00
91. 00   09100   ELTINI C 91. 00   09100   EMERGENCY					90.00
		0. 20548		0	91.00
· ·		0. 52941			
Total (sum of lines 50 through 94 and 96 through 98)	race (line (1)		127, 452	32, 494	
201.00 Less PBP Clinic Laboratory Services-Program only cha	rges (iille oi)		127 452		201. 00
202.00 Net charges (line 200 minus line 201)		I	127, 452	I	202. 00

	Title XVIII Hospital	PPS	ГРШ
		1 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1. 00	
1.00	DRG Amounts Other than Outlier Payments	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	0	1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	4, 750, 795	1. 02
1. 03	<pre>instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)</pre>	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1. 04
2.00	Outlier payments for discharges. (see instructions)		2. 00
2. 01	Outlier reconciliation amount	0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2. 02
2. 03 2. 04	Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)	0 301	2. 03 2. 04
3. 00	Managed Care Simulated Payments	0	3. 00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	37. 36	4. 00
F 00	Indirect Medical Education Adjustment	2.00	F 00
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)	0.00	5. 00
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for	0. 00	6. 00
6. 26	new programs in accordance with 42 CFR 413.79(e) Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of	0.00	6. 26
0. 20	the CAA 2021 (see instructions)	0.00	0. 20
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the	0. 00	7. 01
7. 02	cost report straddles July 1, 2011 then see instructions.  Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural	0.00	7. 02
7.02	track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b)	0.00	7.02
	and 87 FR 49075 (August 10, 2022) (see instructions)		
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0. 00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost	0.00	8. 01
	report straddles July 1, 2011, see instructions.		
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0. 00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see	0.00	8. 21
9. 00	instructions) Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or	0. 00	9. 00
10. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)  FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10. 00
11. 00	FTE count for residents in dental and podiatric programs.		11. 00
12. 00	Current year allowable FTE (see instructions)		12.00
13. 00	Total allowable FTE count for the prior year.		13. 00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,	0. 00	14. 00
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.	0.00	15. 00
16. 00			16. 00
17. 00	Adjustment for residents displaced by program or hospital closure	0.00	17. 00
18.00	Adjusted rolling average FTE count		
19. 00 20. 00	Current year resident to bed ratio (line 18 divided by line 4).  Prior year resident to bed ratio (see instructions)	0. 000000 0. 000000	19. 00 20. 00
21. 00	Enter the Lesser of Lines 19 or 20 (see instructions)	0. 000000	
22. 00	IME payment adjustment (see instructions)	0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)	0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	0.00	22 00
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 $(f)(1)(iv)(C)$ .	0.00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)	0.00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	0. 00	25. 00
26. 00	Instructions) Resident to bed ratio (divide line 25 by line 4)	0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)	0. 000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)	0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	0	28. 01
29. 00 29. 01	Total IME payment (sum of lines 22 and 28)	0	29. 00 29. 01
∠7. ∪ I	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment	0	∠7. UI
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3. 36	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)	16. 91	31.00
32.00	Sum of lines 30 and 31 Allowable disprepartionate share percentage (see instructions)	20. 27	32.00
33. 00 34. 00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)	5. 94 70, 549	
	1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1	,	

Heal th	Financial Systems SAINT JAMES H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10	
	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0161	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part A	pared:	
		Title XVIII	Hospi tal	PPS	ГРШ	
				On/After 10/1		
	Uncomponented Caro Paymont Adjustment		1. 00	2. 00		
35. 00 35. 01 35. 02	Uncompensated Care Payment Adjustment  Total uncompensated care amount (see instructions)  Factor 3 (see instructions)  Hospital UCP, including supplemental UCP (If line 34 is zero,	enter zero on this line	0. 000000000 e) 0	6, 874, 403, 459 0. 000065867 452, 796	35. 01	
35. 03 36. 00			0 452, 796	452, 796	35. 03 36. 00	
40. 00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges (see instructions)	scharges (lines 40 throu	igh 46) 0		40.00	
40.00	Total Medicale discharges (see Histructions)		Before 1/1	On/After 1/1	40. 00	
			1. 00	1. 01		
41. 00 41. 01 42. 00 43. 00 44. 00	Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see instruct Divide line 41 by line 40 (if less than 10%, you do not quali Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divided	fy for adjustment)	0 0.00 0 0.000000	0	1	
45. 00	days)			0.00		
46. 00	Average weekly cost for dialysis treatments (see instructions Total additional payment (line 45 times line 44 times line 41	•	0.00	0. 00	46. 00	
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	5, 274, 441 6, 187, 081		47. 00 48. 00	
	only. (see instructions)	<u> </u>				
				Amount 1.00		
49. 00	Total payment for inpatient operating costs (see instructions	s)		6, 187, 081	49. 00	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar			355, 374		
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	1	
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment	ne 49 see instructions).		0	52. 00 53. 00	
54. 00	Special add-on payments for new technologies			27, 740		
54. 01	Islet isolation add-on payment			0		
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	59)		0	55. 00	
55. 01	Cellular therapy acquisition cost (see instructions)			0	55. 01	
56.00	Cost of physicians' services in a teaching hospital (see intr	•	hannah 2E)	0	56.00	
57. 00 58. 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt.		inrough 35).	0	57. 00 58. 00	
59. 00	Total (sum of amounts on lines 49 through 58)	11, 601. 11 11116 200)		6, 570, 195		
60.00	Primary payer payments			0	60.00	
61. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		6, 570, 195		
62. 00 63. 00	Deductibles billed to program beneficiaries			642, 808	1	
64. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			95, 655		
	Adjusted reimbursable bad debts (see instructions)			62, 176		
66. 00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		88, 920	1	
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			5, 989, 563	1	
68. 00	Credits received from manufacturers for replaced devices for	• •		0	68. 00	
69. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(FOR SCH See Instruction	is)	0	69. 00 70. 00	
70. 50	Rural Community Hospital Demonstration Project (§410A Demonst	tration) adjustment (see	instructions)	Ö	70.50	
70. 75	N95 respirator payment adjustment amount (see instructions)	, ,	,	0	70. 75	
70. 87	Demonstration payment adjustment amount before sequestration			0		
70. 88	SCH or MDH volume decrease adjustment (contractor use only)		0	1		
70. 89 70. 90	Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions)		0	70. 89 70. 90		
70. 90	HSP bonus payment HRR adjustment amount (see instructions)			0	1	
70. 92				0		
70. 93	HVBP payment adjustment amount (see instructions)			0	1	
70. 94						
70. 95	Recovery of accelerated depreciation			0	70. 95	

Heal th	Financial Systems SAINT JAMES HO	OSPI TAL		In Lie	eu of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 14-0161	Peri od: From 10/01/2022 To 09/30/2023	Worksheet E Part A	pared:
	<u> </u>	Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0	0		0	70. 96
70. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or after		2023		1, 047, 749	70. 97
70. 98	, , , , , , , , , , , , , , , , , , , ,		0		0	70. 98
	HAC adjustment amount (see instructions)				o o	70. 99
	Amount due provider (line 67 minus lines 68 plus/minus lines 6	69 & 70)	70)		7, 021, 543	71. 00
	Sequestration adjustment (see instructions)	ŕ			140, 431	71. 01
	Demonstration payment adjustment amount after sequestration				0	71. 02
71.03	Sequestration adjustment-PARHM pass-throughs					71. 03
72.00 Interim payments					6, 912, 145	72. 00
72. 01	Interim payments-PARHM					72. 01
73.00	Tentative settlement (for contractor use only)				0	73. 00
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			-31, 033	74. 00

0

0

0 92.00

0 93.00

0

0 96.00

0.00

111, 716

74. 01

75.00

90.00

91.00

94.00

95.00

	Prior to 10/1	On/After 10/1	
	1. 00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)		0	100. 00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)		0	102. 00
HRR Adjustment for HSP Bonus Payment			
103.00  HRR adjustment factor (see instructions)		0.0000	103.00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)		0	104. 00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00 Is this the first year of the current 5-year demonstration period under the 21st			200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.			
Cost Reimbursement			
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
202.00  Medicare discharges (see instructions)			202. 00
203.00 Case-mix adjustment factor (see instructions)			203. 00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current	5-year demonst	ration	
peri od)			
204.00 Medicare target amount			204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)			205. 00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
Adjustment to Medicare Part A Inpatient Reimbursement			
207.00 Program reimbursement under the §410A Demonstration (see instructions)			207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208. 00
209.00 Adjustment to Medicare IPPS payments (see instructions)			209. 00
210.00 Reserved for future use			210. 00
211.00 Total adjustment to Medicare IPPS payments (see instructions)			211. 00
Comparision of PPS versus Cost Reimbursement			
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)			212. 00
213.00 Low-volume adjustment (see instructions)			213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218. 00
(line 212 minus line 213) (see instructions)			1

73)

Balance due provider/program-PARHM (see instructions)

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

Capital outlier from Wkst. L, Pt. I, line 2

CMS Pub. 15-2, chapter 1, §115.2

Protested amounts (nonallowable cost report items) in accordance with

Operating outlier reconciliation adjustment amount (see instructions)

Capital outlier reconciliation adjustment amount (see instructions)

90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)

94.00 The rate used to calculate the time value of money (see instructions)

Time value of money for operating expenses (see instructions)

96.00 Time value of money for capital related expenses (see instructions)

74. 01

75.00

91.00

92.00

93.00

95.00

Provider CCN: 14-0161

						0 07/30/2023	2/21/2024 2:0	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
	I	0	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	0	0	0	0	1. 00
	payments							
1. 01	DRG amounts other than outlier	1. 01	0	0	0		0	1. 01
	payments for discharges							
1 00	occurring prior to October 1	1 00	4 750 705	0		4 750 705	4 750 705	1 00
1. 02	DRG amounts other than outlier	1. 02	4, 750, 795	0		4, 750, 795	4, 750, 795	1. 02
	payments for discharges							
	occurring on or after October							
1. 03	DRG for Federal specific	1. 03		0	0		0	1. 03
1.03		1.03	U	U			U	1.03
	operating payment for Model 4 BPCI occurring prior to							
	October 1							
1.04	DRG for Federal specific	1. 04	0	0		0	0	1. 04
1.04	operating payment for Model 4	1.04	U	U		U	U	1.04
	BPCI occurring on or after							
	October 1							
2.00	Outlier payments for	2. 00						2. 00
2.00	discharges (see instructions)	2.00						2.00
2. 01	Outlier payments for	2. 02	0	0	1	0	0	2. 01
2.01	discharges for Model 4 BPCI	2.02	ŭ	o o	Ĭ	Ŭ	Ŭ	2.01
2. 02	Outlier payments for	2. 03	n	Λ	0		0	2. 02
2.02	discharges occurring prior to	2.00	٩	0	I			2.02
	October 1 (see instructions)							
2. 03	Outlier payments for	2. 04	301	0		301	301	2. 03
2.00	di scharges occurring on or	2.07	301	0			301	2.00
	after October 1 (see							
	instructions)							
3.00	Operating outlier	2. 01	0	0	0	0	0	3. 00
0.00	reconciliation	2.0.	Ĭ	ŭ			ŭ	0.00
4.00	Managed care simulated	3. 00	0	0	0	0	0	4.00
	payments			_	_			
	Indirect Medical Education Adju	ustment			I.			
5.00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.000000	0.000000		5.00
	A, line 21 (see instructions)							
6.00	IME payment adjustment (see	22. 00	0	0	0	0	0	6.00
	instructions)							
6. 01	IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see							
	instructions)							
	Indirect Medical Education Adj							
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
	(see instructions)		_	_	_	_	_	
8. 00	IME adjustment (see	28. 00	0	0	0	0	0	8. 00
	instructions)	00.04						
8. 01	IME payment adjustment add on	28. 01	U	0	0	0	0	8. 01
	for managed care (see							
0.00	instructions)	20.00	_	_	_		_ ا	0.00
9. 00	Total IME payment (sum of	29. 00	O	0			이	9. 00
9. 01	lines 6 and 8) Total IME payment for managed	29. 01		0	0	0	0	9. 01
7. U I	care (sum of lines 6.01 and	29.01	٩	0	l "	"	Y	7. U I
	8.01)							
	Disproportionate Share Adjustmo	ent .						
	Allowable disproportionate	33.00	0. 0594	0. 0594	0. 0594	0. 0594		10. 00
10.00	share percentage (see	33.00	0. 0394	0.0394	0.0394	0.0394		10.00
	instructions)							
11. 00	Di sproporti onate share	34.00	70, 549	0	0	70, 549	70, 549	11 00
11.00	adjustment (see instructions)	34.00	70, 349	U		70, 347	70, 349	11.00
11. 01	Uncompensated care payments	36. 00	452, 796	0	0	452, 796	452, 796	11 01
	Additional payment for high per					152, 770	102, 770	
12. 00	Total ESRD additional payment	46. 00	n	0 o	0	O	0	12. 00
12.00	(see instructions)	10.00	٩	U			ا	12.00
13. 00	Subtotal (see instructions)	47. 00	5, 274, 441	0	0	5, 274, 441	5, 274, 441	13. 00
14. 00	Hospital specific payments	48. 00	6, 187, 081	0			6, 187, 081	
1 1. 00	(completed by SCH and MDH,	10.00	5, 107, 001	0		3, 107, 001	3, 107, 001	1 1. 00
	small rural hospitals only.)							
	(see instructions)							
15. 00	Total payment for inpatient	49. 00	6, 187, 081	0	0	6, 187, 081	6, 187, 081	15 00
10.00	operating costs (see	17.00	5, 157, 001	U		3, 107, 001	5, 157, 001	10.00
	instructions)							
16. 00	Payment for inpatient program	50.00	355, 374	0	0	355, 374	355, 374	16, 00
	capital (from Wkst. L, Pt. I,		555, 57	· ·			555,571	
	if applicable)							
	••	'	,			'		

Title   Will   Hospital   PPS   PP							rom 10/01/2022 o 09/30/2023	Part A Exhibit Date/Time Pre 2/21/2024 2:0	pared:
Tine   E, Part A   Entitlement to 10/01   00/AFTer 10/01   through 4   17.00					Title	xVIII	Hospi tal	PPS	
Tine   E, Part A   Entitlement to 10/01   00/AFTer 10/01   through 4   17.00		·	W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
17.00   Special add-on payments for   54.00   27,740   0   0   27,740   27,740   17.00   17.01   Not regan aqui sit tion cost   17.02   Credits received from   manufacturers for replaced devices for applicable MS-DRGs   18.00   Capital outlier reconciliation   93.00   0   0   0   0   0   0   0   0   18.00   18.00   19.00			line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
new technologies   17. 01   Net organ aquisition cost   17. 01   Net organ aquisiti			0	1.00		3. 00	4. 00	5. 00	
17. 01   Net organ aquisition cost   17. 01	17. 00	Special add-on payments for	54.00	27, 740	0	(	27, 740	27, 740	17. 00
17. 02   Credits received from manufacturers for replaced devices for applicable MS-DRCs   18. 00   20   0   0   0   0   0   0   0   17. 02		new technologies							
Manufracturers for replaced devices for applicable MS-DRGs   Capital outilier reconciliation adjustment amount (see   Instructions)   93.00	17.01	Net organ aquisition cost							17. 01
18.00   Capital payments   South   Capital pRG other than outlier   1.00   1.00   2.00   3.00   4.00   5.00   2.	17. 02	Credits received from	68. 00	0	0	(	0	0	17. 02
18.00   Capital Dutl'er reconciliation adjustment amount (see instructions)   93.00   0   0   0   0   0   0   0   18.00		manufacturers for replaced							
19.00   SUBTOTAL   W/S L, line   CAMOUNTS From   L)   0   0   0   0   0   0   0   0   0		devices for applicable MS-DRGs							
19.00   Substituctions	18.00	Capital outlier reconciliation	93.00	0	0	(	0	0	18. 00
19.00   SUBTOTAL		adjustment amount (see							
W/S L, line		instructions)							
Capital DRG other than outlier   1.00   355, 374   0   0   355, 374   355, 374   20.00   2.00   Model 4 BPCI Capital DRG other than outlier   1.01   0   0   0   0   0   0   0   0   0	19. 00	SUBTOTAL			0	(	6, 570, 195	6, 570, 195	19. 00
0			W/S L, line	(Amounts from					
20.00   Capital DRG other than outlier   1.00   355, 374   0   0   355, 374   355, 374   20.00									
20.01   Model 4 BPCI Capital DRG other than outlier than outlier   1.01   0   0   0   0   0   0   20.01					2.00	3.00			
Than outlier   Capital DRG outlier payments   2.00   0   0   0   0   0   0   0   0   0	20.00			355, 374	0	(	355, 374	355, 374	20. 00
21.00   Capital DRG outlier payments   2.00   0   0   0   0   0   0   0   21.00	20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	(	0	0	20. 01
21.01   Model 4 BPCl Capital DRG outlier payments   2.01   0   0   0   0   0   0   0   21.01									
Outlier payments   Indirect medical education   Deprechage (see instructions)   S. 00   O. 0000   O. 00000   O. 0000   O. 00	21.00	Capital DRG outlier payments	2. 00	0	0	(	0	0	21. 00
22.00   Indirect medical education percentage (see instructions)   23.00   Indirect medical education percentage (see instructions)   23.00   Indirect medical education adjustment (see instructions)   24.00   Allowable disproportionate share percentage (see instructions)   10.00   0.00000   0.0000   0.0000   0.000000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0	21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	(	0	0	21. 01
23.00   Indirect medical education adjustment (see instructions)   6.00   0   0   0   0   0   0   0   23.00		outlier payments							
23.00   Indirect medical education adjustment (see instructions)   6.00   0   0   0   0   0   0   0   23.00   24.00   Allowable disproportionate share encentage (see instructions)   10.00   0.0000   0.0000   0.0000   0.0000   0.0000   25.00   Disproportionate share adjustment (see instructions)   11.00   0   0   0   0   0   0   0   0   26.00   Total prospective capital payments (see instructions)   12.00   355,374   0   0   0   355,374   355,374   26.00    27.00   Low volume adjustment factor 28.00   Low volume adjustment (see instructions)   70.96   0   0   0   0    27.00   Low volume adjustment (see instructions)   70.96   0   0   0    27.00   Low volume adjustment (see instructions)   70.96   0   0   0    27.00   Transfer amount to Wkst. E, Pt. A, I ine)   100.00   Transfer low volume   Y   100.00    28.00   Transfer low volume   Y   100.00    29.00   Transfer low volume   Y   100.00    20.00   0.00000   0.0000   0.0000    20.000   0.00000   0.0000    20.000   0.00000   0.0000    20.000   0.00000   0.00000    21.00   0   0   0   0    22.00   0   0   0   0    23.00   0   0   0    24.00   0   0   0    25.00   0   0   0    26.00   0   0   0    27.00   0   0   0    28.00   0   0   0    29.00   0   0   0    29.00   0   0   0    20.000	22.00	Indirect medical education	5. 00	0. 0000	0.0000	0.0000	0.0000		22. 00
24.00   Allowable disproportionate share percentage (see instructions)   10.00   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.		percentage (see instructions)							
24. 00 All owable disproportionate share percentage (see instructions)  25. 00 Disproportionate share adjustment (see instructions)  26. 00 Total prospective capital payments (see instructions)  W/S E, Part A (Amounts to E, line Part A)  27. 00 Low volume adjustment factor 28. 00 Low volume adjustment (wkst. E, Pt. A, line)  29. 00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)  10. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00	Indirect medical education	6. 00	0	0	(	0	0	23. 00
Share percentage (see instructions)   25.00   Disproportionate share adjustment (see instructions)   11.00   0   0   0   0   0   0   0   0   0									
11.00   0   0   0   0   0   0   0   0   0	24.00		10.00	0. 0000	0. 0000	0.0000	0.0000		24. 00
25. 00 Disproportionate share adjustment (see instructions) 26. 00 Total prospective capital payments (see instructions)    W/S E, Part A   (Amounts to E, Part A)		share percentage (see							
26.00   Total prospective capital payments (see instructions)   12.00   355, 374   0   0   355, 374   26.00									
26. 00 Total prospective capital payments (see instructions)    V/S E, Part A   (Amounts to E, Part A)	25.00		11. 00	0	0	(	0	0	25. 00
Description									
W/S E, Part A   (Amounts to E, Part A)   0   1.00   2.00   3.00   4.00   5.00	26.00		12.00	355, 374	0	(	355, 374	355, 374	26. 00
Second   S		payments (see instructions)							
27.00   Low volume adjustment factor   28.00   Low volume adjustment   4.00   5.00   27.00   28.00   27.00   28.00   27.00   28.00   27.00   28.00   28.00   28.00   28.00   28.00   29.00									
27. 00 Low volume adjustment factor 28. 00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line) 29. 00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line) 100. 00 Transfer low volume  100. 00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)  100. 00 Transfer low volume  100. 00 Volume adjustment (transfer amount to Wkst. E, Pt. A, line)  100. 00 Transfer low volume  100. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									
28. 00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)  29. 00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)  100. 00 Transfer low volume  70. 96  1, 047, 749  1, 047, 749  1, 047, 749  1, 047, 749  100. 00			0	1. 00	2. 00			5. 00	
(transfer amount to Wkst. E, Pt. A, line) 29.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume   (transfer amount to Wkst. E, Pt. A, line)  100.00 Transfer low volume  Y						0.000000	0. 159470		
Pt. A, line) 29.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume Y	28. 00		70. 96			(		0	28. 00
29. 00 Low volume adjustment 70. 97 (transfer amount to Wkst. E, Pt. A, line) 100. 00 Transfer low volume Y 1,047,749 29. 00									
(transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume  Y									
Pt. A, line) 100.00 Transfer low volume  Y 100.00	29. 00		70. 97				1, 047, 749	1, 047, 749	29. 00
100.00 Transfer Low volume Y   100.00									
adjustments to Wkst. E, Pt. A.	100.00			Y					100. 00
		adjustments to Wkst. E, Pt. A.					1		

Provider CCN: 14-0161 Peri od: Worksheet E From 10/01/2022 Part A Exhibit 5 09/30/2023 Date/Time Prepared: 2/21/2024 2:01 pm Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on 10/01 A. line Wkst. E, Pt. after 10/01 and 3) A) 4. 00 2.00 3. 00 0 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 1.01 discharges occurring prior to October 1 DRG amounts other than outlier payments for 1.02 4.750.795 4, 750, 795 4, 750, 795 1.02 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 O 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 O 0 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 301 301 301 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 0 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.0594 0.0594 0.0594 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 70. 549 0 70.549 70. 549 11.00 instructions) 11.01 0 Uncompensated care payments 36 00 452, 796 452, 796 452, 796 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 O 12.00 instructions) 13 00 47 00 5 274 441 0 Subtotal (see instructions) 5, 274, 441 5, 274, 441 13 00 14.00 Hospital specific payments (completed by SCH 48.00 6, 187, 081 0 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 6, 187, 081 0 6, 187, 081 6, 187, 081 15.00 15.00 (see instructions) 16.00 50 00 355, 374 0 355.374 355.374 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 27, 740 27, 740 27, 740 C 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 0 68.00 17.02 17.02 0 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 18.00

6, 570, 195

6, 570, 195 19. 00

19.00

**SUBTOTAL** 

amount (see instructions)

Heal th	Financial Systems	SAINT JAMES	S HOSPLTAL		In Lie	eu of Form CMS-2	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der CC	F	reriod: rom 10/01/2022 o 09/30/2023	Worksheet E Part A Exhibi Date/Time Pre 2/21/2024 2:0	t 5 pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1.00	355, 374	C	355, 374	355, 374	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	C	0	0	20. 01
21.00	Capital DRG outlier payments	2.00	0	C	0	0	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	C	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0.0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	C	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	0	С	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	355, 374	C	355, 374	355, 374	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1. 00	2. 00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0	0	)	0	
29. 00	Low volume adjustment on or after October 1	70. 97	1, 047, 749		1, 047, 749	1, 047, 749	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	0	C	0	0	30. 00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	C	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-15, 769	C	-15, 769	-15, 769	31. 00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0	c	0	0	31. 01

0

70. 99

(Amt. to Wkst. E, Pt. A) 4.00

0 32.00

100.00

3.00

0

2.00

0

1.00

Ν

instructions)

32.00 HAC Reduction Program adjustment (see

instructions)

100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

			To 09/30/2023	Date/Time Prep 2/21/2024 2:0	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			906	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruction OPPS or REH payments	tions)		3, 849, 722 4, 640, 590	2. 00 3. 00
4. 00	Outlier payment (see instructions)			4, 640, 590	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000	5. 00
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0.00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)			0.00	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9. 00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)  COMPUTATION OF LESSER OF COST OR CHARGES			906	11. 00
	Reasonable charges				
12. 00	Ancillary service charges			29, 177	1
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 69)		0 29, 177	13. 00 14. 00
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			29, 177	14.00
15. 00	Aggregate amount actually collected from patients liable for patie	payment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	. 3	n a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(4) Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0. 000000	17. 00
	Total customary charges (see instructions)			29, 177	18.00
19. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	28, 271	19. 00
20.00	instructions)	lv if lima 11 avasada li	no 10) (coo	0	20.00
20. 00	Excess of reasonable cost over customary charges (complete onlinstructions)	ry it title it exceeds it	ne ro) (see	) 	20.00
21. 00	Lesser of cost or charges (see instructions)			906	21. 00
	Interns and residents (see instructions)			0	22. 00
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instactional prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ructions)		4, 640, 590	23. 00 24. 00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			4, 040, 370	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	•		0	25. 00
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)]			870, 056 3, 771, 440	
27.00	instructions)	prus the sum of filles 22	and 23] (See	3, 771, 440	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ine 50)		0	28. 00
	REH facility payment amount				28. 50
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50 and 29)			0 3, 771, 440	
31. 00	Primary payer payments			379	1
32. 00	Subtotal (line 30 minus line 31)	250)		3, 771, 061	32. 00
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. I-5, line 11)	JES)		0	33.00
	Allowable bad debts (see instructions)			81, 456	
	Adjusted reimbursable bad debts (see instructions)			52, 946	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	ructi ons)		79, 117	
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			3, 824, 007 0	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		_	39. 50
39. 75 39. 97	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration			0	
39. 97 39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	1
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		,	0	39. 99
	Subtotal (see instructions)			3, 824, 007	1
40. 01 40. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			76, 480 0	1
40. 03	Sequestration adjustment-PARHM pass-throughs			ا	40. 03
	Interim payments			3, 843, 395	1
41. 01 42. 00	Interim payments-PARHM			0	41. 01
	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)				42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			-95, 868	ı
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	cnapter 1,	9, 450	44. 00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0 00	
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	•
	Total (sum of lines 91 and 93)				94. 00

Health Financial Systems	SAINT JAMES HO	SPI TAL	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0161	Peri od:	Worksheet E	
			From 10/01/2022		
			To 09/30/2023	Date/Time Pr	epared:
				2/21/2024 2:	01 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

Heal th Financial Systems SANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared: Provider CCN: 14-0161

Title XVIII					10 09/30/2023	2/21/2024 2:0	
1.00			Title	XVIII	Hospi tal		
1.00   Total interim payments paid to provider   1.00   2.00   3.00   4.00   1.00   1.100			Inpatien	t Part A	Par	t B	
1.00   Total interim payments paid to provider   1.00   2.00   3.00   4.00   1.00   1.100							
1.00							
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, write "NoNE" or enter a zero.    3.00			1. 00				
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero   2.00				6, 912, 14			
Services rendered in the cost reporting period. If none, write "NONE" or netre a zero.	2.00				0	0	2.00
write "NONE" or enter a zero 3.00  Note in the separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  ADJUSTMENTS TO PROVIDER  O 06/07/2023 32,300 3.01 3.02 3.03 3.04 3.05  Provider to Program  ADJUSTMENTS TO PROGRAM  O 0 0 3.02 3.50  Provider to Program  ADJUSTMENTS TO PROGRAM  O 0 0 3.50  Provider to Program  3.50  ADJUSTMENTS TO PROGRAM  O 0 0 3.50  Solution of lines 3.01-3.49 minus sum of lines 0 0 0 3.52 3.53 3.54  O 0 0 32,300 3.50  Provider to Program  ADJUSTMENTS TO PROGRAM  O 0 0 3.50  Solution of lines 3.01-3.49 minus sum of lines 0 0 3.50  (transfer to Wkst. E or Wkst. E-3. line and column as appropriate)  To BE COMPLETED BY CONTRACTOR  FOR ULst separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  TENTATIVE TO PROGRAM  O 0 0 5.01  5.00  Provider to Program  FIENTATIVE TO PROGRAM  O 0 0 5.50  5.50  Sprovider to Program  FIENTATIVE TO PROGRAM  O 0 0 5.50  5.50  Sprovider to Program  FIENTATIVE TO PROGRAM  O 0 0 5.50  Sprovider to Program  FIENTATIVE TO PROGRAM  O 0 0 5.50  Sprovider to Program  FIENTATIVE TO PROGRAM  O 0 0 5.50  Sprovider to Program  FIENTATIVE TO PROGRAM  O 0 0 5.50  Sprovider to Program  O 0 0 5.50  Sprovider to Program liability (see instructions)  O 0 0 0.50  STILLEMENT TO PROGRAM  31,033  95,868 6.02  7,00 Total Medicare program liability (see instructions)  O 1.00  Contractor Number (Mo/Obay/Yr)							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
amount based on subsequent revision of the interin rate 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 3.02 3.03 3.04 3.05 8.00 9.00 9.03 3.03 3.04 3.05 8.00 9.00 9.03 3.03 3.04 3.05 8.00 9.00 9.03 9.05 8.00 9.00 9.03 9.05 8.00 9.00 9.03 9.05 9.00 9.00 9.03 9.05 9.00 9.00 9.03 9.00 9.03 9.00 9.03 9.00 9.03 9.03	3 00						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	0.00						0.00
Program to Provider   ADJUSTMENTS TO PROVIDER   0   06/07/2023   32,300   3. 01   3. 02   3. 03   3. 04   3. 05   3. 04   3. 05   3. 04   3. 05   3.							
ADJUSTMENTS TO PROVIDER							
3.02							
3.03   0		ADJUSTMENTS TO PROVIDER					
3. 04							
ADJUSTMENTS TO PROGRAM							
Provider to Program   ADJUSTMENTS TO PROGRAM   0   0   3 . 50     3. 51   3. 52   0   0   0   3 . 51     3. 52   0   0   0   3 . 51     3. 53   0   0   0   3 . 51     3. 53   0   0   0   3 . 51     3. 54   0   0   0   3 . 53     3. 54   0   0   0   3 . 53     3. 54   0   0   0   3 . 53     3. 59   Subtotal (sum of lines 3 .01-3.49 minus sum of lines 3 . 50-3.99)   0   0   0   3 . 53     4. 00   Total interim payments (sum of lines 1, 2, and 3.99)   0   0   0   0     (transfer to West. E or West. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR     5. 00   E COMPLETED BY CONTRACTOR							
ADJUSTMENTS TO PROGRAM	3.05	Durand days to Discourse			O	0	3.05
3.51   3.52   3.53   0   0   0   3.51   3.52   3.53   3.53   0   0   0   3.53   3.53   3.54   3.59   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.59   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   6.912,145   3.843,395   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   6.912,145   3.843,395   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   6.912,145   3.843,395   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   6.912,145   3.843,395   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   6.912,145   3.843,395   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   6.912,145   3.843,395   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   6.912,145   3.843,395   4.00   Total interim payments (sum of lines 2, line and column as appropriate)   5.00   Total interim payments (sum of lines 2, line and column as appropriate)   5.00   Total interim payments (sum of lines 2, line and column as appropriate)   5.00   Total interim payments (sum of lines 2, line and column as appropriate)   5.00   Total interim payments (sum of lines 2, line and column as appropriate)   5.00   Total interim payments (sum of lines 2, line and column as appropriate)   5.00   Total interim payments (sum of lines 2, line and column as appropriate)   5.00   Total interim payments (sum of lines 2, line and column as appropriate)   5.00   Total interim payments (sum of lines 2, line and column as appropriate)   5.00   Total interim payments (sum of lines 2, line and column as appropriate)   5.00   Total interim payments (sum of lines 2, line and column as appropriate)   5.00   Total interim payments (sum of lines 2, line and column as appropriate)   5.00   Total interim payments (sum of lines 2, line and column as appropriate)   5.00   Total interim payments (sum of lines 2, line and column as appropriate)   5.00   Total interim payments (sum of lines 3, line and solumn as appropriate)   5.00   Total interim payments (sum of lines 3, line an	2 50						2 50
3.52   3.53   3.54   3.99   3.50		ADJUSTWENTS TO PROGRAW					
3.53   3.54   0   0   3.53   0   0   3.53   3.54   0   0   3.53   3.50   3.99   3.50   3.50   3.99   3.50						- 1	
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   6,912,145   3,843,395   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR							
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.05-3.98)   32,300   3.99   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   6,912,145   3,843,395   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR					0	l ol	
3.50-3.98   Total interim payments (sum of lines 1, 2, and 3.99)   6, 912, 145   3, 843, 395   4.00		Subtotal (sum of lines 3.01-3.49 minus sum of lines					
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR		3. 50-3. 98)					
appropriate   TO BE COMPLETED BY CONTRACTOR	4.00			6, 912, 14	5	3, 843, 395	4.00
TO BE COMPLETED BY CONTRACTOR							
5.00							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	г оо						Г 00
Write "NONE" or enter a zero. (1)   Program to Provider	5.00						5.00
Program to Provider							
TENTATI VE TO PROVIDER							
Solution   Settlement amount (balance due) based on the cost report. (1)   Settlement TO PROGRAM   S	5. 01				0	0	5. 01
Provider to Program	5.02				0	0	5. 02
TENTATI VE TO PROGRAM	5.03				0	0	5.03
5.51 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)   Contractor Number (Mo/Day/Yr)  0 1.00 2.00					_		
5.52   0 0 5.52 5.99   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00   Determined net settlement amount (balance due) based on the cost report. (1) 6.01   SETTLEMENT TO PROVIDER   0 0 0 6.01 6.02   SETTLEMENT TO PROGRAM   31,033   95,868 6.02 7.00   Total Medicare program liability (see instructions)   6,881,112   3,747,527 7.00   Contractor NPR Date (Mo/Day/Yr)   0 1.00 2.00		TENTATI VE TO PROGRAM					
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1. 00 2. 00							
5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1. 00 2. 00							
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00	5. 99				0	0	5. 99
the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions)  0 0 0 6. 01 95, 868 6. 02 7. 00 Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	4 00						4 00
6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1. 00 2. 00	6.00						6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6. 01				0		6. 01
7.00 Total Medicare program liability (see instructions) 6,881,112 3,747,527 7.00  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00					-	_	
Contractor         NPR Date           Number         (Mo/Day/Yr)           0         1.00         2.00							
0 1.00 2.00							
8.00   Name of Contractor     8.00			(	)	1. 00	2. 00	
	8.00	Name or Contractor					8. 00

Health Financial Systems S.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 14-0161 | Peri od: From 10/01/2022 | Part | From 10/01/2022 | Part | Date/Time Prepared: 2/21/2024 2:01 pm

					2/21/2024 2:0	1 pm
				wing Beds - SNF		
		Inpatien	t 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		56, 824	1	0	1. 00
2.00	Interim payments payable on individual bills, either		. (		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	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)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		(		0	3. 01
3.02			(		0	3. 02
3.03			(		0	3. 03
3.04			(		0	3. 04
3.05			(		0	3. 05
	Provider to Program					1
3.50	ADJUSTMENTS TO PROGRAM		(	)	0	3. 50
3.51			(		0	3. 51
3.52			(		0	3. 52
3.53			(		0	3. 53
3.54			(		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		56, 824	1	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					]
	TO BE COMPLETED BY CONTRACTOR			_		
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		T	Т	Г	
5. 01	TENTATI VE TO PROVI DER		(		0	
5. 02			(		0	
5.03			(	)	0	5. 03
	Provi der to Program				_	
5. 50	TENTATI VE TO PROGRAM		(		0	
5. 51			(		0	
5. 52			(		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(	)	0	5. 99
	5. 50-5. 98)					/ 00
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		,		0	6. 01
6. 01	SETTLEMENT TO PROVIDER  SETTLEMENT TO PROGRAM		(		0	
					0	0.02
7. 00	Total Medicare program liability (see instructions)		56, 824		NPR Date	7. 00
				Contractor Number	(Mo/Day/Yr)	
		(	 )	1. 00	2. 00	
8. 00	Name of Contractor			1.00	2.00	8. 00
5. 00	name of contractor			1	I	1 0.00

Heal th	Financial Systems SAINT JAMES F	IOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0161	Peri od: From 10/01/2022	Worksheet E-1 Part II	I
			To 09/30/2023	Date/Time Pre	
		Title XVIII	Hospi tal	PPS	, p
	<u> </u>				
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				_
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, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				_
	Initial/interim HIT payment adjustment (see instructions)				30. 00
	Other Adjustment (specify)				31. 00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32. 00

	ouiipoilo.			2/21/2024 2:0	1 pm
		tle XVIII	Swing Beds - SNF		
			Part A	Part B	
	COMPUTATION OF NET COST OF COVERED SERVICES		1. 00	2. 00	
1. 00	Inpatient routine services - swing bed-SNF (see instructions)		61, 784	0	1. 00
2. 00	Inpatient routine services - swing bed-NF (see instructions)		0.,,0.		2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and	sum of Wkst. D,	0	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pa	ss-through, see			
	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 teaching progr	am (see		0. 00	4. 00
F 00	instructions)		10/	0	F 00
5. 00 6. 00	Program days Interns and residents not in approved teaching program (see instruction	nc)	106	0	5. 00 6. 00
7. 00	Utilization review - physician compensation - SNF optional method only		0	U	7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		61, 784	0	8. 00
9. 00	Primary payer payments (see instructions)		0.770	0	9. 00
10. 00	Subtotal (line 8 minus line 9)		61, 784	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable to	physi ci an	0	0	11. 00
	professional services)				
12. 00	Subtotal (line 10 minus line 11)		61, 784	0	12.00
13. 00	Coinsurance billed to program patients (from provider records) (exclud	e coi nsurance	3, 800	0	13. 00
44.00	for physician professional services)				44.00
14.00	80% of Part B costs (line 12 x 80%)		F7 004	0	14.00
15. 00 16. 00	Subtotal (see instructions)   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		57, 984	0	15. 00 16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0	U	16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstration) p	avment	0		16. 55
	adjustment (see instructions)	ayorre			10.00
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	0	17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18. 00
19. 00	Total (see instructions)		57, 984	0	19. 00
19. 01	Sequestration adjustment (see instructions)		1, 160	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
19. 03	Sequestration adjustment-PARHM pass-throughs			0	19. 03 19. 25
19. 25 20. 00	Sequestration for non-claims based amounts (see instructions) Interim payments		56, 824	0	20.00
20. 00	Interim payments  Interim payments-PARHM		30, 024	U	20. 00
21. 00	Tentative settlement (for contractor use only)		0	0	21. 00
21. 01	Tentative settlement-PARHM (for contractor use only)				21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25,	20, and 21)	0	0	22. 00
22. 01	Balance due provider/program-PARHM (see instructions)				22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordance with	CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				
200 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A				200 00
200.00	Is this the first year of the current 5-year demonstration period unde Century Cures Act? Enter "Y" for yes or "N" for no.	r the Zist			200. 00
	Cost Rei mbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1	. Pt. II. line			201. 00
	66 (title XVIII hospital))	,			
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D	-3, col. 3, line			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)	6.11			204. 00
	Computation of Demonstration Target Amount Limitation (N/A in first ye	ar of the currer	it 5-year demonst	ration	
205.00	period) Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line	204)			206. 00
200.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement	201)			200.00
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1	, sum of lines 1			208. 00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209. 00
210.00	Reserved for future use				210. 00
015 00	Comparision of PPS versus Cost Reimbursement	1: 210) (			015 00
∠15.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus instructions)	1111e 21U) (See			215. 00
	11134 354 513)		1 1		1

Heal th	Financial Systems SAINT JAMES H	OSPI TAL	In Lie	u of Form CMS-2	552-10
OUTLI E	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 14-0161	Peri od: From 10/01/2022	Worksheet E-5	
			To 09/30/2023	Date/Time Prep 2/21/2024 2:01	
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instr	uctions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instruc	tions)		0	4.00
5.00	The rate used to calculate the time value of money (see instr	uctions)		0.00	5.00
6.00	Time value of money for operating expenses (see instructions)			0	6.00
7.00	Time value of money for capital related expenses (see instruc	tions)		0	7.00

Health Financial Systems

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

Provider CCN: 14-0161 Period From 1

Peri od: Worksheet G From 10/01/2022 To 09/30/2023 Date/Ti me Prepared: 2/21/2024 2:01 pm

			0 10	E	2/21/2024 2:0	1 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS		2.00	0.00	1. 00	
1.00	Cash on hand in banks	70, 759, 232	C	0	0	1.00
2.00	Temporary investments	0	) c	0	0	2. 00
3.00	Notes receivable	0	C	0	0	3. 00
4.00	Accounts receivable	28, 973, 489	r  C	0	0	4. 00
5.00	Other recei vable	0	) C	0	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-19, 066, 332	l .	0	0	6. 00
7.00	Inventory	882, 553	1	0	0	7. 00
8.00	Prepaid expenses	4, 063	l .	0	0	8. 00
9.00	Other current assets	255, 516	1		0	9.00
10.00	Due from other funds	81, 808, 521	C	'l "I	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	81,808,521	<u> </u>	) U	0	11. 00
12. 00	Land	600, 013		0	0	12. 00
13. 00	Land improvements	2, 301, 596	· ·	-	0	13.00
14. 00	Accumul ated depreciation	-2, 208, 963	1		0	14. 00
15. 00	Bui I di ngs	40, 649, 652	1	-	0	15. 00
16. 00	Accumulated depreciation	-27, 185, 456	1	o o	0	16. 00
17. 00	Leasehold improvements	7, 095	1	o o	0	17. 00
18. 00	Accumulated depreciation	-7, 095	1	o	0	18. 00
19. 00	Fi xed equipment	0	d	o	0	19. 00
20. 00	Accumulated depreciation	0		o	0	20. 00
21. 00	Automobiles and trucks	0	ď	o	0	21. 00
22. 00	Accumul ated depreciation	0		o	0	22. 00
23. 00	Maj or movable equipment	24, 773, 230		ol	0	23. 00
24.00	Accumul ated depreciation	-18, 403, 352	1	o	0	24. 00
25.00	Mi nor equi pment depreci abl e	0	ol c	0	0	25. 00
26.00	Accumul ated depreciation	0	ıl c	o	0	26. 00
27.00	HIT designated Assets	0	) c	0	0	27. 00
28. 00	Accumul ated depreciation	0	) c	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	1, 155, 925	C	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	21, 682, 645	C	0	0	30. 00
	OTHER ASSETS					
31. 00	Investments	1, 011, 797	506, 094	918, 867	0	31. 00
32. 00	Deposits on Leases	0	) c	0	0	32. 00
33. 00	Due from owners/officers	0	) C	0	0	33. 00
34. 00	Other assets	0	C	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	1, 011, 797			0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	104, 502, 963	506, 094	918, 867	0	36. 00
27.00	CURRENT LIABILITIES	(40.201	1 0	ار	0	27.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	649, 381 32, 387	1	-	0	37. 00 38. 00
39. 00	Payroll taxes payable	32, 307			0	39.00
40. 00	Notes and Loans payable (short term)				0	40.00
41. 00	Deferred income	122, 262			0	41.00
42. 00	Accel erated payments	122, 202			O	42.00
43. 00	Due to other funds	0	ر (		0	43. 00
44. 00	Other current liabilities	2, 131, 526	Ì		0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	2, 935, 556		ا ا	_	45. 00
.0.00	LONG TERM LIABILITIES	2/ /00/ 000	· · · · · · · · · · · · · · · · · · ·	, <u> </u>		10.00
46. 00	Mortgage payable	0	C	ol	0	46. 00
47. 00	Notes payable	0	d	O	0	47. 00
48. 00	Unsecured Loans	0	d		0	48. 00
49. 00	Other long term liabilities	458, 473	c	O	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	458, 473	l .	O	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3, 394, 029	C	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	101, 108, 934				52. 00
53.00	Specific purpose fund		506, 094			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			918, 867		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
F0 05	replacement, and expansion	104 100 55			_	F0 00
59. 00	Total fund balances (sum of lines 52 thru 58)	101, 108, 934	1		0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and	104, 502, 963	506, 094	918, 867	0	60.00
	[59]	I	I	1		I

Provider CCN: 14-0161

					10 04/30/2023	2/21/2024 2:0	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	, p
		1.00	2.00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		100, 788, 078		373, 832		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6, 387, 723				2.00
3.00	Total (sum of line 1 and line 2)		107, 175, 801		373, 832		3.00
4.00	Additions - FOUNDATION	0			0	-4, 041	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10. 00	Total additions (sum of line 4-9)		0		0		10.00
11. 00	Subtotal (line 3 plus line 10)		107, 175, 801		373, 832		11. 00
12. 00	EQUITY TRANSFER	6, 066, 867			0	0	12.00
13. 00	DEDUCTIONS - FOUNDATION	0		-132, 2	62	0	13. 00
14. 00		0			0	0	14. 00
15. 00		0			0	0	15. 00
16. 00		0			0	0	16. 00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 12-17)		6, 066, 867		-132, 262		18. 00
19. 00	Fund balance at end of period per balance		101, 108, 934		506, 094		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	 PI ant	Fund			
		Lildowillett Turid	FIAIIL	Tuliu			
		6.00	7. 00	8. 00			
1. 00	Fund balances at beginning of period	922, 908		0.00	0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)	, , , , ,					2. 00
3.00	Total (sum of line 1 and line 2)	922, 908			0		3. 00
4.00	Additions - FOUNDATION		o				4. 00
5.00			o				5. 00
6.00			o				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)	-4, 041			0		10.00
11. 00	Subtotal (line 3 plus line 10)	918, 867			0		11. 00
12. 00	EQUITY TRANSFER		0				12.00
13. 00	DEDUCTIONS - FOUNDATION		0				13.00
14. 00			0				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			0		18. 00
19. 00	Fund balance at end of period per balance	918, 867			0		19. 00
	sheet (line 11 minus line 18)		ļ				

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-0161

			To	09/30/2023	Date/Time Pre 2/21/2024 2:0	
	Cost Center Description		Inpatient	Outpati ent	Total	, p
	<u> </u>		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		10, 054, 452		10, 054, 452	1. 00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3. 00
4. 00 5. 00	SUBPROVI DER Swing bed - SNF		0		0	4. 00 5. 00
6. 00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY		J		· ·	7. 00
8.00	NURSI NG FACILITY					8. 00
9.00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)		10, 054, 452		10, 054, 452	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT		2, 550, 111		2, 550, 111	11. 00
12. 00	CORONARY CARE UNIT					12. 00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15. 00 16. 00	OTHER SPECIAL CARE (SPECIFY) Total intensive care type inpatient hospital services (sum of	lines	2, 550, 111		2, 550, 111	15. 00 16. 00
10.00	11-15)	111163	2, 330, 111		2, 330, 111	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		12, 604, 563		12, 604, 563	17. 00
18. 00	Ancillary services		33, 839, 105	182, 413, 472	216, 252, 577	18. 00
19.00	Outpatient services		22, 060	719, 476	741, 536	19. 00
20.00	RURAL HEALTH CLINIC - STREATOR		0	8, 854, 856	8, 854, 856	20. 00
20. 01	RURAL HEALTH CLINIC - PONTIAC		0	5, 831, 731	5, 831, 731	20. 01
20. 02	RURAL HEALTH CLINIC - CULLOM		0	698, 436	698, 436	
20. 03	RURAL HEALTH CLINIC - DWIGHT		0	1, 236, 278	1, 236, 278	
20. 04	RURAL HEALTH CLINIC - FAIRBURY		0	1, 433, 997	1, 433, 997	20. 04
20. 05 20. 06	RURAL HEALTH CLINIC - MINONK		0	1, 217, 170	1, 217, 170	20. 05 20. 06
20. 00	RURAL HEALTH CLINIC - FLANAGAN RURAL HEALTH CLINIC - REYNOLDS		0	746, 387 3, 246, 945	746, 387 3, 246, 945	
20. 07	RURAL HEALTH CLINIC - KLINOLDS		o o	1, 481, 525	1, 481, 525	20. 07
20. 09	RURAL HEALTH CLINIC - CLINTON		Ö	3, 346, 009	3, 346, 009	20. 09
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY					22. 00
23.00	AMBULANCE SERVICES					23. 00
24. 00	CMHC					24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )					25. 00
26. 00	HOSPI CE		_			26. 00
27. 00	PROFESSIONAL FEES	±- WI±	0	5, 639, 872	5, 639, 872	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 G-3, line 1)	to WKST.	46, 465, 728	216, 866, 154	263, 331, 882	28. 00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			75, 353, 133		29. 00
30.00	ADD (SPECIFY)		О			30. 00
31.00			0			31. 00
32.00			0			32. 00
33. 00			0			33. 00
34. 00			0			34. 00
35. 00	T 1 1 1111 ( C 11 20 25)		0			35. 00
36. 00 37. 00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)			0		36. 00 37. 00
38. 00	DEDUCT (SPECIFF)		0			38.00
39. 00			0			39. 00
40. 00			Ö	ļ		40. 00
41.00			O			41. 00
42.00	Total deductions (sum of lines 37-41)			o		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	)(transfer		75, 353, 133		43. 00
	to Wkst. G-3, line 4)			l		

	Financial Systems SAINT JAME MENT OF REVENUES AND EXPENSES	S HOSPITAL Provider CCN: 14-0161	Peri od:	u of Form CMS-2 Worksheet G-3	
SIAIL	MENT OF REVENUES AND EXPENSES	FIOVIDE CCN. 14-0101	From 10/01/2022	WOI KSHEET G-3	
			To 09/30/2023		
				2/21/2024 2: 0	1 pm
				1.00	
1 00	Tatal wat: aut gaverner (form What C 2 Dant L and war 2	1: 20)		1.00	1 00
1. 00 2. 00	Total patient revenues (from Wkst. G-2, Part I, column 3,			263, 331, 882	1. 00 2. 00
2. 00 3. 00	Less contractual allowances and discounts on patients' acc	counts		184, 463, 900 78, 867, 982	
3. 00 4. 00	Net patient revenues (line 1 minus line 2)	no 42)			
4. 00 5. 00	Less total operating expenses (from Wkst. G-2, Part II, Ii	ne 43)		75, 353, 133	
5.00	Net income from service to patients (line 3 minus line 4) OTHER INCOME			3, 514, 849	5. 00
6. 00	Contributions, donations, bequests, etc			392, 757	6.00
7. 00	Income from investments			0	
8. 00	Revenues from telephone and other miscellaneous communicat	ion services		ő	
9. 00	Revenue from television and radio service	TOTT SET VICES		ő	
10. 00	Purchase di scounts				10.00
11. 00	Rebates and refunds of expenses			o l	1
12. 00	Parking Lot receipts			o l	12.00
13. 00	Revenue from Laundry and Linen service			0	13. 00
14. 00	Revenue from meals sold to employees and guests			143, 406	
15. 00	Revenue from rental of living quarters			0	
16. 00	Revenue from sale of medical and surgical supplies to other	er than patients		o	16.00
17. 00	Revenue from sale of drugs to other than patients	, in the second		0	
18. 00	Revenue from sale of medical records and abstracts			80	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			o	19.00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			6, 162	21.00
22. 00	Rental of hospital space			0	22.00
23. 00	Governmental appropriations			0	23.00
24. 00	OTHER INCOME			2, 457, 773	24.00
24. 50	COVI D-19 PHE Fundi ng			0	
25. 00	Total other income (sum of lines 6-24)			3, 000, 178	25. 00
26. 00	Total (line 5 plus line 25)			6, 515, 027	26.00
27. 00	OTHER EXPENSES			127, 304	
28. 00	Total other expenses (sum of line 27 and subscripts)			127, 304	
	Net income (or loss) for the period (line 26 minus line 28	3)		6, 387, 723	

Health Financial Systems CALCULATION OF CAPITAL P		ANT JAMES HOSPITAL  Provider CCN: 14-0161		u of Form CMS-2 Worksheet L	2552-1
CALCULATION OF CAPITAL P	AYMENI	Provider CCN: 14-0161	Peri od: From 10/01/2022 To 09/30/2023	Parts I-III	nared:
			70 077 007 2020	2/21/2024 2:0	
		Title XVIII	Hospi tal	PPS	
				1. 00	
PART I - FULLY PRO					
1.00 CAPITAL FEDERAL AM				355, 374	1.0
, ·	tal DRG other than outlier			355, 374	1
2.00 Capital DRG outli				0	
	tal DRG outlier payments			0	
		n the cost reporting period (see inst	ructions)	11. 65	1
4.00 Number of interns	& residents (see instructions)		·	0.00	4.0
5.00 Indirect medical	education percentage (see instru	ucti ons)		0.00	5.0
6.00 Indirect medical (1.01) (see instruc		ine 5 by the sum of lines 1 and 1.01	, columns 1 and	0	6.0
30) (see instruct	ions)	care Part A patient days (Worksheet E	, part A line	0.00	7.0
	icaid patient days to total days	s (see instructions)		0.00	
9.00 Sum of lines 7 and				0.00	
	ortionate share percentage (see			0.00	
1	share adjustment (see instruction	· ·		0	
12.00   Total prospective	capital payments (see instructi	OHS)		355, 374	12.0
				1. 00	
	UNDER REASONABLE COST				
, ,	routine capital cost (see instr	,		0	
	ancillary capital cost (see ins			0	
	rogram capital cost (line 1 plus ent factor (see instructions)	s title 2)		0	
1 '	rogram capital cost (line 3 x li	ne 4)		0	
noo protar inpatrone p	og. a cap. ta. coct (c c x				<u> </u>
DART III _ COMPUT/	ATION OF EXCEPTION PAYMENTS			1. 00	
	capital costs (see instructions	5)		0	1. (
		circumstances (see instructions)		0	
	ient capital costs (line 1 minus			0	3. (
1.00 Applicable except	ion percentage (see instructions	5)		0.00	4. (
	comparison to payments (line 3 $ ightarrow$			0	"
	ment for extraordinary circumsta			0.00	
1 2	1 3	extraordinary circumstances (line 2 x	: line 6)	0	
	ayment level (line 5 plus line 7	,		0	
	tal payments (from Part I, line		loog line ()	0	
	mulated capital minimum payment	nt level to capital payments (line 8 level over capital payment (from pri		0	
		to capital payments (line 10 plus lin	ie 11)	0	12. (
		sitive, enter the amount on this line		0	
		level over capital payment for the f		0	
	gative, enter the amount on this				' ' '
	wable operating and capital paym			0	15. 0
13. 00 Carrent year arro					
16.00 Current year opera	ating and capital costs (see ins ption offset amount (see instruc			0	

	Financial Systems	SAINT JAMES				u of Form CMS-2	2552-10
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	narod:
			Component	JCN. 14-0024	10 07/30/2023	2/21/2024 2:0	
					RHC I	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	/04 705					
1.00	Physi ci an	631, 735	ł	631, 73		640, 222	
2.00	Physician Assistant	0	0		0 0	0	2.00
3.00	Nurse Practitioner	981, 228	0	981, 22	13, 183		3.00
4.00	Visiting Nurse	0	0		0	0	1
5. 00 6. 00	Other Nurse	0	0		0	0	5. 00 6. 00
7. 00	Clinical Psychologist Clinical Social Worker	0	0		0	0	7.00
8. 00	Laboratory Techni ci an	0	0		0	0	8.00
9. 00	Other Facility Health Care Staff Costs	1, 146, 053	0	1, 146, 05	3 15, 397	1, 161, 450	
10.00	Subtotal (sum of lines 1 through 9)	2, 759, 016		2, 759, 01		2, 796, 083	
11. 00	Physician Services Under Agreement	2, 757, 010	258, 517	258, 51		258, 517	11.00
12. 00	Physician Supervision Under Agreement	0	230, 317	230, 31	0 0	230, 317	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	258, 517	258, 51	7 0	258, 517	14. 00
15. 00	Medical Supplies	0	330, 571	330, 57		330, 571	15. 00
16. 00	Transportation (Health Care Staff)	0	3, 252	3, 25		3, 252	
17. 00	Depreciation-Medical Equipment	0	0	3, =3	0 0	0	1
18.00	Professional Liability Insurance	0	6, 487	6, 48	7 0	6, 487	18. 00
19.00	Other Health Care Costs	0	16, 416	16, 41	6 0	16, 416	19. 00
20.00	Allowable GME Costs			·			20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	356, 726	356, 72	6 0	356, 726	21. 00
22. 00	Total Cost of Health Care Services (sum of	2, 759, 016	615, 243	3, 374, 25	9 37, 067	3, 411, 326	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0		0	0	
24. 00	Dental	0	0		0	0	24. 00
25. 00	Optometry	0	0		0	0	25. 00
25. 01	Tel eheal th	0	0		0	0	25. 01
25. 02	Chronic Care Management	0	0		0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0	0	26. 00
27. 00 28. 00	Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23	^	_			0	27. 00 28. 00

491, 545

3, 250, 561

93, 983 788, 040

882, 023

1, 497, 266

93, 983

-237, 722

-237, 722

-200, 655

1, 279, 585

1, 373, 568

4, 747, 827

29.00

30.00

31.00

32.00

93, 983 1, 041, 863

1, 135, 846

4, 547, 172

through 27)
FACILITY OVERHEAD
29. 00 Facility Costs

and 31)

31.00 32.00

30.00 Administrative Costs

Total Facility Overhead (sum of lines 29 and

Health Financial Systems	SAINT JAMES HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 14-0161	Period: Worksheet M-1 From 10/01/2022
	Component CCN: 14-8624	

			Component	CN: 14-8624	10 09/30/2023	2/21/2024 2:0	
					RHC I	Cost	71 piii
		Adjustments	Net Expenses		1		
			or Allocation				
			(col. 5 + col.				
			6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	-10, 760	629, 462				1. 00
2.00	Physician Assistant	0	0				2. 00
3.00	Nurse Practitioner	-7, 775	986, 636				3. 00
4.00	Visiting Nurse	0	0				4. 00
5. 00	Other Nurse	0	0				5. 00
6.00	Clinical Psychologist	-73	-73				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	-6, 257	1, 155, 193				9. 00
10.00	Subtotal (sum of lines 1 through 9)	-24, 865	2, 771, 218				10. 00
11. 00	Physician Services Under Agreement	0	258, 517				11. 00
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	258, 517				14. 00
15. 00	Medical Supplies	0	330, 571				15. 00
16.00	Transportation (Health Care Staff)	0	3, 252				16. 00
17. 00	Depreciation-Medical Equipment	0	0				17. 00
18.00	Professional Liability Insurance	0	6, 487				18. 00
19. 00	Other Health Care Costs	U	16, 416				19. 00
20.00	Allowable GME Costs		05/ 70/				20.00
21. 00	Subtotal (sum of lines 15 through 20)	04.045	356, 726				21. 00
22. 00	Total Cost of Health Care Services (sum of	-24, 865	3, 386, 461				22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						+
33 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	24, 865	24, 865				25. 00
25. 01	Chronic Care Management	24,000	24, 003				25. 02
26. 00	All other nonreimbursable costs	0	0				26. 00
27. 00	Nonallowable GME costs	o l	Ĭ				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	24, 865	24, 865				28. 00
20.00	through 27)	21,000	21,000				20.00
	FACILITY OVERHEAD		l				
29. 00		0	93, 983				29. 00
30.00	Administrative Costs	209, 321	1, 251, 184				30.00
31.00	Total Facility Overhead (sum of lines 29 and	209, 321	1, 345, 167				31. 00
	30)	,					
32.00	Total facility costs (sum of lines 22, 28	209, 321	4, 756, 493				32. 00
	and 31)						

Heal th	Health Financial Systems SAINT JAMES HOSPITAL In Lieu of Form CMS-2552-10								
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider Co		Peri od:	Worksheet M-1			
					From 10/01/2022	5 . (7) 5			
			Component	CCN: 14-8654	To 09/30/2023	Date/Time Pre 2/21/2024 2:0			
					RHC II	Cost	Грііі		
		Compensation	Other Costs	Total (col. 1	Reclassificati				
				+ col . 2)	ons	Trial Balance			
				<u> </u>		(col. 3 + col.			
						4)			
		1. 00	2. 00	3.00	4. 00	5. 00			
	FACILITY HEALTH CARE STAFF COSTS								
1.00	Physi ci an	653, 016	0	653, 01	· ·	664, 023	1. 00		
2.00	Physici an Assistant	1, 641	0	1, 64			2. 00		
3.00	Nurse Practitioner	241, 281	0	241, 28	1 4, 067	245, 348			
4. 00	Visiting Nurse	0	0		0	0	4. 00		
5.00	Other Nurse	0	0		0 0	0	5. 00		
6.00	Clinical Psychologist	0	0		0	0	6. 00		
7. 00	Clinical Social Worker	0	0		0	0	7. 00		
8.00	Laboratory Techni ci an	0	0		0	0	8. 00		
9. 00	Other Facility Health Care Staff Costs	538, 873	0	538, 87					
10. 00	Subtotal (sum of lines 1 through 9)	1, 434, 811	0	1, 434, 81	1 24, 185	1, 458, 996			
11. 00	Physician Services Under Agreement	0	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	13. 00		
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14. 00		
15. 00	Medical Supplies	0	142, 574			142, 574			
16. 00	Transportation (Health Care Staff)	0	10, 046	10, 04	6 0	10, 046			
17. 00	Depreciation-Medical Equipment	0	0		U 0	0	17. 00		
18. 00	Professional Liability Insurance	0	4, 437	4, 43	/  0	4, 437	18. 00		

0 0 0

433, 646

433, 646

1, 868, 457

1, 434, 811

28, 613

185, 670

185, 670

0

0

0

8, 567

361, 851

370, 418

556, 088

28, 613

185, 670

0

0

0

0

0

8, 567

795, 497

804, 064

2, 424, 545

1, 620, 481

0

0 0 0

24, 185

-137, 624

-137, 624

-113, 439

28, 613

185, 670

0

0 24.00

0 25.01

0

0 28.00

8, 567

657, 873

666, 440

2, 311, 106

1, 644, 666

19.00

20.00

21.00

22.00

23.00

25.00

25.02

26.00

27. 00

29.00

30.00

31.00

32.00

19.00 Other Health Care Costs

Pharmacy

Optometry

Tel eheal th

Dental

and 31)

20.00

21.00

22.00

23.00

24.00

25.00

25.01

25.02

26.00

27. 00 28. 00

29.00

30.00

31.00

32.00

Allowable GME Costs

Chronic Care Management

Nonallowable GME costs

through 27)
FACILITY OVERHEAD
Facility Costs

Administrative Costs

Subtotal (sum of lines 15 through 20)

lines 10, 14, and 21)
COSTS OTHER THAN RHC/FQHC SERVICES

All other nonreimbursable costs

Total Cost of Health Care Services (sum of

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Health Financial Systems	SAINT JAMES HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Period: Worksheet M-1 From 10/01/2022
	Component CCN: 14-8654	

			Component	JCIN. 14-0054	10 07/30/2023	2/21/2024 2:01 pm	•
					RHC II	Cost	_
		Adjustments	Net Expenses		<u>'                                    </u>		
			for Allocation				
			(col. 5 + col.				
			6)				
		6.00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	-8, 212	655, 811			1.0	)()
2.00	Physician Assistant	0	1, 669			2. 0	)()
3.00	Nurse Practitioner	-732	244, 616			3.0	)()
4.00	Visiting Nurse	0	0			4. 0	)()
5.00	Other Nurse	0	0			5.0	)()
6.00	Clinical Psychologist	0	0			6.0	
7.00	Clinical Social Worker	0	0			7.0	
8.00	Laboratory Techni ci an	0	0			8.0	
9.00	Other Facility Health Care Staff Costs	-2, 272	545, 684			9. 0	
10.00	Subtotal (sum of lines 1 through 9)	-11, 216	1, 447, 780			10.0	
11. 00	Physician Services Under Agreement	0	0			11.0	
12. 00	Physician Supervision Under Agreement	0	0			12. 0	
13.00	Other Costs Under Agreement	0	0			13. 0	
14. 00	Subtotal (sum of lines 11 through 13)	0	0			14.0	
15. 00	Medical Supplies	0	142, 574			15. 0	
16. 00	Transportation (Health Care Staff)	0	10, 046			16. 0	
17. 00	Depreciation-Medical Equipment	0	0			17. 0	
18. 00	Professional Liability Insurance	0	4, 437			18. 0	
19. 00	Other Health Care Costs	0	28, 613			19. 0	
20. 00	Allowable GME Costs					20. 0	
21. 00	Subtotal (sum of lines 15 through 20)	0	185, 670	•		21. 0	
22. 00	Total Cost of Health Care Services (sum of	-11, 216	1, 633, 450			22. 0	)0
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES			I			
23. 00	Pharmacy	0	0			23. 0	
24. 00	Dental	0	0			24. 0	
25. 00	Optometry	11 01/	11 01 (			25. 0	
25. 01	Tel eheal th	11, 216	11, 216	1		25. 0	
25. 02	Chronic Care Management	0	0			25. 0	
26. 00	All other nonreimbursable costs	U	0			26. 0	
27. 00	Nonallowable GME costs	11 01/	11 01/			27. 0	
28. 00	Total Nonreimbursable Costs (sum of lines 23	11, 216	11, 216			28. 0	)()
	through 27) FACILITY OVERHEAD						
29. 00		ol	8, 567			29. 0	10
30.00	Administrative Costs	103, 505	8, 567 761, 378			30.0	
31.00	Total Facility Overhead (sum of lines 29 and	103, 505	761, 378 769, 945			30.0	
31.00	30)	103, 303	107, 943			31.0	,0
32. 00	Total facility costs (sum of lines 22, 28	103, 505	2, 414, 611			32. 0	00
32.00	and 31)	103, 303	2, 414, 011			32.0	,,,
	1	1		1		1	

	Financial Systems	SAINT JAMES				eu of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 14-0161	Period: From 10/01/2022	Worksheet M-1	
			Component		To 09/30/2023	Date/Time Pre 2/21/2024 2:0	
					RHC III	Cost	ı pııı
		Compensation	Other Costs	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
		· ·		+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	_					1
1.00	Physi ci an	0	0		0	0	
2.00	Physician Assistant	63, 014	0	63, 01	4 1, 110		1
3.00	Nurse Practitioner	0	0		0	0	0.00
4.00	Visiting Nurse	0	0		0	0	
5.00	Other Nurse	0	0		0	0	0.00
6.00	Clinical Psychologist	0	0		0	0	0.00
7.00	Clinical Social Worker	0	0		0	0	
8.00	Laboratory Techni ci an	0	0		0	0	0.00
9.00	Other Facility Health Care Staff Costs	68, 461	0	68, 46			9. 00
10.00	Subtotal (sum of lines 1 through 9)	131, 475	0	131, 47			10.00
11. 00	Physician Services Under Agreement	0	0	1	0	0	
12. 00	Physician Supervision Under Agreement	0	0	1	0	0	1
13.00	Other Costs Under Agreement	0	0	1	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0		
15.00	Medical Supplies	0	24, 683			24, 683	1
16.00	Transportation (Health Care Staff)	0	583	58		583	
17. 00	Depreciation-Medical Equipment	0		1	0	0	17. 00
18.00	Professional Liability Insurance	0	12 727	10.70	0	-	
19. 00 20. 00	Other Health Care Costs Allowable GME Costs	0	13, 727	13, 72	/	13, 727	19. 00 20. 00
			20.002	20.00	2	20,002	
21. 00 22. 00	Subtotal (sum of lines 15 through 20)	131, 475	38, 993 38, 993			00,770	1
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	131,4/5	38, 993	170, 46	8 2, 316	172, 784	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23. 00	Pharmacy	0			0 0	0	23. 00
24. 00	Dental	0			0 0	1	1
25. 00	Optometry	0				0	25. 00
25. 01	Tel eheal th	0			o o	0	1
25. 02	Chronic Care Management	l ő	1		o o	0	25. 02
26. 00	All other nonreimbursable costs	l ő	1		0 0		26. 00
20.00	11 11 11 01F	1	ı	1	-1	ı	1

72, 232

203, 707

27. 00

29.00

30.00

31.00

32.00

0 28.00

4, 100 115, 256

119, 356

292, 140

0

-17, 820

-17, 820

-15, 504

4, 100

133, 076

137, 176

307, 644

4, 100

60, 844

64, 944

103, 937

27. 00

28.00

31.00

32.00

Nonallowable GME costs

through 27) FACILITY OVERHEAD

30.00 Administrative Costs

29.00 Facility Costs

and 31)

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Health Financial Systems	SAINT JAMES HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-0161	Period: Worksheet M-1 From 10/01/2022
	Component CCN: 14-8640	To 09/30/2023 Date/Time Prepared:

			Component	JCIN. 14-0040	10 07/30/2023	2/21/2024 2: 01 pm	
					RHC III	Cost	
		Adjustments	Net Expenses		<u> </u>		
			for Allocation				
			(col. 5 + col.				
			6)				
		6.00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	0			1.	. 00
2.00	Physician Assistant	-2, 930	61, 194			2.	. 00
3.00	Nurse Practitioner	0	0			3.	. 00
4.00	Visiting Nurse	0	0			4.	. 00
5.00	Other Nurse	0	0			5.	. 00
6.00	Clinical Psychologist	0	0			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	-819	68, 848			9.	. 00
10.00	Subtotal (sum of lines 1 through 9)	-3, 749	130, 042			10.	. 00
11.00	Physician Services Under Agreement	0	0			11.	. 00
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	24, 683			15.	. 00
16.00	Transportation (Health Care Staff)	0	583			16.	. 00
17.00	Depreciation-Medical Equipment	0	0			17.	. 00
18. 00	Professional Liability Insurance	0	0				. 00
19.00	Other Health Care Costs	0	13, 727				. 00
20.00	Allowable GME Costs						. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	38, 993			l	. 00
22.00	Total Cost of Health Care Services (sum of	-3, 749	169, 035			22.	. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES			T			
23. 00	Pharmacy	0	0	•			. 00
24. 00	Dental	0	0				. 00
25. 00	Optometry	0	0				. 00
25. 01	Tel eheal th	3, 749	3, 749	1			. 01
25. 02	Chronic Care Management	0	0			1	. 02
26. 00	All other nonreimbursable costs	0	0				. 00
27. 00	Nonallowable GME costs						. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	3, 749	3, 749			28.	. 00
	through 27)						
20.00	FACILITY OVERHEAD		4 400				00
29. 00	Facility Costs	0	4, 100			l .	. 00
30.00	Administrative Costs	0	115, 256			1	. 00
31. 00	Total Facility Overhead (sum of lines 29 and	0	119, 356			31.	. 00
22 00	30) Total facility costs (sum of lines 22, 29		202 140			22	00
32. 00	Total facility costs (sum of lines 22, 28 and 31)	۷	292, 140			32.	. 00
	Jana 51)			I		ı	

69, 365

360, 422

131, 145

112, 751

243, 896

296, 118

131, 145

182.116

313, 261

656, 540

-32 541

-32, 541

-27, 527

131, 145

149, 575

280, 720

629, 013

29.00

30 00

31.00

32.00

through 27) FACILITY OVERHEAD

and 31)

Facility Costs

Administrative Costs

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

29.00

30.00

31.00

32.00

Health Financial Systems	SAINT JAMES HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-0161	Peri od: Worksheet M-1
	Component CCN: 14-8641	To 09/30/2023 Date/Time Prepared:

			Component CCN: I	14-8041	10 09.	/30/2023	2/21/2024 2:	
					RHC	CIV	Cost	o i piii
		Adjustments	Net Expenses		KIIC	, I V	0031	
			or Allocation					
			col. 5 + col.					
			6)					
		6. 00	7.00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	-971	131, 258					1.00
2.00	Physician Assistant	o	0					2. 00
3.00	Nurse Practitioner	-58	40, 084					3. 00
4.00	Visiting Nurse	0	0					4. 00
5.00	Other Nurse	o	o					5. 00
6.00	Clinical Psychologist	o	o					6. 00
7.00	Clinical Social Worker	o	o					7. 00
8. 00	Laboratory Techni ci an	o	o					8. 00
9.00	Other Facility Health Care Staff Costs	-218	123, 482					9. 00
10.00	Subtotal (sum of lines 1 through 9)	-1, 247	294, 824					10.00
11. 00	Physician Services Under Agreement	0	0					11.00
12.00	Physician Supervision Under Agreement	0	O					12. 00
13.00	Other Costs Under Agreement	o	o					13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	o					14. 00
15.00	Medical Supplies	0	29, 596					15. 00
16.00	Transportation (Health Care Staff)	O	3, 718					16. 00
17.00	Depreciation-Medical Equipment	0	0					17. 00
18.00	Professional Liability Insurance	0	1, 259					18. 00
19.00	Other Health Care Costs	0	17, 649					19. 00
20.00	Allowable GME Costs							20. 00
21.00	Subtotal (sum of lines 15 through 20)	О	52, 222					21. 00
22. 00	Total Cost of Health Care Services (sum of	-1, 247	347, 046					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	1, 247	1, 247					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)	1, 247	1, 247					28. 00
	through 27)							
	FACILITY OVERHEAD							
	Facility Costs	0	131, 145					29. 00
30.00	Administrative Costs	30, 303	179, 878					30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	30, 303	311, 023					31. 00
	30)							
32. 00	Total facility costs (sum of lines 22, 28	30, 303	659, 316					32. 00
	and 31)							

	5	CALNT JAMES	LIOCOLTAL			6.5. 046.4	0550 40
	Financial Systems SIS OF HOSPITAL-BASED RHC/FQHC COSTS	SAINT JAMES	Provider C	CN: 14-0161	Peri od:	worksheet M-1	
			Component		From 10/01/2022 To 09/30/2023		
					RHC V	Cost	· p
		Compensation	Other Costs	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	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	119, 126		119, 12			
2.00	Physician Assistant	9, 149	0	9, 14			2. 00
3.00	Nurse Practitioner	72, 831	0	72, 83	1, 261	74, 092	3. 00
4.00	Visiting Nurse	0	0		0	0	4. 00
5.00	Other Nurse	0	0		0	0	5. 00
6.00	Clinical Psychologist	0	0		0	0	6. 00
7.00	Clinical Social Worker	0	0		0	0	1
8.00	Laboratory Techni ci an	0	0		0	0	0.00
9.00	Other Facility Health Care Staff Costs	177, 557		177, 55			9. 00
10.00	Subtotal (sum of lines 1 through 9)	378, 663	l e	378, 66	· ·		1
11. 00	Physician Services Under Agreement	0	30, 393	30, 39	3 0	30, 393	
12.00	Physician Supervision Under Agreement	0	0		0	0	1
13.00	Other Costs Under Agreement	0	0		0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	30, 393			00,070	
15.00	Medical Supplies	0	65, 816			65, 816	1
16. 00	Transportation (Health Care Staff)	0	1, 953	1, 95	3 0	1, 953	1
17. 00	Depreciation-Medical Equipment	0	0		0		17. 00
18. 00	Professional Liability Insurance	0	956			, , , ,	
19. 00	Other Health Care Costs	0	22, 497	22, 49	7 0	22, 497	
20. 00	Allowable GME Costs						20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	91, 222			91, 222	21. 00
22. 00	Total Cost of Health Care Services (sum of	378, 663	121, 615	500, 27	8 6, 555	506, 833	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES		Г	T	T	T	
23. 00	Pharmacy	0	0		0	1	
24. 00	Dental	0	0		0		24. 00
25. 00	Optometry	0	0		0	0	25. 00
25. 01	Tel eheal th	0	0		0	0	
25. 02	Chronic Care Management	0	0		0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		U 0	0	26. 00

133, 046

511, 709

27. 00

29.00

30.00

31.00

32.00

0 28.00

15, 237 286, 069

301, 306

808, 139

0

-34, 619

-34, 619

-28, 064

15, 237

320, 688

335, 925

836, 203

15, 237 187, 642

202, 879

324, 494

27. 00

28.00

31. 00 32. 00 Nonallowable GME costs

through 27) FACILITY OVERHEAD

30.00 Administrative Costs

29.00 Facility Costs

and 31)

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Health Financial Systems	SAINT JAMES HOSPITAL	In Lieu of Form CMS	S-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-0161	Period: Worksheet Marksheet Markshee	-1
	Component CCN: 14-8643	To 09/30/2023 Date/Time Pi	

						2/21/2024 2:0	01 pm
					RHC V	Cost	
		Adjustments	Net Expenses				
			for Allocation	ı			
			(col. 5 + col.				
			6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	-1, 209	119, 979	)			1. 00
2.00	Physician Assistant	-30	9, 277	·			2. 00
3.00	Nurse Practitioner	-492	73, 600				3. 00
4.00	Visiting Nurse	0	l c				4. 00
5.00	Other Nurse	0	l c				5. 00
6.00	Clinical Psychologist	0	l c				6.00
7.00	Clinical Social Worker	0	l c	o			7. 00
8.00	Laboratory Techni ci an	0	l c				8.00
9.00	Other Facility Health Care Staff Costs	-626	180, 005				9.00
10.00	Subtotal (sum of lines 1 through 9)	-2, 357					10.00
11. 00	Physician Services Under Agreement	0					11.00
12. 00	Physician Supervision Under Agreement	0					12.00
13. 00		0	-	•			13. 00
	Subtotal (sum of lines 11 through 13)	0	30, 393				14. 00
	Medical Supplies	0	65, 816	1			15. 00
	Transportation (Health Care Staff)	0	1, 953				16.00
	Depreciation-Medical Equipment	0	1, 700	1			17. 00
	Professional Liability Insurance	0	956	1			18. 00
	Other Health Care Costs	0	22, 497	1			19. 00
	Allowable GME Costs	0	22, 477				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	91, 222	,			21.00
22. 00	Total Cost of Health Care Services (sum of	-2, 357		1			22. 00
22.00	lines 10, 14, and 21)	-2, 337	304, 470	'			22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23 00	Pharmacy	0	C	1			23. 00
24. 00	Dental	0	-	•			24. 00
25. 00	Optometry	0		1			25. 00
	Tel eheal th	2, 357	2, 357	1			25. 00
	Chronic Care Management	2, 337	2, 337	1			25. 01
26. 00	All other nonreimbursable costs	0		1			26. 00
27. 00	Nonallowable GME costs	0		<b>'</b>			27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	2, 357	2, 357	,			28.00
26.00	through 27)	2, 337	2, 337				20.00
	FACILITY OVERHEAD						
20.00	Facility Overhead Facility Costs	0	15, 237	·I			29. 00
30.00	Administrative Costs	33, 723					30.00
31.00	Total Facility Overhead (sum of lines 29 and	33, 723					31.00
31.00	30)	JJ, 123	330, 029				31.00
32. 00	Total facility costs (sum of lines 22, 28	33, 723	841, 862	,			32. 00
32.00	and 31)	JJ, 123	041, 802				32.00
	lana 31)		I	I			1

Heal th	Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			C		From 10/01/2022		
			Component	CCN: 14-8653	To 09/30/2023	Date/Time Pre 2/21/2024 2:0	
					RHC VI	Cost	Грііі
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati		
				+ col . 2)	ons	Trial Balance	
				Í		(col. 3 + col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	122, 813	C	122, 81	3 2, 174	124, 987	1. 00
2.00	Physician Assistant	0	C		0	0	2. 00
3.00	Nurse Practitioner	63, 732	C	63, 73	1, 128	64, 860	3. 00
4.00	Visiting Nurse	0	C		0	0	4. 00
5.00	Other Nurse	0	C		0	0	5. 00
6.00	Clinical Psychologist	0	C		0	0	6. 00
7.00	Clinical Social Worker	0	C		0	0	7. 00
8.00	Laboratory Techni ci an	0	C		0	0	8. 00
9.00	Other Facility Health Care Staff Costs	80, 950	C	80, 95	· ·		9. 00
	Subtotal (sum of lines 1 through 9)	267, 495	C	267, 49	95 4, 735	272, 230	
11. 00	Physician Services Under Agreement	0	C	)	0	0	11. 00
12.00	Physician Supervision Under Agreement	0	C	)	0	0	12. 00
	Other Costs Under Agreement	0	C	)	0	0	13. 00
	Subtotal (sum of lines 11 through 13)	0	C		0	0	14. 00
15. 00	Medical Supplies	0	51, 904	1		51, 904	15. 00
16. 00	Transportation (Health Care Staff)	0	1, 428	1, 42	.8	1, 428	
	Depreciation-Medical Equipment	0	C	)	0	0	17. 00
18. 00	Professional Liability Insurance	0	1, 136	1, 13	66 0	1, 136	18. 00

84, 344

84, 344

351, 839

267, 495

16, 780

71, 248

71, 248

0

0

8, 346

94, 476

102, 822

174,070

16, 780

71, 248

338, 743

0

0

0

0

0

0

8, 346

178, 820

187, 166

525, 909

0

0 0 0

-28, 899

-28, 899

-24, 164

4, 735

16, 780

71, 248

343, 478

0

0 24.00

0 25.01

0

0 28.00

8, 346

149, 921

158, 267

501, 745

19.00

20.00

21.00

22.00

23.00

25.00

25.02

26.00

27. 00

29.00

30.00

31.00

32.00

19.00 Other Health Care Costs

Pharmacy

Optometry

Tel eheal th

Dental

and 31)

20.00

21.00

22.00

23.00

24.00

25.00

25.01

25.02

26.00

27.00

28.00

29.00

30.00

31.00

32.00

Allowable GME Costs

Chronic Care Management

Nonallowable GME costs

through 27)
FACILITY OVERHEAD
Facility Costs

Administrative Costs

Subtotal (sum of lines 15 through 20)

lines 10, 14, and 21)
COSTS OTHER THAN RHC/FOHC SERVICES

All other nonreimbursable costs

Total Cost of Health Care Services (sum of

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Health Financial Systems	SAINT JAMES HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Period: From 10/01/2022	Worksheet M-1
	Component CCN: 14-8653	To 09/30/2023	

Adjustments				Component	CCN. 14-0055	10 07/30/2	2/21/2024	
FACILITY HEALTH CARE STAFF COSTS						RHC VI		
FACILITY HEALTH CARE STAFF COSTS   1.00   7.00   1.00			Adjustments	Net Expenses				
FACILITY HEALTH CARE STAFF COSTS			•	for Allocation	n			
FACILITY HEALTH CARE STAFF COSTS				(col. 5 + col.				
FACILITY HEALTH CARE STAFF COSTS   1.00				6)				
1.00			6. 00	7.00				
2.00		FACILITY HEALTH CARE STAFF COSTS						
3.00	1.00	Physi ci an	-2, 339	122, 648	3			1.00
4.00	2.00	Physician Assistant	0	C				2. 00
5.00	3.00	Nurse Practitioner	-322	64, 538	3			3.00
6.00	4.00	Visiting Nurse	0	l c				4.00
7.00	5.00	Other Nurse	0	l c				5.00
8. 00	6.00	Clinical Psychologist	0	l c				6.00
9.00   Other Facility Health Care Staff Costs   -837   81,546   0.00   Subtotal (sum of lines 1 through 9)   -3,498   268,732   10.00   11.00   Physician Supervision Under Agreement   0   0   0   12.00   13.00   14.00   15.00   14.00   15.00   14.00   15.00   14.00   15.00   14.00   15.00   14.00   15.00   14.00   15.00   15.00   14.00   15.00   15.00   15.00   16.00   17.00   15.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   16.00   17.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   17.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   17.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   17.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   17.00   16	7.00	Clinical Social Worker	0	l c	ol			7.00
10.00   Subtotal (sum of lines 1 through 9)   -3,498   268,732   10.00   26.00   27.	8.00	Laboratory Techni ci an	0	l c	o			8.00
10.00   Subtotal (sum of lines 1 through 9)   -3,498   268,732   10.00   26.00   27.	9.00	Other Facility Health Care Staff Costs	-837	81, 546	5			9. 00
11.00   Physician Services Under Agreement   0   0   0   12.00   Physician Supervision Under Agreement   0   0   0   12.00   13.00   0   14.00   14.00   15.00   0   0   14.00   15.00   14.00   15.00   16.00   17.00   16.00   17.00   16.00   17.	10.00		-3, 498	268, 732	2			10.00
12.00   Physici an Supervision Under Agreement   0   0   0   0   0   0   13.00   0   0   0   0   14.00   0   0   14.00   0   0   0   0   0   0   0   0   0	11. 00				1			11.00
13.00   Other Costs Under Agreement   0   0   0   0   14.00	12.00		0		ol			12. 00
14. 00   Subtotal (sum of lines 11 through 13)   0   0   0   0   15. 00   Medical Supplies   0   0   51, 904   15. 00   16. 00   17. 00   Depreciation (Health Care Staff)   0   1, 428   16. 00   17. 00   Depreciation-Medical Equipment   0   0   0   0   0   0   0   0   0	13.00	, ,	0		ol			13. 00
15.00   Medical Supplies		i i	0					14. 00
16.00 Transportation (Heal th Care Staff) 0 1,428 16.00 17.00 Depreciation-Medical Equipment 0 0 17.00 18.00 Professional Liability Insurance 0 1,136 18.00 19.00 Other Heal th Care Costs 0 16,780 19.00 20.00 All owable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 71,248 21.00 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 22.00 23.00 Pharmacy 0 0 0 24.00 24.00 Dental 0 0 0 25.00 25.01 Teleheal th 3,498 3,498 25.01 25.02 Chronic Care Management 0 0 0 25.00 27.00 Nonall owable GME costs 0 0 0 26.00 27.00 Nonall owable GME costs 0 0 0 26.00 27.00 Nonall owable GME costs 0 0 0 26.00 28.00 Total Konreimbursable Costs (sum of lines 23 3,498 3,498 3,498 27.00 28.00 Total Nonreimbursable Costs (sum of lines 23 3,498 3,498 3,498 27.00 28.00 Total Ronreimbursable Costs (sum of lines 23 3,498			0	51, 904	1			15. 00
17. 00   Depreciation-Medical Equipment   0   0   17. 00     18. 00   Professional Liability Insurance   0   1, 136   18. 00     19. 00   Other Heal th Care Costs   0   16, 780     20. 00   Allowable GME Costs   20. 00     21. 00   Subtotal (sum of lines 15 through 20)   0   71, 248     22. 00   Total Cost of Heal th Care Services (sum of lines 10, 14, and 21)     COSTS OTHER THAN RHC/FOHC SERVICES   0   0     23. 00   Dental   0   0     24. 00   Dental   0   0     25. 00   Optometry   0   0     25. 01   Tel eheal th   3, 498   3, 498     25. 01   Tel eheal th   3, 498   3, 498     25. 02   Chronic Care Management   0   0     26. 00   All other nonreimbursable costs   0   0     27. 00   Nonallowable GME costs   27. 00     28. 00   Total Nonreimbursable Costs (sum of lines 23   3, 498   3, 498     29. 00   Facility Costs   0     29. 00   Facility Costs   0     30. 00   Administrative Costs   0   149, 921     30. 00   Total Facility Overhead (sum of lines 29 and 30)     32. 00   Total facility costs (sum of lines 22, 28   0   501, 745   32. 00     Total facility costs (sum of lines 22, 28   0   501, 745   32. 00     30. 00   Total facility costs (sum of lines 22, 28   0   501, 745   32. 00     Costs   C			0		1			16. 00
18. 00       Professional Liability Insurance       0       1,136       18.00         19. 00       Other Heal th Care Costs       0       16,780       19.00         20. 00       Allowable GME Costs       20.00       20.00         21. 00       Subtotal (sum of lines 15 through 20)       0       71,248       21.00         22. 00       Total Cost of Heal th Care Services (sum of lines 10, 14, and 21)       21.00       22.00         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       3,498       3,498       25.01         25. 02       Chronic Care Management       0       0       0         26. 00       All other nonreimbursable costs       0       0       26.00         27. 00       Nonallowable GME costs       0       0       27.00         28. 00       Total Nonreimbursable costs (sum of lines 23 3,498			0		•			17. 00
19.00   Other Health Care Costs   0   16,780   19.00   20.00   All lowable GME Costs   20.00   Costs of Health Care Services (sum of lines 15 through 20)   0   71,248   21.00   Costs Of Health Care Services (sum of lines 10, 14, and 21)   Costs Of Health Care Services (sum of lines 10, 14, and 21)   Costs Of Health Care Services (sum of lines 10, 14, and 21)   Costs Of Health Care Services (sum of lines 10, 14, and 21)   Costs Of Health Care Services (sum of lines 23, 498   339, 980   23.00   24.00   24.00   25.00   Optometry   0   0   0   0   24.00   25.00   Optometry   0   0   0   0   25.00   25.00   Optometry   0   0   0   0   0   25.00   25.00   Optometry   0   0   0   0   0   0   0   0   0			0	1. 136				18. 00
20. 00   Allowable GME Costs   20. 00   21. 00   22. 00   22. 00   22. 00   23. 00   24. 00   23. 00   24. 00   25. 00   25. 00   26. 00			0					19. 00
22. 00	20.00	Allowable GME Costs						20. 00
22. 00	21. 00	Subtotal (sum of lines 15 through 20)	0	71, 248	3			21. 00
Lines 10, 14, and 21)   COSTS OTHER THAN RHC/FQHC SERVICES	22. 00	,	-3, 498					22. 00
23.00   Pharmacy   0   0   0   24.00   25.00   0ptometry   0   0   0   0   0   25.01   Tel eheal th   3,498   3,498   25.02   26.00   All other nonreimbursable costs   0   0   0   26.00   27.00   Nonall owable GME costs   27.00   Nonall owable GME costs   27.00   Edility Overhead (sum of lines 23   3,498   3,498   3,498   3,498   26.00   27.00   27.00   28.00   Total Nonreimbursable Costs (sum of lines 23   3,498   3,498   3,498   28.00   27.00   28.00   Total Facility Overhead (sum of lines 29 and 30.00   30.0			,					
24.00 Dental 0 0 0 0 25.00 Optometry 0 0 0 0 25.00   25.01 Tel eheal th 3,498 3,498 25.01   25.02 Chronic Care Management 0 0 0 0 25.02   26.00 All other nonreimbursable costs 0 0 0 26.00   27.00 Nonallowable GME costs   27.00 Nonallowable GME costs (sum of lines 23 3,498 3,498   28.00 Total Nonreimbursable Costs (sum of lines 23 3,498 3,498   28.00 Facility Overhead   29.00 Facility Costs 0 149,921 30.00   30.00 Administrative Costs   31.00 Total Facility Overhead (sum of lines 29 and 30)   32.00 Total facility costs (sum of lines 22, 28 0 501,745 32.00					•			
25. 00 Optometry 0 0 0 0 25. 00 25. 01 Tel eheal th 3,498 3,498 25. 01 25. 02 Chronic Care Management 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs 27. 00 Nonallowable GME costs (sum of lines 23 3,498 3,498 28. 00 through 27) FACILITY OVERHEAD  29. 00 Facility Costs 0 8, 346 30. 00 Administrative Costs 0 149, 921 30. 00 31. 00 Total Facility Overhead (sum of lines 29 and 30) Total facility costs (sum of lines 22, 28 0 501,745 32. 00	23.00	Pharmacy	0	C				23. 00
25. 01 Telehealth 3,498 3,498 25. 01 25. 02 Chronic Care Management 0 0 0 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs 27. 00 28. 00 Total Facility Overhead (sum of lines 29 and 30) 32. 00 Total facility costs (sum of lines 22, 28 0 50,745 32. 00 30. 07 Total facility costs (sum of lines 29, 28 0 501,745 32. 00	24.00	Dental	0	(				24. 00
25. 02 Chronic Care Management 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs 28. 00 Total Nonreimbursable Costs (sum of lines 23 3, 498 3, 498 28. 00  29. 00 Facility Costs 0 8, 346 29. 00 30. 00 Administrative Costs 0 149, 921 30. 00 31. 00 Total Facility Overhead (sum of lines 29 and 30) 32. 00 Total facility costs (sum of lines 22, 28 0 501, 745 32. 00	25.00	Optometry	0	(				25. 00
26.00	25. 01	Tel eheal th	3, 498	3, 498	3			25. 01
27. 00	25. 02	Chronic Care Management	0					25. 02
28.00 Total Nonreimbursable Costs (sum of lines 23 3,498 3,498 28.00 through 27) FACILITY OVERHEAD  29.00 Facility Costs 0 8,346 29.00 30.00 Administrative Costs 0 149,921 30.00 Total Facility Overhead (sum of lines 29 and 30)  32.00 Total facility costs (sum of lines 22, 28 0 501,745 32.00	26.00	All other nonreimbursable costs	0	l c				26. 00
through 27) FACILITY OVERHEAD  29.00 Facility Costs 30.00 Administrative Costs 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 501,745 32.00	27.00	Nonallowable GME costs						27. 00
FACILITY OVERHEAD  29. 00 Facility Costs  30. 00 Administrative Costs  10 149, 921  31. 00 Total Facility Overhead (sum of lines 29 and 30)  32. 00 Total facility costs (sum of lines 22, 28  32. 00 Total facility costs (sum of lines 22, 28  38. 346  29. 00  149, 921  31. 00  31. 00  32. 00  32. 00	28.00	Total Nonreimbursable Costs (sum of lines 23	3, 498	3, 498	3			28. 00
29.00 Facility Costs		through 27)						
30.00 Administrative Costs 0 149,921 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) Total facility costs (sum of lines 22, 28 0 501,745 32.00		FACILITY OVERHEAD						
31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 501,745 31.00	29. 00	Facility Costs	0	8, 346	Б			29. 00
30) 32.00 Total facility costs (sum of lines 22, 28 0 501,745 32.00	30.00	Administrative Costs	0	149, 921	ı			30.00
32.00 Total facility costs (sum of lines 22, 28 0 501,745 32.00	31.00	Total Facility Overhead (sum of lines 29 and	0	158, 267	7			31.00
		30)						
and 31)	32.00	Total facility costs (sum of lines 22, 28	0	501, 745	5			32. 00
		and 31)						

	Financial Systems	SAINT JAMES				eu of Form CMS-	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component		From 10/01/2022 To 09/30/2023	Date/Time Pre	
					RHC VII	2/21/2024 2:0 Cost	ı pm
		Compensation	Other Costs	Total (col 1	Reclassi fi cati	Reclassi fi ed	
		Compensation	Utilei Costs	+ col . 2)	ons	Trial Balance	
				+ (01. 2)	Ulis	(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4, 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS					0.00	
1.00	Physi ci an	51, 108	O	51, 10	8 917	52, 025	1.00
2.00	Physici an Assistant	64, 444	l	64, 44	4 1, 157	65, 601	2.00
3.00	Nurse Practitioner	0	l		0 0	0	3.00
4.00	Visiting Nurse	0	l	)	0 0	0	4.00
5.00	Other Nurse	0	l	)	0 0	0	5.00
6.00	Clinical Psychologist	0	l	)	0 0	0	6.00
7.00	Clinical Social Worker	0	l o	)	0 0	0	7.00
8.00	Laboratory Techni ci an	0	l c		0 0	0	8. 00
9.00	Other Facility Health Care Staff Costs	64, 598	l c	64, 59	1, 160	65, 758	9. 00
10.00	Subtotal (sum of lines 1 through 9)	180, 150	l o	180, 15	0 3, 234	183, 384	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	Other Costs Under Agreement	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	19, 798	19, 79	8 0	19, 798	15. 00
16.00	Transportation (Health Care Staff)	0	1, 807	1, 80	7 0	1, 807	16. 00
17. 00	Depreciation-Medical Equipment	0	0	1	0	0	17. 00
18. 00	Professional Liability Insurance	0	332			332	18. 00
19. 00		0	7, 300	7, 30	0	7, 300	
20.00	Allowable GME Costs						20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	29, 237			29, 237	21. 00
22. 00	Total Cost of Health Care Services (sum of	180, 150	29, 237	209, 38	7 3, 234	212, 621	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES		Г _	T		T -	
23. 00		0	0	1	0	-	0.00
24. 00	Dental	0	0	1	0		
25. 00	Optometry	0	0	1	0	0	
25. 01	Tel eheal th	0		1	0	0	25. 01
25. 02	Chronic Care Management	0		1	0	· -	
26. 00	All other nonreimbursable costs	O			0	0	20.00
27. 00 28. 00	Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23		,			0	27. 00 28. 00
∠0. 00	through 27)						20.00

79, 795

259, 945

15, 321 93, 833

109, 154

138, 391

15, 321 173, 628

188, 949

398, 336

-22, 928

-22, 928

-19, 694

29.00

30.00

31.00

32.00

15, 321 150, 700

166, 021

378, 642

through 27)
FACILITY OVERHEAD
29.00 Facility Costs
30.00 Administrative Costs

and 31)

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

31.00

32.00

Health Financial Systems	SAINT JAMES HOSPITAL	In Lieu of Form CMS-2552-10	
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 14-0161	Period: Worksheet M-1 From 10/01/2022	
	Component CCN: 14-8644	To 09/30/2023 Date/Time Prepared:	

			Component CC	N: 14-8644	10 09/30/20	2/21/2024 2:	
					RHC VII	Cost	OT PIII
		Adjustments	Net Expenses		I KIIO VIII	0031	
			for Allocation				
			(col. 5 + col.				
			6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	-385	51, 640				1.00
2.00	Physician Assistant	-372	65, 229				2. 00
3.00	Nurse Practitioner	ol	0				3.00
4.00	Visiting Nurse	ol	o				4. 00
5.00	Other Nurse	ol	o				5. 00
6.00	Clinical Psychologist	ol	o				6. 00
7.00	Clinical Social Worker	ol	o				7. 00
8.00	Laboratory Techni ci an	ol	o				8. 00
9.00	Other Facility Health Care Staff Costs	-350	65, 408				9. 00
10.00	Subtotal (sum of lines 1 through 9)	-1, 107	182, 277				10.00
11. 00	Physician Services Under Agreement	O	0				11.00
12.00	Physician Supervision Under Agreement	ol	o				12.00
13.00	Other Costs Under Agreement	ol	o				13.00
14. 00	Subtotal (sum of lines 11 through 13)	ol	o				14. 00
15. 00	Medical Supplies	ol	19, 798				15. 00
16. 00	Transportation (Health Care Staff)	ol	1, 807				16, 00
17. 00	Depreciation-Medical Equipment	O	0				17. 00
18.00	Professional Liability Insurance	o	332				18. 00
19.00	Other Health Care Costs	o	7, 300				19. 00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	O	29, 237				21. 00
22. 00	Total Cost of Health Care Services (sum of	-1, 107	211, 514				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	1, 107	1, 107				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	1, 107	1, 107				28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	15, 321				29. 00
30.00	Administrative Costs	0	150, 700				30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	0	166, 021				31. 00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	0	378, 642				32. 00
	and 31)						I

Heal th	Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 14-0161	Peri od:	Worksheet M-1	
					From 10/01/2022		
			Component	CCN: 14-8650	To 09/30/2023	Date/Time Prep	
						2/21/2024 2: 0 <sup>2</sup>	1 pm
					RHC VIII	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Reclassi fied	
				+ col . 2)	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	404, 111	0	404, 1	11 7, 523	411, 634	1.00
2.00	Physician Assistant	22, 419	0	22, 4°	19 417	22, 836	2.00

		oompensa er on	011101 00313	+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
	•	1. 00	2. 00	3. 00	4. 00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1.00	Physi ci an	404, 111	0	404, 111	7, 523	411, 634	1. 00
2. 00	Physician Assistant	22, 419	0	1	417		2.00
3. 00	Nurse Practitioner	189, 441	0	189, 441	3, 527		3. 00
4. 00	Vi si ting Nurse	107, 111	Ō	0	0, 027	0	4. 00
5. 00	Other Nurse	0	0	,	0	0	5. 00
6. 00	Clinical Psychologist	0	0	o o	0	0	6. 00
7. 00	Clinical Social Worker	0	0	0	0	0	7. 00
8.00	Laboratory Techni ci an	0	0	0	0	0	8. 00
9. 00	Other Facility Health Care Staff Costs	171, 800	0	171, 800	3, 198	174, 998	9. 00
10.00	Subtotal (sum of lines 1 through 9)	787, 771	0		14, 665		
11. 00	Physician Services Under Agreement	0	0	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	86, 507	86, 507	0	86, 507	15. 00
16.00	Transportation (Health Care Staff)	0	538	538	0	538	16. 00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17. 00
18.00	Professional Liability Insurance	0	1, 259	1, 259	0	1, 259	18. 00
19.00	Other Health Care Costs	0	49, 962	49, 962	0	49, 962	19. 00
20.00	Allowable GME Costs						20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	138, 266	138, 266	0	138, 266	21.00
22. 00	Total Cost of Health Care Services (sum of	787, 771	138, 266	926, 037	14, 665	940, 702	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FOHC SERVICES						
23. 00	Pharmacy	0	0	0	0	0	23. 00
24. 00	Dental	0	0	0	0	0	24. 00
25. 00	Optometry	0	0	0	0	0	25. 00
25. 01	Tel eheal th	0	0	0	0	0	25. 01
25. 02	Chronic Care Management	0	0	0	0	0	25. 02
26. 00	All other nonreimbursable costs	0	Ü	0	0	0	26. 00
27. 00	Nonallowable GME costs	0			0		27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	0	0	0	28. 00
	through 27) FACILITY OVERHEAD						
20.00	Facility Overhead Facility Costs	^	121, 913	121, 913	^	121, 913	29. 00
30. 00	Administrative Costs	230, 281	265, 948		-95, 266		
31. 00	Total Facility Overhead (sum of lines 29 and	230, 281	387, 861		-95, 266		
31.00	30)	230, 201	307, 001	010, 142	- 75, 200	322, 870	31.00
32. 00	Total facility costs (sum of lines 22, 28	1, 018, 052	526, 127	1, 544, 179	-80, 601	1, 463, 578	32. 00
52. 00	and 31)	.,010,002	323, 127	., 5 , 1, 1, 7	33, 301	1, 100, 070	52.00
	· · · · · · · · · · · · · · · · · · ·		'			•	•

Health Financial Systems	SAINT JAMES HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS	Provi der CCN: 14-0161	Period: Worksheet M-1 From 10/01/2022
		To 09/30/2023 Date/Time Prepared:

			Component	CCN: 14-8650	То	09/30/2023	Date/Time Pro 2/21/2024 2:0	
						RHC VIII	Cost	51 piii
		Adjustments	Net Expenses					
			for Allocation	ו				
			(col. 5 + col.					
	•	/ 00	6)	-				
	FACILITY HEALTH CARE STAFF COSTS	6. 00	7. 00					
1.00	Physician	-653	410, 98	1				1.00
2.00	Physician Assistant	-83		1				2.00
3.00	Nurse Practitioner	-1, 236						3.00
4. 00	Visiting Nurse	-1, 230	171, 732	1				4.00
5. 00	Other Nurse	0						5.00
6. 00	Clinical Psychologist	0						6.00
7. 00	Clinical Social Worker	0	ì					7. 00
8. 00	Laboratory Techni ci an	0	ì					8.00
9. 00	Other Facility Health Care Staff Costs	-928	174, 070	ol .				9. 00
10.00	Subtotal (sum of lines 1 through 9)	-2, 900						10.00
11. 00	Physician Services Under Agreement	2,700	(	1				11.00
12. 00	Physician Supervision Under Agreement	0	(					12.00
13. 00	Other Costs Under Agreement	0						13. 00
14.00	Subtotal (sum of lines 11 through 13)	0						14.00
15. 00	Medical Supplies	0	86, 507	7				15. 00
16.00	Transportation (Health Care Staff)	0	538					16.00
17.00	Depreciation-Medical Equipment	0		ol				17. 00
18.00	Professional Liability Insurance	0	1, 259	9				18. 00
19.00	Other Health Care Costs	0	49, 962	2				19. 00
20.00	Allowable GME Costs							20.00
21.00	Subtotal (sum of lines 15 through 20)	0	138, 266	5				21. 00
22.00	Total Cost of Health Care Services (sum of	-2, 900	937, 802	2				22. 00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
23. 00	Pharmacy	0	(	1				23. 00
24. 00	Dental	0	(					24. 00
25. 00	Optometry	0	(					25. 00
25. 01	Tel eheal th	2, 900	2, 900					25. 01
25. 02	Chronic Care Management	0	(					25. 02
26. 00	All other nonreimbursable costs	0	(					26. 00
27. 00	Nonallowable GME costs							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	2, 900	2, 900					28. 00
	through 27)							
20.00	FACILITY OVERHEAD	^	101.04					1 20 00
29. 00	Facility Costs	0.544	121, 913	1				29. 00
30.00	Administrative Costs	-9, 561	391, 402	1				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-9, 561	513, 315					31. 00
32. 00	30)	0 5/1	1 454 01-	7				32. 00
ა∠. ∪∪	Total facility costs (sum of lines 22, 28 and 31)	-9, 561	1, 454, 017	'				32.00
	lana 31)		I	I				1

Heal th	Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 14-0161	Peri od:	Worksheet M-1	
			Component		From 10/01/2022 To 09/30/2023	Date/Time Pre 2/21/2024 2:0	
					RHC IX	Cost	
		Compensation	Other Costs	Total (col.	Reclassi fi cati	Reclassi fied	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS			1			
1.00	Physi ci an	118, 597	0			120, 679	
2.00	Physician Assistant	0	0		0	0	
3.00	Nurse Practitioner	120, 031	0	120, 03	1 2, 108	122, 139	1
4.00	Visiting Nurse	0	0		0 0	0	
5.00	Other Nurse	0	0		0 0	0	0.00
6.00	Clinical Psychologist	0	0		0 0	0	0.00
7.00	Clinical Social Worker	0	0		0 0	0	7. 00
8.00	Laboratory Techni ci an	0	0		0 0	0	0.00
9.00	Other Facility Health Care Staff Costs	146, 399	0	146, 39		148, 970	
10.00	Subtotal (sum of lines 1 through 9)	385, 027	0	385, 02	-	391, 788	1
11. 00	Physician Services Under Agreement	0	0		0	0	11. 00
12. 00	Physician Supervision Under Agreement	0	0		0	0	
13. 00	Other Costs Under Agreement	0	1, 123			1, 123	
14. 00	Subtotal (sum of lines 11 through 13)	0	1, 123	1		1, 123	
15.00	Medical Supplies	0	55, 144	55, 14		55, 144	
16.00	Transportation (Health Care Staff)	0	5, 656	5, 65	6	5, 656	
17. 00	Depreciation-Medical Equipment	0	1 017	1 01	0	0	17. 00
18.00	Professional Liability Insurance	0	1, 017	1, 01		1, 017	18.00
19.00	Other Health Care Costs	Ü	34, 201	34, 20		34, 201	19.00
20.00	Allowable GME Costs	0	0/ 010	0/ 01	0	0/ 010	20.00
21. 00	Subtotal (sum of lines 15 through 20)	205 027	96, 018			96, 018	
22. 00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	385, 027	97, 141	482, 16	8 6, 761	488, 929	22. 00
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23. 00	Pharmacy	0	0		0 0	0	23. 00
24. 00	Dental	0	0		0 0	0	
25. 00	Optometry	0	0		0 0	0	
25. 00	Tel eheal th	0	0		0 0	0	
25. 01	Chronic Care Management	0	0		0 0	0	1
26. 00	All other nonreimbursable costs	0			0 0	0	26. 00
27. 00	Nonallowable GME costs	O				O	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	n		0	0	
20.00	through 27)	O			٦		20.00
	FACILITY OVERHEAD			1	<u> </u>		1
29. 00	Facility Costs	0	-32, 445	-32, 44	5 0	-32, 445	29. 00
	Administrative Costs	152, 998	131, 234			· ·	

152, 998

538, 025

-32, 445 131, 234

98, 789

195, 930

-32, 445 284, 232

251, 787

733, 955

-37, 941

-37, 941

-31, 180

-32, 445 246, 291

213, 846

702, 775

31.00

32.00

30.00 Administrative Costs

and 31)

31.00 Total Facility Overhead (sum of lines 29 and

Health Financial Systems	SAINT JAMES HOSPITAL	In Lieu of Form CMS-2552-10	
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-0161	Peri od: Worksheet M-1 From 10/01/2022	
	Component CCN: 14-8642	To 09/30/2023 Date/Time Prepared:	

2.00     Physician Assistant     0     0       3.00     Nurse Practitioner     -428     121,711       4.00     Visiting Nurse     0     0       5.00     Other Nurse     0     0	
FACILITY HEALTH CARE STAFF COSTS	
COI . 5 + COI . 6)   6.00   7.00	
FACILITY HEALTH CARE STAFF COSTS	
FACILITY HEALTH CARE STAFF COSTS	
FACILITY HEALTH CARE STAFF COSTS   1.00   Physician   -3,149   117,530   0   0   0   0   0   0   0   0   0	
1.00     Physician     -3,149     117,530       2.00     Physician Assistant     0     0       3.00     Nurse Practitioner     -428     121,711       4.00     Visiting Nurse     0     0       5.00     Other Nurse     0     0	
2.00     Physician Assistant     0     0       3.00     Nurse Practitioner     -428     121,711       4.00     Visiting Nurse     0     0       5.00     Other Nurse     0     0	
3.00 Nurse Practitioner -428 121,711 3.00 Visiting Nurse 0 0 0 5.00 Other Nurse 0 0 0 5.00 Other Nurse 0 0 0 0 5.00 Other Nurse 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00
4.00   Visiting Nurse	2. 00
5.00 Other Nurse 0 0 9	3. 00
	4. 00
6.00 Clinical Psychologist 0 0	5. 00
	5. 00
7.00   Clinical Social Worker   0   0	7. 00
8.00 Laboratory Technician 0 0 8	3. 00
9.00 Other Facility Health Care Staff Costs -1,089 147,881	9. 00
10.00   Subtotal (sum of lines 1 through 9) -4,666 387,122	0. 00
11.00 Physician Services Under Agreement 0 0 1	1. 00
12.00 Physician Supervision Under Agreement 0 0 12	2. 00
13.00 Other Costs Under Agreement 0 1,123 13	3. 00
14.00   Subtotal (sum of lines 11 through 13)   0   1,123   14	4. 00
15.00 Medical Supplies 0 55,144 15	5. 00
16.00 Transportation (Health Care Staff) 0 5,656	5. 00
17.00 Depreciation-Medical Equipment 0 0 1	7. 00
18.00 Professional Liability Insurance 0 1,017 18	3. 00
19.00 Other Health Care Costs 0 34, 201 19	9. 00
20.00 Allowable GME Costs	0. 00
21.00   Subtotal (sum of lines 15 through 20) 0 96,018   2'	1. 00
22.00 Total Cost of Health Care Services (sum of   -4,666 484,263 22	2. 00
lines 10, 14, and 21)	
COSTS OTHER THAN RHC/FQHC SERVICES	
23.00   Pharmacy   0   0   23	3. 00
24. 00   Dental   0   0   24	4. 00
25.00   Optometry   0   0   25	5. 00
25. 01 Tel eheal th 4, 666 4, 666 225	5. 01
25.02   Chronic Care Management   0   0   25	5. 02
	5. 00
27.00 Nonallowable GME costs	7. 00
28.00   Total Nonreimbursable Costs (sum of lines 23   4,666   4,666   28	3. 00
through 27)	
FACILITY OVERHEAD	
<b>3</b>	9. 00
	0. 00
31.00 Total Facility Overhead (sum of lines 29 and 0 213,846 3	1. 00
30)	
	2. 00
and 31)	

Heal th	Financial Systems	SAINT JAMES	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component		From 10/01/2022 To 09/30/2023		
					RHC X	Cost	
		Compensation	Other Costs	Total (col. '	Recl assi fi cati		
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS			1			
1. 00	Physi ci an	461, 884		461, 88			•
2.00	Physi ci an Assi stant	55, 063	0	55, 06			2. 00
3. 00	Nurse Practitioner	69, 697	0	69, 69	7 1, 209	70, 906	1
4.00	Visiting Nurse	0	0	)	0	0	4. 00
5. 00	Other Nurse	0	0	)	0	0	5. 00
6.00	Clinical Psychologist	0	0	1	0	0	6. 00
7.00	Clinical Social Worker	0	0	1	0	0	7. 00
8.00	Laboratory Techni ci an	0	0	1	0	0	8. 00
9.00	Other Facility Health Care Staff Costs	125, 436	0	125, 43	6 2, 177	127, 613	9. 00
10.00	Subtotal (sum of lines 1 through 9)	712, 080	0	712, 08	0 12, 357	724, 437	10.00

1.00   2.00   3.00   4.00   5.00							(COI. 3 + COI. 4)	
FACILITY HEALTH CARE STAFF COSTS			1. 00	2.00	3. 00	4. 00		
1.00		FACILITY HEALTH CARE STAFF COSTS			5.55			
3.00	1.00		461, 884	0	461, 884	8, 015	469, 899	1.00
4.00	2.00	Physician Assistant	55, 063	0	55, 063	956	56, 019	2.00
5.00         Other Nurse         0         0         0         0         5.00         0         5.00         0	3.00	Nurse Practitioner	69, 697	0	69, 697	1, 209	70, 906	3.00
Company   Comp	4.00	Visiting Nurse	0	0	0	0	0	4.00
1.00	5.00	Other Nurse	0	0	0	0	0	5.00
8.00	6.00	Clinical Psychologist	0	0	0	0	0	6.00
9.00 Other Facility Health Care Staff Costs 125, 436 0 125, 436 2, 177 127, 613 9.00   Subtotal (sum of lines 1 through 9) 712, 080 0 712, 080 12, 357 724, 437 10.00   Physician Services Under Agreement 0 0 0 0 0 0 0 0 12.00   12.00 Physician Supervision Under Agreement 0 0 0 0 0 0 0 0 12.00   13.00 Other Costs Under Agreement 0 0 0 0 0 0 0 0 0 13.00   14.00 Subtotal (sum of lines 11 through 13) 0 0 0 0 0 0 0 0 0 14.00   15.00 Medical Supplies 0 94,069 94,069 0 94,069 0 94,069 15.00   16.00 Transportation (Health Care Staff) 0 3,223 3,223 0 3,223 16.00   17.00 Depreciation-Medical Equipment 0 0 0 0 0 0 0 0 0 17.00   18.00 Professional Liability Insurance 0 2,506 2,506 0 2,506 19.00   19.00 Other Health Care Costs 0 59,319 59,319 0 59,319 19.00   20.00 Allowable GME Costs 0 59,319 59,319 0 59,319 12.00   20.00 Allowable GME Costs 0 159,117 159,117 0 159,117 21.00   21.00 Subtotal (sum of lines 15 through 20) 0 159,117 159,117 0 159,117 22.00   22.00 Total Cost of Health Care Services (sum of 712,080 159,117 159,117 0 159,117 22.00   23.00 Other Health Care Services (sum of 712,080 159,117 159,117 0 159,117 22.00   24.00 Dental 0 0 0 0 0 0 0 0 25.00   25.01 Telehealth 0 0 0 0 0 0 0 0 0 25.00   25.01 Telehealth 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00	Clinical Social Worker	0	0	0	0	0	7. 00
10. 00   Subtotal (sum of lines 1 through 9)   712,080   0   712,080   12,357   724,437   10.00	8.00	Laboratory Techni ci an	0	0	0	0	0	8. 00
11.00   Physician Services Under Agreement   0   0   0   0   0   0   11.00	9.00	Other Facility Health Care Staff Costs		0	125, 436	2, 177	127, 613	9. 00
12. 00	10.00	Subtotal (sum of lines 1 through 9)	712, 080	0	712, 080	12, 357	724, 437	10.00
13.00   Other Costs Under Agreement   0   0   0   0   0   0   13.00     14.00   Subtotal (sum of lines 11 through 13)   0   0   0   0   0   0   0     14.00   Subtotal (sum of lines 11 through 13)   0   0   0   0   0   0     14.00   Subtotal (sum of lines 11 through 13)   0   0   0   0   0     14.00   Subtotal (sum of lines 11 through 13)   0   0   0   0   0     15.00   Medical Supplies   0   94,069   94,069   0   94,069     15.00   Medical Supplies   0   94,069   94,069   0   94,069     15.00   Other Health Care Staff   0   0   0   0   0   0     17.00   Other Health Care Costs   0   59,319   59,319   0   59,319     19.00   Other Health Care Costs   0   59,319   59,319   0   59,319     19.00   Other Health Care Services (sum of lines 15 through 20)   0   159,117   159,117   159,117   0   159,117     10.00   Total Cost of Health Care Services (sum of lines 15,4,4,4,4,4,4,4,4,4,4,4,4,4,4,4,4,4,4,4	11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
14. 00     Subtotal (sum of lines 11 through 13)     0     0     0     0     0     0     14. 00       15. 00     Medical Supplies     0     94,069     94,069     94,069     0     94,069     15. 00       17. 00     Depreciation-Medical Equipment     0     0     0     0     0     0     0     0     17. 00       18. 00     Professional Liability Insurance     0     2,506     2,506     0     2,506     18. 00       19. 00     Other Heal th Care Costs     0     59,319     59,319     0     59,319     19. 00       20. 00     Allowable GME Costs     0     59,319     59,319     0     59,319     19. 00       21. 00     Subtotal (sum of lines 15 through 20)     0     159,117     159,117     159,117     0     159,117     21. 00       22. 00     Total Cost of Heal th Care Services (sum of lines 15,112,120     0     159,117     17,19     12,357     883,554       23. 00     Pharmacy     0     0     0     0     0     0     0       24. 00     Dotometry     0     0     0     0     0     0     0       25. 01     Dotometry     0     0     0     0     0     0<	12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
15.00   Medical Supplies	13.00	Other Costs Under Agreement	0	0	0	0	0	13. 00
16.00 Transportation (Health Care Staff) 0 3, 223 3, 223 0 3, 223 16.00 17.00 Depreciation-Medical Equipment 0 0 0 0 0 0 0 0 17.00 17.00 Depreciation-Medical Equipment 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14.00		0	0	0	0	0	
17.00   Depreciation-Medical Equipment   0	15.00	Medical Supplies	0	94, 069	94, 069	0	94, 069	15. 00
18.00			0	3, 223	3, 223	0	3, 223	16. 00
19.00   Other Health Care Costs   0   59, 319   59, 319   0   59, 319   20.00   All owable GME Costs   20.00   159, 117   159, 117   159, 117   0   159, 117   21.00   20.00   170	17.00	Depreciation-Medical Equipment	0	0	0	0	0	17. 00
20. 00   Allowable GME Costs   21. 00   Subtotal (sum of lines 15 through 20)   0   159, 117   159, 117   0   159, 117   21. 00			0			0	2, 506	
21. 00   Subtotal (sum of lines 15 through 20)   0   159, 117   159, 117   0   159, 117   21. 00			0	59, 319	59, 319	0	59, 319	
22. 00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)  COSTS OTHER THAN RHC/FOHC SERVICES  23. 00 Pharmacy Dental Optometry Opto	20.00	Allowable GME Costs						20.00
Iines 10, 14, and 21)   COSTS OTHER THAN RHC/FOHC SERVICES			0	159, 117	159, 117	0	159, 117	21.00
COSTS OTHER THAN RHC/FOHC SERVICES   23.00   Pharmacy   0   0   0   0   0   0   23.00	22. 00		712, 080	159, 117	871, 197	12, 357	883, 554	22. 00
23. 00 Pharmacy								
24.00 Dental 0 0 0 0 0 0 0 24.00 25.00 Optometry 0 0 0 0 0 0 0 0 25.00 25.01 Tel eheal th 0 0 0 0 0 0 0 0 0 0 25.00 25.01 Tel eheal th 0 0 0 0 0 0 0 0 0 0 25.00 25.01 Chronic Care Management 0 0 0 0 0 0 0 0 0 25.00 26.00 All other nonreimbursable costs 0 0 0 0 0 0 0 0 25.00 26.00 Nonal lowable GME costs 0 0 0 0 0 0 0 0 0 28.00 27.00 Nonal lowable GME costs 0 0 0 0 0 0 0 0 28.00 26.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 28.00 26.00 27.00 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 28.00 28.00 27.00 28.00 27.00 Total Facility Overhead (sum of lines 29 and 30.00 Administrative Costs 207,156 237,059 444,215 -77,966 366,249 30.00 30.00 Administrative Costs (sum of lines 29 and 30.00 Total facility Costs (sum of lines 22, 28 919,236 408,747 1,327,983 -65,609 1,262,374 32.00								4
25. 00			-	-		ŭ	_	
25. 01 Tel eheal th			0	0	0	0	_	
25. 02 Chronic Care Management 0 0 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 0 0 0 26. 00 27. 00 Nonallowable GME costs  28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 '	0	0	0	0	_	
26.00 All other nonreimbursable costs 0 0 0 0 0 0 26.00 27.00 Nonallowable GME costs		ų .	0	0	0	0	ı	
27. 00 Nonallowable GME costs  Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 28. 00 14hrough 27)  FACILITY OVERHEAD  29. 00 Facility Costs			0	0	0	0	0	
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 28.00 1 1 2 571 29.00 FACILITY OVERHEAD  29.00 Facility Costs 0 12,571 12,571 0 12,571 29.00 30.00 Administrative Costs 207,156 237,059 444,215 -77,966 366,249 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30)  32.00 Total facility costs (sum of lines 22, 28 919,236 408,747 1,327,983 -65,609 1,262,374 32.00		1	0	0	0	0	0	
through 27) FACILITY OVERHEAD  29. 00 Facility Costs 30. 00 Administrative Costs 31. 00 Total Facility Overhead (sum of lines 29 and 30)  32. 00 Total facility costs (sum of lines 22, 28 919, 236 408, 747 1, 327, 983 -65, 609 1, 262, 374 32. 00			_	_	_	_	_	
FACILITY OVERHEAD  29.00 Facility Costs  30.00 Administrative Costs  Total Facility Overhead (sum of lines 29 and 30)  32.00 Total facility costs (sum of lines 22, 28 919, 236 408, 747 1, 327, 983 -65, 609 1, 262, 374 32.00	28. 00	,	0	0	0	0	0	28.00
29.00 Facility Costs 0 12,571 12,571 0 12,571 29.00 30.00 Administrative Costs 207,156 237,059 444,215 -77,966 366,249 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) Total facility costs (sum of lines 22, 28 919,236 408,747 1,327,983 -65,609 1,262,374 32.00								ļ
30.00 Administrative Costs 31.00 Total Facility Overhead (sum of lines 29 and 30)  Total facility costs (sum of lines 22, 28)  Total facility costs (sum of lines 22, 28)  207, 156 207	00.00		ام	40 574	40.574		40.574	00.00
31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 919, 236 408, 747 1, 327, 983 -65, 609 1, 262, 374 32.00		1	۳			77.0((	· ·	
30) 32.00 Total facility costs (sum of lines 22, 28 919, 236 408, 747 1, 327, 983 -65, 609 1, 262, 374 32.00								
32.00 Total facility costs (sum of lines 22, 28 919, 236 408, 747 1, 327, 983 -65, 609 1, 262, 374 32.00	31.00		207, 156	249, 630	456, /86	- / / , 966	378,820	31.00
	22 00	1::/	010 224	400 747	1 227 002	4E 400	1 242 274	22 00
failu 31)	32.00		919, 236	408, 747	1, 327, 983	-65, 609	1, 262, 3/4	32.00
		Tallu 31)	l	l				ı

Health Financial Systems	SAINT JAMES HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Peri od: Worksheet M-1 From 10/01/2022
	Component CCN: 14-8639	

			Component	CCN. 14-0037	10 077 307 2023	2/21/2024 2:01 pm
					RHC X	Cost
		Adjustments	Net Expenses			
			for Allocation			
			(col. 5 + col.			
			6)			
		6.00	7. 00			
	FACILITY HEALTH CARE STAFF COSTS					
1.00	Physi ci an	-5, 009	464, 890			1.00
2.00	Physician Assistant	-892	55, 127			2. 00
3.00	Nurse Practitioner	-179	70, 727			3.00
4.00	Visiting Nurse	0	0			4. 00
5.00	Other Nurse	0	0			5. 00
6.00	Clinical Psychologist	0	0			6. 00
7. 00	Clinical Social Worker	0	0			7. 00
8.00	Laboratory Techni ci an	0	0	1		8. 00
9.00	Other Facility Health Care Staff Costs	-1, 751	125, 862			9. 00
10. 00	Subtotal (sum of lines 1 through 9)	-7, 831	716, 606	1		10. 00
11. 00	Physician Services Under Agreement	0	0			11. 00
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	94, 069			15. 00
16. 00	Transportation (Health Care Staff)	0	3, 223			16. 00
17. 00	Depreciation-Medical Equipment	0	0	1		17. 00
18. 00	Professional Liability Insurance	0	2, 506	1		18. 00
19. 00	Other Health Care Costs	0	59, 319			19. 00
20. 00	Allowable GME Costs					20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	159, 117			21. 00
22. 00	Total Cost of Health Care Services (sum of	-7, 831	875, 723			22. 00
	lines 10, 14, and 21)					
22.00	COSTS OTHER THAN RHC/FQHC SERVICES	ما	0	I		22.00
23. 00	Pharmacy	0	0	•		23. 00
24. 00	Dental	0	0	•		24. 00 25. 00
25. 00 25. 01	Optometry	7, 831	7, 831	1		25. 00
25. 01	Tel eheal th	7,831	7, 831	1		25. 01
26. 00	Chronic Care Management All other nonreimbursable costs	0	0			26. 00
27. 00	Nonallowable GME costs	U	U			27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	7, 831	7, 831			28. 00
20.00	through 27)	7,031	7,031			28.00
	FACILITY OVERHEAD					
29. 00		n	12, 571	1		29. 00
30. 00	Administrative Costs	0	366, 249			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	378, 820			31.00
31.00	30)	٥	370,020			31.00
32. 00	Total facility costs (sum of lines 22, 28	0	1, 262, 374			32.00
32. 30	and 31)	٩	., 202, 071			32. 00
	'					1

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SAINT JAMES ERVICES	Provi der Co		Peri od:	u of Form CMS-2 Worksheet M-2	
			Component		From 10/01/2022 To 09/30/2023	Date/Time Prep 2/21/2024 2:0	
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1. 00	2. 00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	1. 85	6, 614	4, 20	0 7, 770		1. 00
2.00	Physician Assistant	0. 03	86	2, 10	0 63		2. 00
3.00	Nurse Practitioner	7. 22	21, 284	2, 10	0 15, 162		3. 00
4.00	Subtotal (sum of lines 1 through 3)	9. 10	27, 984		22, 995	27, 984	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	0. 00	0			0	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
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	9. 10	27, 984			27, 984	8. 00
	through 7)		_			_	
9. 00	Physician Services Under Agreements		0			0	9. 00
	DETERMINATION OF ALLOWARD F COOT ARRIVOARD F TO					1. 00	
40.00	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			VICES		0.007.474	10.00
	Total costs of health care services (from Wks					3, 386, 461	
	Total nonreimbursable costs (from Wkst. M-1,					24, 865	
12.00	Cost of all services (excluding overhead) (si					3, 411, 326	
13.00	Ratio of hospital-based RHC/FQHC services (I			04)		0. 992711	
14.00	Total hospital-based RHC/FQHC overhead - (fro			ne 31)		1, 345, 167	
15.00	Parent provider overhead allocated to facili	ty (see Instruc	ctions)			2, 879, 358	
16.00	Total overhead (sum of lines 14 and 15)					4, 224, 525	
17. 00	Allowable GME overhead (see instructions)					4 224 525	17.00
	Enter the amount from line 16		10   ! 1	0)		4, 224, 525	
	Overhead applicable to hospital-based RHC/FQI					4, 193, 732	
20.00	Total allowable cost of hospital-based RHC/F	unt services (s	sum of Tines 10	and 19)		7, 580, 193	∠U. UU

	Financial Systems	SAINT JAMES					u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provid	der CC		Peri od:	Worksheet M-2	
			Compor	nent (		From 10/01/2022 To 09/30/2023	Date/Time Pre 2/21/2024 2:0	
						RHC II	Cost	
		Number of FTE	Total Vi	si ts		Minimum Visits		
		Personnel			Standard (1)	(col. 1 x col.		
						3)	4	
	hu ou to take propulative to	1.00	2. 00	)	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY							
4 00	Posi ti ons	4.5	·	- 4	4.00			1 00
1.00	Physi ci an	1. 65		7, 177	4, 20			1.00
2.00	Physician Assistant	0.01		102	2, 10			2.00
3.00	Nurse Practitioner	1. 35		6, 889	2, 10	0 2, 835 9, 786		3.00
4. 00 5. 00	Subtotal (sum of lines 1 through 3)	3. 01 0. 00		4, 168		9, 786		4. 00 5. 00
6. 00	Visiting Nurse Clinical Psychologist	0.00		0			0	6.00
7. 00	Clinical Social Worker	0.00		0			0	7.00
7. 00 7. 01	Medical Nutrition Therapist (FQHC only)	0.00		0			0	7.00
7. 01	Diabetes Self Management Training (FQHC	0.00		0			0	7. 01
7.02	only)	0.00		Ŭ			U	7.02
8. 00	Total FTEs and Visits (sum of lines 4	3. 01	1	4, 168			14, 168	8.00
0.00	through 7)	0.0.	·	.,			,	0.00
9.00	Physician Services Under Agreements	•		o			0	9. 00
		'				-		
							1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	) HOSPITAL-BASE	D RHC/FQH	IC SER	VI CES			
10.00	Total costs of health care services (from Wk:	st. M-1, col. 7	, line 22	2)			1, 633, 450	10. 00
11. 00							11, 216	
12.00	Cost of all services (excluding overhead) (se						1, 644, 666	
13.00	Ratio of hospital-based RHC/FQHC services (I						0. 993180	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			7, li	ne 31)		769, 945	
15. 00	Parent provider overhead allocated to facili	ty (see instruc	ctions)				1, 415, 289	
16. 00	Total overhead (sum of lines 14 and 15)						2, 185, 234	16. 00
17. 00	Allowable GME overhead (see instructions)						0	17. 00
			40 '		0)		2, 185, 234	
	Overhead applicable to hospital-based RHC/FQI						2, 170, 331	
20.00	Total allowable cost of hospital-based RHC/F	unc services (s	sum of IIN	ies 10	and 19)		3, 803, 781	J 20.00

	Financial Systems	SAINT JAMES				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2022 To 09/30/2023	Date/Time Pre	nared:
			Component	CCN. 14-0040	10 09/30/2023	2/21/2024 2:0	
					RHC III	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.		
					3)	4	
	MICLIES AND PROPRIOTIVE TV	1.00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						ļ
1. 00	Posi ti ons Physi ci an	0.00					1. OC
1. 00 2. 00	1 3	0.00	l .		0 0 924		2.00
2. 00 3. 00	Physician Assistant Nurse Practitioner	0. 44			0 924		3.00
4. 00	Subtotal (sum of lines 1 through 3)	0.00			924	1, 307	4.00
5. 00	Visiting Nurse	0.44			724	1, 307	5.00
6. 00	Clinical Psychologist	0.00				0	6.00
7. 00	Clinical Social Worker	0.00	<b>l</b>			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	l e			0	7. 02
	only)						
8.00	Total FTEs and Visits (sum of lines 4	0. 44	1, 307	'		1, 307	8.00
	through 7)						
9.00	Physician Services Under Agreements		C	)		0	9. 00
	DETERMINATION OF ALLOWARD F COOT ARRIVED TO					1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			RVICES		1/0 025	10.00
	Total costs of health care services (from Wk Total nonreimbursable costs (from Wkst. M-1,					169, 035 3, 749	
12.00	Cost of all services (excluding overhead) (s					3, 749 172, 784	
13. 00	Ratio of hospital -based RHC/FQHC services (I					0. 978302	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		119, 356	
15. 00	Parent provider overhead allocated to facili			110 31)		193, 300	
16. 00	Total overhead (sum of lines 14 and 15)	., (300 mistrac	5115)			312, 656	
17. 00	Allowable GME overhead (see instructions)					012,000	17. 00
	Enter the amount from line 16					312, 656	
	Overhead applicable to hospital-based RHC/FQ	HC services (li	ne 13 x line 1	8)		305, 872	
	Total allowable cost of hospital-based RHC/F					474, 907	20 00

ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der Co		Period: From 10/01/2022	Worksheet M-2	
			Component		To 09/30/2023	Date/Time Prep 2/21/2024 2:0	
					RHC IV	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1. 00	Physi ci an	0. 53					1. 00
2.00	Physici an Assistant	0.00					2.00
3.00	Nurse Practitioner	0. 30					3.00
4.00	Subtotal (sum of lines 1 through 3)	0. 83	2, 675		2, 856	2, 856	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	0.00	0			0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0. 00	0			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4 through 7)	0. 83	2, 675			2, 856	8. 00
9. 00	Physician Services Under Agreements		0			0	9. 00
	1J		-	I.	L	-	
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	', line 22)			347, 046	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			1, 247	11. 00
12. 00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			348, 293	12.00
13. 00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			0. 996420	13.00
14. 00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. N	1-1, col. 7, li	ne 31)		311, 023	14.00
15. 00	Parent provider overhead allocated to facili			•		308, 493	15. 00
16. 00	Total overhead (sum of lines 14 and 15)		•			619, 516	16.00
17. 00	Allowable GME overhead (see instructions)					0	17. 00
18. 00	Enter the amount from line 16					619, 516	18.00
19. 00	Overhead applicable to hospital-based RHC/FC	MC services (li	ne 13 x line 1	8)		617, 298	19.00
	Total allowable cost of hospital-based RHC/F					964, 344	1 20 00

	Financial Systems	SAINT JAMES				eu of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2022 To 09/30/2023		narod:
			Component	0010. 14 0045	10 07/30/2023	2/21/2024 2:0	
					RHC V	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.		
					3)	4	
	hu ou to take propuotivu tu	1.00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						1
1 00	Posi ti ons	0.22	1 077	1 20	0 1 207		1 00
1.00	Physician	0. 33			·		1.00
2.00	Physician Assistant Nurse Practitioner	0. 08 0. 54					2. 00 3. 00
4.00		0. 54			1, 134 2, 688		
5.00	Subtotal (sum of lines 1 through 3) Visiting Nurse	0. 95			2, 088	3, 1/5	1
6. 00	Clinical Psychologist	0.00				0	6.00
7. 00	Clinical Social Worker	0.00				0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	l .			0	7. 02
7.02	only)	0.00					7.02
8. 00	Total FTEs and Visits (sum of lines 4	0. 95	3, 175			3, 175	8. 00
	through 7)					·	
9.00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			VI CES			
	Total costs of health care services (from Wk					504, 476	
	Total nonreimbursable costs (from Wkst. M-1,					2, 357	
12.00	Cost of all services (excluding overhead) (s					506, 833	
13. 00	Ratio of hospital -based RHC/FQHC services (I					0. 995350	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		335, 029	
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			594, 944	
16.00	Total overhead (sum of lines 14 and 15)					929, 973	
17.00	Allowable GME overhead (see instructions) Enter the amount from line 16					0 929, 973	
	Overhead applicable to hospital-based RHC/FQ	UC corvices (Li	no 12 v lino 1	0)		929, 973	
	Total allowable cost of hospital-based RHC/Fu					1, 430, 125	
∠∪. ∪∪	Tiotal allowable cost of hospital-based RHC/F	unc services (S	sum of filles to	and 19)		1, 430, 125	J 20.00

	Financial Systems	SAINT JAMES				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der CO		Peri od:	Worksheet M-2	
			Component (		From 10/01/2022 Fo 09/30/2023	Date/Time Pre	nared.
			ooporrorre			2/21/2024 2:0	
					RHC VI	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
		4.00	0.00	2.00	3)	4	
	VICITE AND DECENICATIVITY	1.00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY Positions						1
1. 00	Physi ci an	0. 36	1, 209	4, 200	1, 512		1.00
2. 00	Physician Assistant	0. 30		•			2.00
3.00	Nurse Practitioner	0. 00					3.00
4.00	Subtotal (sum of lines 1 through 3)	0. 42		2, 100	2, 394	2, 647	4.00
5.00	Visiting Nurse	0.70			2, 374	2, 047	
6. 00	Clinical Psychologist	0.00				0	6.00
7. 00	Clinical Social Worker	0.00				0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00				0	7. 02
	only)						
8.00	Total FTEs and Visits (sum of lines 4	0. 78	2, 647			2, 647	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
	DETERMINATION OF ALLOWARIE COOT ARRIVE TO A					1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			VICES		222 222	10.00
	Total costs of health care services (from Wk Total nonreimbursable costs (from Wkst. M-1,					339, 980 3, 498	
12.00	Cost of all services (excluding overhead) (s					3, 498 343, 478	
12.00	Ratio of hospital-based RHC/FQHC services (I					0. 989816	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			no 21)		158, 267	
15. 00	Parent provider overhead allocated to facili			116 31)		296, 478	
16. 00	Total overhead (sum of lines 14 and 15)	ty (See This true	0113)			454, 745	
17. 00	Allowable GME overhead (see instructions)					434, 743	
	Enter the amount from line 16					454, 745	
	Overhead applicable to hospital-based RHC/FC	MC services (li	ne 13 x line 1	8)		450, 114	

2.00   Physician Assistant   0.38   1,120   2,100   798   2.00   3.00   Nurse Practitioner   0.00   0   0   2,100   0   3.00   Nurse Practitioner   0.00   0   0   2,100   0   0   3.00   0   3.00   0   0   0   0   0   0   0   0   0		Financial Systems	SAINT JAMES				eu of Form CMS-:	<u>2552-10</u>
Number of FTE   Total Visits   Productivity   Minimum Visits   Greater of Personnel	ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C				
Number of FTE   Total Visits   Productivity   Ninimum Visits   Greater of col. 2 or col. 3				Component			Date/Time Pre	
Personnel   Standard (1)   (col. 1 x col. 2 or col. 3)   4   4   4   4   4   4   4   4   4						RHC VII	Cost	
VI SITS AND PRODUCTIVITY   Positions			Number of FTE	Total Visits	Producti vi ty			
1.00   2.00   3.00   4.00   5.00			Personnel		Standard (1)			
VISITS AND PRODUCTIVITY								
Positions   Physician   Positions			1.00	2.00	3.00	4. 00	5. 00	
1.00   Physician								
2.00 Physician Assistant								1
3.00 Nurse Practitioner		1 3						1. 00
4. 00 Subtotal (sum of lines 1 through 3)			1				1	2. 00
5.00 Visiting Nurse				•	•		1	3. 00
6.00 Clinical Psychologist 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					5	1, 554	•	1
7.00 Clinical Social Worker			1	•			1	
7. 01 Medical Nutrition Therapist (FOHC only)			1	<b>.</b>			1	
7. 02 Di abetes Self Management Training (FOHC 0.00 0 0 0 0 0 7.00 0 0 0 7.00 0 0 0 7.00 0 0 0			1	<b>.</b>			1	
only)  Total FTEs and Visits (sum of lines 4 0.56 1,786 1,786 1,786 1,786 8.00 1,786 1,786 1,786 1,786 1,786 1,786 1,786 1,786 8.00 1,786			1	<b>.</b>				1
through 7) Physician Services Under Agreements  0 9.00  Physician Services Under Agreements  0 9.00  DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES  10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 436, 469 19.00	7. 02		0.00	(	)		0	7. 02
9.00 Physician Services Under Agreements 0 1.00  DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES  10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 211,514 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 1, 107 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 212,621 12.00 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 0.994794 13.00 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 166,021 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 272,732 15.00 16.00 Total overhead (sum of lines 14 and 15) 438,753 16.00 17.00 Allowable GME overhead (see instructions) 438,753 18.00 18.00 Enter the amount from line 16 438,753 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 436,469 19.00	8. 00		0. 56	1, 786	6		1, 786	8. 00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES  10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22)  11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)  12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11)  13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12)  14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31)  15.00 Parent provider overhead allocated to facility (see instructions)  17.00 Allowable GME overhead (see instructions)  18.00 Enter the amount from line 16  19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18)  10.00 Total verhead (see instructions)  10.00 Total overhead (see instructions)  10.00 Total overhead (see instructions)	9 00						0	9 00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES  10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22)  11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)  12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11)  13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12)  14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31)  15.00 Parent provider overhead allocated to facility (see instructions)  16.00 Total overhead (sum of lines 14 and 15)  17.00 Allowable GME overhead (see instructions)  18.00 Enter the amount from line 16  19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18)  211, 514  211, 514  20.00  211, 514  10.00  212, 621  12.00  212, 621  12.01  213, 514  10.02  14.01  15.02  16.02  17.01  16.03  17.01  18.01  19.01  19.01  19.01	7. 00	Triyareran bervices under Agreements			4			7.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES  10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22)  11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)  12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11)  13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12)  14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31)  15.00 Parent provider overhead allocated to facility (see instructions)  16.00 Total overhead (sum of lines 14 and 15)  17.00 Allowable GME overhead (see instructions)  18.00 Enter the amount from line 16  19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18)  211, 514  211, 514  20.00  211, 514  10.00  212, 621  12.00  212, 621  12.01  213, 514  10.00  214, 601  14.00  214, 601  215, 612  216, 621  217, 612  217, 621  210, 612  210							1 00	
10.00       Total costs of health care services (from Wkst. M-1, col. 7, line 22)       211,514       10.00         11.00       Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)       1,107       11.00         12.00       Cost of all services (excluding overhead) (sum of lines 10 and 11)       212,621       12.00         13.00       Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)       0.994794       13.00         14.00       Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)       166,021       14.00         15.00       Parent provider overhead allocated to facility (see instructions)       272,732       15.00         16.00       Total overhead (sum of lines 14 and 15)       438,753       16.00         17.00       Allowable GME overhead (see instructions)       0       17.00         18.00       Enter the amount from line 16       438,753       18.00         19.00       Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)       436,469       19.00		DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O HOSPITAL-BASE	D RHC/FOHC SEE	RVLCES			
11.00       Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)       1, 107       11.00         12.00       Cost of all services (excluding overhead) (sum of lines 10 and 11)       212,621       12.00         13.00       Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)       0.994794       13.00         14.00       Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)       166,021       14.00         15.00       Parent provider overhead allocated to facility (see instructions)       272,732       15.00         17.00       Allowable GME overhead (see instructions)       438,753       16.00         18.00       Enter the amount from line 16       438,753       18.00         19.00       Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)       436,469       19.00	10.00						211, 514	10.00
12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 12.00 13.00 142.00 15.00 166,021 14.00 166,021 14.00 172.00 173.00 174.00 175.00 177.00 177.00 178.00 Enter the amount from line 16 179.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	11.00						1, 107	11.00
13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 10.094794 13.00 14.00 15.00 166,021 14.00 166,021 14.00 166,021 14.00 166,021 14.00 172,732 15.00 17.00 1	12.00						212, 621	12.00
15.00 Parent provider overhead allocated to facility (see instructions)  16.00 Total overhead (sum of lines 14 and 15)  17.00 Allowable GME overhead (see instructions)  18.00 Enter the amount from line 16  19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)  272, 732 15.00  438, 753 16.00  17.00 438, 753 18.00  438, 753 18.00  436, 469 19.00	13.00						0. 994794	13.00
16.00       Total overhead (sum of lines 14 and 15)       438,753       16.00         17.00       Allowable GME overhead (see instructions)       0       17.00         18.00       Enter the amount from line 16       438,753       18.00         19.00       Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)       436,469       19.00	14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. M	1-1, col. 7, li	ne 31)		166, 021	14. 00
17.00 Allowable GME overhead (see instructions)  18.00 Enter the amount from line 16  19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)  0 17.00 438,753 18.00 438,753 18.00 436,469 19.00	15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)	•		272, 732	15. 00
18.00 Enter the amount from line 16 438,753 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 436,469 19.00	16.00	Total overhead (sum of lines 14 and 15)	-	•			438, 753	16. 00
19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 436,469 19.00	17. 00	Allowable GME overhead (see instructions)					0	17. 00
	18. 00	Enter the amount from line 16					438, 753	18. 00
20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) 647,983 20.00	19.00	Overhead applicable to hospital-based RHC/FQ	HC services (li	ne 13 x line 1	18)		436, 469	19. 00
	20.00	Total allowable cost of hospital-based RHC/F	QHC services (s	sum of lines 10	o and 19)		647, 983	20.00

	Financial Systems	SAINT JAMES				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2022 To 09/30/2023	Date/Time Pre 2/21/2024 2:0	
					RHC VIII	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits		
		Personnel		Standard (1)			
					3)	4	
	I	1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	1. 00					1.00
2.00	Physician Assistant	0. 26		·			2. 00
3.00	Nurse Practitioner	1. 26		·			3. 00
4.00	Subtotal (sum of lines 1 through 3)	2. 52		1	7, 392	-	4. 00
5.00	Visiting Nurse	0.00				0	5. 00
6. 00	Clinical Psychologist	0.00				0	6. 00
7.00	Clinical Social Worker	0.00				0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2. 52	7, 270			7, 392	8. 00
9. 00	Physician Services Under Agreements		0			0	9. 00
7. 00	Triysi ci air Sei vi ces onder Agreements					0	7.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	) HOSPI TAL-BASE	D RHC/FOHC SER	VLCES			
10.00	Total costs of health care services (from Wks					937, 802	10.00
11. 00						2, 900	
12. 00	Cost of all services (excluding overhead) (si					940, 702	12.00
13. 00	Ratio of hospital-based RHC/FQHC services (I					0. 996917	
14.00	Total hospital-based RHC/FQHC overhead - (from	om Worksheet. M	N-1, col. 7, li	ne 31)		513, 315	14.00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)	,		699, 135	15. 00
16.00	Total overhead (sum of lines 14 and 15)	•	ŕ			1, 212, 450	16. 00
17.00	Allowable GME overhead (see instructions)					0	17. 00
18.00	Enter the amount from line 16					1, 212, 450	18. 00
19.00	Overhead applicable to hospital-based RHC/FQ	HC services (li	ne 13 x line 1	8)		1, 208, 712	19. 00
20 00	Total allowable cost of hospital-based RHC/F	OHC services (s	sum of lines 10	and 19)		2, 146, 514	20 00

	Financial Systems	SAINT JAMES				eu of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2022 To 09/30/2023	Date/Time Pre 2/21/2024 2:0	
					RHC IX	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits		
		Personnel		Standard (1)			
					3)	4	
	I	1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	1					
1. 00	Physi ci an	0. 34				1	1. 00
2.00	Physician Assistant	0. 00		_,		l	2. 00
3.00	Nurse Practitioner	0. 80					3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 14			3, 108		
5.00	Visiting Nurse	0.00				0	
6. 00	Clinical Psychologist	0.00				0	6. 00
7.00	Clinical Social Worker	0.00				0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02
8.00	Total FTEs and Visits (sum of lines 4	1. 14	2, 958			3, 108	8. 00
0.00	through 7)		0			0	0.00
9. 00	Physician Services Under Agreements		0			U	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	) HOSPI TAL-BASE	D RHC/FOHC SER	VLCES		1.00	
10.00	Total costs of health care services (from Wks					484, 263	10.00
11. 00						4, 666	
12. 00	Cost of all services (excluding overhead) (si					488, 929	
13.00	Ratio of hospital-based RHC/FQHC services (1)					0. 990457	13. 00
14.00	Total hospital-based RHC/FQHC overhead - (from	om Worksheet. M	/-1, col. 7, li	ne 31)		213, 846	14. 00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)	,		451, 642	15. 00
16.00	Total overhead (sum of lines 14 and 15)	,				665, 488	16. 00
17.00	Allowable GME overhead (see instructions)					0	17. 00
18. 00	Enter the amount from line 16					665, 488	18. 00
19.00	Overhead applicable to hospital-based RHC/FQ	HC services (li	ne 13 x line 1	8)		659, 137	19. 00
20.00	Total allowable cost of hospital-based RHC/F	QHC services (s	sum of lines 10	and 19)		1, 143, 400	20.00

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SAINT JAMES SERVICES	Provider Co		Peri od:	u of Form CMS-2 Worksheet M-2	
			Component (		From 10/01/2022 To 09/30/2023	Date/Time Prep 2/21/2024 2:0	
					RHC X	Cost	
	·	Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2. 00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 94					1. 00
2.00	Physician Assistant	0. 39	1, 456				2. 00
3.00	Nurse Practitioner	0. 53					3.00
4.00	Subtotal (sum of lines 1 through 3)	1. 86	7, 269		5, 880	7, 269	4.00
5.00	Visiting Nurse	0. 00	0			0	5.00
6.00	Clinical Psychologist	0. 00				0	6.00
7.00	Clinical Social Worker	0.00				0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00	l e			0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0. 00	0			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4 through 7)	1. 86	7, 269			7, 269	8. 00
9. 00	Physician Services Under Agreements		0			0	9. 00
	<u> </u>	•			*		
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL-BASE	D RHC/FQHC SER	VI CES			
	Total costs of health care services (from Wk					875, 723	
11.00	Total nonreimbursable costs (from Wkst. M-1,					7, 831	11.00
12.00	Cost of all services (excluding overhead) (s					883, 554	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 991137	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		378, 820	
15. 00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			725, 313	
16. 00	Total overhead (sum of lines 14 and 15)					1, 104, 133	
17. 00						0	17. 00
	Enter the amount from line 16					1, 104, 133	
	Overhead applicable to hospital-based RHC/FC					1, 094, 347	
20 00	Total allowable cost of hospital-based RHC/F	OHC services (s	sum of lines 10	and 19)		1, 970, 070	20.00

	Financial Systems SAINT JAMES HOS	-		u of Form CMS-2	
CALCUL SERVI (	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-0161	Peri od: From 10/01/2022	Worksheet M-3	
JLKVI (	LS	Component CCN: 14-8624	To 09/30/2023	Date/Time Prep 2/21/2024 2:0	
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			11 00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			7, 580, 193	
2.00	Cost of injections/infusions and their administration (from Wk			483, 497	
3. 00 4. 00	Total allowable cost excluding injections/infusions (line 1 mi Total Visits (from Wkst. M-2, column 5, line 8)	nus IIne 2)		7, 096, 696 27, 984	3. 00 4. 00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		27, 704	5. 00
6.00	Total adjusted visits (line 4 plus line 5)			27, 984	6. 00
7.00	Adjusted cost per visit (line 3 divided by line 6)			253. 60	7. 00
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(10/01/2022	(01/01/2023	
			through 12/31/2022)	through 09/30/2023)	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	202.03	209. 71	8. 00
9.00	Rate for Program covered visits (see instructions)	•	202. 03	209. 71	9. 00
10. 00	CALCULATION OF SETTLEMENT  Program covered visits excluding mental health services (from	contractor records)	1, 564	4, 540	10.00
11. 00	Program cost excluding costs for mental health services (line		315, 975	952, 083	
12.00	Program covered visits for mental health services (from contra		0	0	12. 00
13. 00	Program covered cost from mental health services (line 9 x lin		0	0	13. 00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instructions Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	1, 268, 058	15. 00 16. 00
16. 01	Total program charges (see instructions) (from contractor's rec			1, 670, 207	1
16. 02	Total program preventive charges (see instructions)(from provi	•		15, 097	1
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			11, 462	16. 03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 (Titles V and XIX see instructions.)	and 18) times .80)		859, 259	16. 04
16. 05	Total program cost (see instructions)		0	870, 721	16. 05
17. 00	Pri mary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		182, 522	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	s) (from contractor		294, 349	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			870, 721	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		153, 356	1
22. 00	Total reimbursable Program cost (line 20 plus line 21)			1, 024, 077	22. 00
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24. 00 25. 00	Allowable bad debts for dual eligible beneficiaries (see instr OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	uctions)		0	24. 00 25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instructions	)		0	l .
25. 99	Demonstration payment adjustment amount before sequestration			0	25. 99
26. 00	Net reimbursable amount (see instructions)			1, 024, 077	
26. 01	Sequestration adjustment (see instructions)			20, 482	1
26. 02 27. 00	Demonstration payment adjustment amount after sequestration Interim payments			0 719, 243	
28. 00	1			717, 243	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0			284, 352	1
30.00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-II,		0	30. 00

CALCUL	Financial Systems SAINT JAMES HO ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-0161	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (		Component CCN: 14-8654	From 10/01/2022 To 09/30/2023	Date/Time Prep 2/21/2024 2:0	pared:
	·	Title XVIII	RHC I I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	n Wkst. M-2, line 20)		3, 803, 781	1.00
2. 00	Cost of injections/infusions and their administration (from WI			148, 130	
3.00	Total allowable cost excluding injections/infusions (line 1 mi	nus line 2)		3, 655, 651	3.00
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5, l	ine 9)		14, 168 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	THE 7)		14, 168	
7. 00	Adjusted cost per visit (line 3 divided by line 6)			258. 02	7. 00
			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	
3. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	113.00	126. 00	8. 00
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT	·	113. 00	126. 00	9. 00
10. 00	Program covered visits excluding mental health services (from	contractor records)	0	2, 325	10.00
11. 00	Program cost excluding costs for mental health services (line	•	0	292, 950	
12.00	Program covered visits for mental health services (from contra	•	0	0	
13. 00 14. 00	Program covered cost from mental health services (line 9 x line 1 Limit adjustment for mental health services (see instructions)		0	0	13. 00 14. 00
15. 00	Graduate Medical Education Pass Through Cost (see instructions			O	15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	292, 950	16. 00
16. 01	Total program charges (see instructions) (from contractor's red	•		669, 381	ı
16. 02 16. 03	Total program preventive charges (see instructions) (from provi	•		27, 413	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.03			11, 997 198, 802	
	(Titles V and XIX see instructions.)	3 a.u. 10, 11 mes 100,		. 70, 002	10.0.
16. 05	Total program cost (see instructions)		0	210, 799	
17.00	Primary payer amounts	(6		0	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		32, 450	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		121, 904	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			210, 799	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		21, 302	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			232, 101	
23. 00	Allowable bad debts (see instructions)			0	
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	cuctions)		0	
25. 00	· ·	uetrons)		0	
25. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	
25. 99	Demonstration payment adjustment amount before sequestration			0	
26. 00	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			232, 101	
26. 01 26. 02	Demonstration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			4, 642 0	1
27. 00	Interim payments			202, 336	
28. 00	Tentative settlement (for contractor use only)			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0	· · · · · · · · · · · · · · · · · · ·		25, 123	
30. 00	Protested amounts (nonallowable cost report items) in accordanchapter I, §115.2	nce with CMS Pub. 15-II,		0	30.00

	nancial Systems SAINT JAMES HO TON OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	SPITAL Provider CCN: 14-0161	In Lie	u of Form CMS-2 Worksheet M-3	2552-10
SERVI CES	TON OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-DASED KNO/FUNC	Component CCN: 14-8640	From 10/01/2022 To 09/30/2023	Date/Time Pre	nared·
		·		2/21/2024 2: 0 <sup>2</sup>	
		Title XVIII	RHC III	Cost	
				1. 00	
	TERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1	otal Allowable Cost of hospital-based RHC/FQHC Services (from			474, 907	1.00
1	ost of injections/infusions and their administration (from Wo otal allowable cost excluding injections/infusions (line 1 mi			24, 539 450, 368	2. 00 3. 00
	otal Visits (from Wkst. M-2, column 5, line 8)	Thus Title 2)		1, 307	4.00
1	nysicians visits under agreement (from Wkst. M-2, column 5,	ine 9)		0	5. 00
	otal adjusted visits (line 4 plus line 5)	,		1, 307	6. 00
7.00 Ad	djusted cost per visit (line 3 divided by line 6)			344. 58	7. 00
			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 Pe	er visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	113.00	126. 00	8. 00
1	ate for Program covered visits (see instructions)		113.00	126. 00	9. 00
CA	LCULATION OF SETTLEMENT				
1	rogram covered visits excluding mental health services (from	· · · · · · · · · · · · · · · · · · ·	0	164	10.00
1	rogram cost excluding costs for mental health services (line	•	0	20, 664	•
	rogram covered visits for mental health services (from contra rogram covered cost from mental health services (line 9 x lin		0	0	12. 00 13. 00
4	mit adjustment for mental health services (see instructions)	,		0	14.00
4	raduate Medical Education Pass Through Cost (see instructions				15. 00
	otal Program cost (sum of lines 11, 14, and 15, columns 1, 2		o	20, 664	16. 00
1	otal program charges (see instructions)(from contractor's re	•		60, 129	•
1	otal program preventive charges (see instructions) (from provi	•		4, 422	
	otal program preventive costs ((line 16.02/line 16.01) times			1, 520	
	otal Program non-preventive costs ((line 16 minus lines 16.0% Fitles V and XIX see instructions.)	and 16) times .60)		12, 446	10.04
1 7	otal program cost (see instructions)		o	13, 966	16. 05
	imary payer amounts			0	17. 00
	ess: Beneficiary deductible for RHC only (see instructions)	(from contractor		3, 587	18. 00
	ecords)	oo) (from contractor		10 424	19. 00
	eneficiary coinsurance for RHC/FQHC services (see instruction ecords)	is) (Troill Contractor		10, 424	19.00
20.00 Ne	et Medicare cost excluding vaccines (see instructions)			13, 966	20.00
1	rogram cost of vaccines and their administration (from Wkst.	M-4, line 16)		3, 642	•
	otal reimbursable Program cost (line 20 plus line 21)			17, 608	
1	lowable bad debts (see instructions)			0	23. 00 23. 01
	djusted reimbursable bad debts (see instructions) Iowable bad debts for dual eligible beneficiaries (see inst	cuctions)		0	24.00
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	deti ons)		Ö	25. 00
	oneer ACO demonstration payment adjustment (see instructions	s)		0	25. 50
	emonstration payment adjustment amount before sequestration			0	25. 99
4	et reimbursable amount (see instructions)			17, 608	
4	equestration adjustment (see instructions)			352	
	emonstration payment adjustment amount after sequestration naterim payments			0 13, 182	
	entative settlement (for contractor use only)			13, 182	28.00
	alance due component/program (line 26 minus lines 26.01, 26.0	02. 27. and 28)		4, 074	
	rotested amounts (nonallowable cost report items) in accordan			0	30.00
	napter I, §115.2	•			1

DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES  1.00 Total Allowable Cost of hospital-based RHC/FOHC Services (from Wkst. M-2, line 20) 964 2.00 Cost of injections/infusions and their administration (from Wkst. M-4, line 15) 34 3.00 Total allowable cost excluding injections/infusions (line 1 minus line 2) 929 4.00 Total Visits (from Wkst. M-2, column 5, line 8) 2 5.00 Physicians visits under agreement (from Wkst. M-2, column 5, line 9) 6.00 Total adjusted visits (line 4 plus line 5) 2	M-3 Prepa 2: 01 pst  , 344 , 392 , 952 , 856	ared:
Component CCN: 14-8641 To 09/30/2023 Date/Time 2/21/2022  Title XVIII RHC IV Component CCN: 14-8641 To 09/30/2023 Date/Time 2/21/2022  Title XVIII RHC IV Component CCN: 14-8641 To 09/30/2023 Date/Time 2/21/2022  Title XVIII RHC IV Component CCN: 14-8641 To 09/30/2023 Date/Time 2/21/2022  Title XVIII RHC IV Component CCN: 14-8641 To 09/30/2023 Date/Time 2/21/2022  Title XVIII RHC IV Component CCN: 14-8641 To 09/30/2023 Date/Time 2/21/2022  Title XVIII RHC IV Component CCN: 14-8641 To 09/30/2023 Date/Time 2/21/2022  Title XVIII RHC IV Component CCN: 14-8641 To 09/30/2023 Date/Time 2/21/2022  Title XVIII RHC IV Component CCN: 14-8641 To 09/30/2023 Date/Time 2/21/2022  Title XVIII RHC IV Component CCN: 14-8641 To 09/30/2024 Time 2/21/2022  Title XVIII RHC IV Component CCN: 14-8641 To 09/30/2024 Time 2/21/2024  Title XVIII RHC IV Component CCN: 14-8641 To 09/30/2024 Time 2/21/2024  Title XVIII RHC IV Component CCN: 14-8641 To 09/30/2024 Time 2/21/2024  Title XVIII RHC IV Component CCN: 14-8641 To 09/30/2024 Time 2/21/2024  Title XVIII RHC IV Component CCN: 14-8641 Time 2/2/21/2024  Title XVIII RHC IV Component CCN: 14-8641 Time 2/2/21/2024  Title XVIII RHC IV Component CCN: 14-8641 Time 2/2/21/2024  Title XVIII RHC IV Component CCN: 14-8641 Time 2/2/21/2024  Title XVIII RHC IV Component CCN: 14-8641 Time 2/2/21/2024  Title XVIII RHC IV Component CCN: 14-8641 Time 2/2/21/2024  Title XVIII RHC IV Component CCN: 14-8641 Time 2/2/21/2024  Title XVIII RHC IV Component CCN: 14-8641 Time 2/2/21/2024  Title XVIII RHC IV COmponent CCN: 14-8641 Time 2/2/21/2024  Title XVIII RHC IV COMPONENT CCN: 14-8641 Time 2/2/21/2024  Title XVIII RHC IV COMPONENT CCN: 14-8641 Time 2/2/21/2024  Title XVIII RHC IV COMPONENT CCN: 14-8641 Time 2/2/21/2024  Title XVIII RHC IV COMPONENT CCN: 14-8641 Time 2/2/21/2024  Title XVIII RHC IV COMPONENT CCN: 14-8641 Time 2/2/21/2024  Title XVIII RHC IV COMPONENT CCN: 14-8641 Time 2/2/21/2024  Title XVIII RHC IV COMPONENT CCN: 14-8641 Time 2/2/21/2024  Title XVIII RHC IV COMPONENT CCN: 14-8641 Time 2/2/2	2: 01 ost , 344 , 392 , 952 , 856 0 , 856 5. 61 1)	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
Title XVIII RHC IV  DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES  1.00 Total Allowable Cost of hospital-based RHC/FOHC Services (from Wkst. M-2, line 20) 2.00 Cost of injections/infusions and their administration (from Wkst. M-4, line 15) 3.00 Total allowable cost excluding injections/infusions (line 1 minus line 2) 4.00 Total Visits (from Wkst. M-2, column 5, line 8) 5.00 Physicians visits under agreement (from Wkst. M-2, column 5, line 9) 6.00 Total adjusted visits (line 4 plus line 5) 7.00 Adjusted cost per visit (line 3 divided by line 6)  Calculation of Limit (  Rate Period 1 Rate Period 1 (10/01/2022 through through through through control of the contro	, 344 , 392 , 952 , 856 0 0, 856 5. 61 11)	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES  1.00 Total Allowable Cost of hospital-based RHC/FOHC Services (from Wkst. M-2, line 20) 2.00 Cost of injections/infusions and their administration (from Wkst. M-4, line 15) 3.00 Total allowable cost excluding injections/infusions (line 1 minus line 2) 4.00 Total Visits (from Wkst. M-2, column 5, line 8) 5.00 Physicians visits under agreement (from Wkst. M-2, column 5, line 9) 6.00 Total adjusted visits (line 4 plus line 5) 7.00 Adjusted cost per visit (line 3 divided by line 6)  Calculation of Limit (  Rate Period 1 (10/01/2022 through	, 392 , 952 , 856 0 , 856 5. 61 1)	2. 00 3. 00 4. 00 5. 00 6. 00
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES  1.00 Total Allowable Cost of hospital-based RHC/FOHC Services (from Wkst. M-2, line 20) 2.00 Cost of injections/infusions and their administration (from Wkst. M-4, line 15) 3.00 Total allowable cost excluding injections/infusions (line 1 minus line 2) 4.00 Total Visits (from Wkst. M-2, column 5, line 8) 5.00 Physicians visits under agreement (from Wkst. M-2, column 5, line 9) 6.00 Total adjusted visits (line 4 plus line 5) 7.00 Adjusted cost per visit (line 3 divided by line 6)  Calculation of Limit (  Rate Period 1 (10/01/2022 through	, 392 , 952 , 856 0 , 856 5. 61 1)	2. 00 3. 00 4. 00 5. 00 6. 00
Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)  2.00 Cost of injections/infusions and their administration (from Wkst. M-4, line 15)  3.00 Total allowable cost excluding injections/infusions (line 1 minus line 2)  4.00 Total Visits (from Wkst. M-2, column 5, line 8)  5.00 Physicians visits under agreement (from Wkst. M-2, column 5, line 9)  6.00 Total adjusted visits (line 4 plus line 5)  7.00 Adjusted cost per visit (line 3 divided by line 6)  Calculation of Limit (  Rate Period 1  (10/01/2022 through	, 392 , 952 , 856 0 , 856 5. 61 1)	2. 00 3. 00 4. 00 5. 00 6. 00
3.00 Total allowable cost excluding injections/infusions (line 1 minus line 2) 4.00 Total Visits (from Wkst. M-2, column 5, line 8) 5.00 Physicians visits under agreement (from Wkst. M-2, column 5, line 9) 6.00 Total adjusted visits (line 4 plus line 5) 7.00 Adjusted cost per visit (line 3 divided by line 6)  Calculation of Limit (  Rate Period 1 (10/01/2022 through who will be a continuous line 2)  Calculation of Limit (10/01/2022 through who will be a continuous line 2)  929  Calculation of Limit (10/01/2022 through who will be a continuous line 2)  929  Calculation of Limit (10/01/2022 through who will be a continuous line 2)  929  Calculation of Limit (10/01/2022 through who will be a continuous line 2)  10	, 952 , 856 0 , 856 5. 61 1) od 2	3. 00 4. 00 5. 00 6. 00
4.00 Total Visits (from Wkst. M-2, column 5, line 8) 5.00 Physicians visits under agreement (from Wkst. M-2, column 5, line 9) 6.00 Total adjusted visits (line 4 plus line 5) 7.00 Adjusted cost per visit (line 3 divided by line 6)  Calculation of Limit (  Rate Period 1 (10/01/2022 through through through)	, 856 0 , 856 5. 61 1) od 2	4. 00 5. 00 6. 00
5.00 Physicians visits under agreement (from Wkst. M-2, column 5, line 9)  Total adjusted visits (line 4 plus line 5)  7.00 Adjusted cost per visit (line 3 divided by line 6)  Calculation of Limit (  Rate Period 1 (10/01/2022 through through)	0 , 856 5. 61 1) od 2	5. 00 6. 00
6.00 Total adjusted visits (line 4 plus line 5) 7.00 Adjusted cost per visit (line 3 divided by line 6)  Calculation of Limit (  Rate Period 1 (10/01/2022 through through)	, 856 5. 61 1) od 2 )23	6. 00
7.00 Adjusted cost per visit (line 3 divided by line 6)  Calculation of Limit (  Rate Period 1 (10/01/2022 through through)	5. 61 1) od 2 )23	
Rate Period 1 Rate Period (10/01/2022 through	1) od 2 )23	7. 00
(10/01/2022 (01/01/20 through through	)23	
(10/01/2022 (01/01/20 through through	)23	
through through		
1.00 2.00		
8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor) 113.00 12	6. 00	8. 00
	6. 00	9. 00
CALCULATION OF SETTLEMENT  10.00 Program covered visits excluding mental health services (from contractor records)  0	372 1	10. 00
, , , , , , , , , , , , , , , , , , ,		11. 00
12.00 Program covered visits for mental health services (from contractor records)		12. 00
13.00 Program covered cost from mental health services (line 9 x line 12) 0		13. 00
14.00 Limit adjustment for mental health services (see instructions) 0	0 1	14.00
15.00 Graduate Medical Education Pass Through Cost (see instructions)		15.00
		16.00
		16. 01 16. 02
		16. 02
		16. 04
(Titles V and XIX see instructions.)		
, ,		16. 05
17.00 Primary payer amounts		17. 00
18.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)	, 288 1	18. 00
	, 736 1	19. 00
records)		
, , , , , , , , , , , , , , , , , , ,		20.00
· · · · · · · · · · · · · · · · · · ·		21.00
22.00   Total reimbursable Program cost (line 20 plus line 21) 23.00   Allowable bad debts (see instructions)		22. 00 23. 00
23.00 Arrowable bad debts (see instructions)  23.01 Adjusted reimbursable bad debts (see instructions)		23. 00
24.00 Allowable bad debts for dual eligible beneficiaries (see instructions)		24. 00
25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0 2	25. 00
25.50 Pioneer ACO demonstration payment adjustment (see instructions)		25. 50
25.99 Demonstration payment adjustment amount before sequestration		25. 99
, , , , , , , , , , , , , , , , , , ,		26. 00
26.01 Sequestration adjustment (see instructions) 26.02 Demonstration payment adjustment amount after sequestration		26. 01 26. 02
		27. 00
28. 00 Tentative settlement (for contractor use only)		28. 00
29.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)	, 363 2	29. 00
30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,	0 3	30.00
chapter	- 1	

	inancial Systems SAINT JAMES HC TON OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	Provider CCN: 14-0161	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI CES		Component CCN: 14-8643	From 10/01/2022 To 09/30/2023	Date/Time Prep 2/21/2024 2:0	
		Title XVIII	RHC V	Cost	
				1 00	
DE	ETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1. 00	
	otal Allowable Cost of hospital-based RHC/FQHC Services (from	n Wkst. M-2. line 20)		1, 430, 125	1.00
1	ost of injections/infusions and their administration (from W			81, 593	•
	otal allowable cost excluding injections/infusions (line 1 mi	nus line 2)		1, 348, 532	3.00
	otal Visits (from Wkst. M-2, column 5, line 8)	>		3, 175	4.00
	hysicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		0	5.00
1	otal adjusted visits (line 4 plus line 5) djusted cost per visit (line 3 divided by line 6)			3, 175 424. 73	6. 00 7. 00
7.00 A	djusted cost per visit (iiile 3 divided by iiile b)		Cal cul ati on		7.00
			our cur a troir	01 21 1111 (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 Pe	er visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	113.00	126. 00	8. 00
1	ate for Program covered visits (see instructions)	, ,	113. 00	126. 00	•
CA	ALCULATION OF SETTLEMENT				
	rogram covered visits excluding mental health services (from		0	545	
1	rogram cost excluding costs for mental health services (line	*	0	68, 670	
1	rogram covered visits for mental health services (from contra	•	0	0	12. 00 13. 00
	rogram covered cost from mental health services (line 9 x lir imit adjustment for mental health services (see instructions)		0	0	14.00
	raduate Medical Education Pass Through Cost (see instructions		\ \	O	15. 00
	otal Program cost (sum of lines 11, 14, and 15, columns 1, 2		o	68, 670	1
	otal program charges (see instructions)(from contractor's rec			164, 023	16. 01
1	otal program preventive charges (see instructions)(from provi	-		4, 500	ı
	otal program preventive costs ((line 16.02/line 16.01) times			1, 884	
	otal Program non-preventive costs ((line 16 minus lines 16.0% Titles V and XIX see instructions.)	and 18) times .80)		46, 477	16. 04
	otal program cost (see instructions)		o	48, 361	16. 05
1	rimary payer amounts			0	17. 00
	ess: Beneficiary deductible for RHC only (see instructions)	(from contractor		8, 690	18. 00
	ecords)				
	eneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		30, 167	19. 00
1	ecords) et Medicare cost excluding vaccines (see instructions)			48, 361	20.00
	rogram cost of vaccines and their administration (from Wkst.	M-4. Line 16)		13, 494	
4	otal reimbursable Program cost (line 20 plus line 21)	,		61, 855	
23. 00 AI	Howable bad debts (see instructions)			0	23.00
1	djusted reimbursable bad debts (see instructions)			0	23. 01
1	llowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	
1	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
	ioneer ACO demonstration payment adjustment (see instructions emonstration payment adjustment amount before sequestration	5)		0	
	et reimbursable amount (see instructions)			61, 855	
	equestration adjustment (see instructions)			1, 237	
	emonstration payment adjustment amount after sequestration			0	1
1	nterim payments			46, 511	
	entative settlement (for contractor use only)	22 202		0	1
	alance due component/program (line 26 minus lines 26.01, 26.0			14, 107	1
	rotested amounts (nonallowable cost report items) in accordar hapter I, §115.2	ICE WITH CIND PUD. 15-11,		0	30.00

	Financial Systems SAINT JAMES HO ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	Provider CCN: 14-0161	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (		Component CCN: 14-8653	From 10/01/2022 To 09/30/2023	Date/Time Prep 2/21/2024 2:0	pared:
		Title XVIII	RHC VI	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			790, 094	
2. 00	Cost of injections/infusions and their administration (from W			44, 227	2.00
3. 00 4. 00	Total allowable cost excluding injections/infusions (line 1 mi Total Visits (from Wkst. M-2, column 5, line 8)	nus IIne 2)		745, 867 2, 647	3. 00 4. 00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		2, 047	
5. 00	Total adjusted visits (line 4 plus line 5)	,		2, 647	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			281. 78	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	
3. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	113.00	126. 00	
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		113. 00	126. 00	9.00
10. 00	Program covered visits excluding mental health services (from	contractor records)	ol	462	10.00
11. 00	Program cost excluding costs for mental health services (line	•	o	58, 212	
12. 00	Program covered visits for mental health services (from contra	*	0	0	
13.00	Program covered cost from mental health services (line 9 x line)	•	0	0	
14. 00 15. 00	Limit adjustment for mental health services (see instructions) Graduate Medical Education Pass Through Cost (see instructions		٩	U	14. 00 15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		o	58, 212	
16. 01	Total program charges (see instructions)(from contractor's red	•		127, 694	
16. 02	Total program preventive charges (see instructions) (from provi	•		5, 171	
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.03			2, 357 35, 059	
10.01	(Titles V and XIX see instructions.)	s and ref trilles . eef		00,007	10.0
16. 05	Total program cost (see instructions)		O	37, 416	
17.00	Primary payer amounts	(6		0	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		12, 031	18.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		22, 098	19.00
	records)				
20. 00 21. 00	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.	M 4 lino 16)		37, 416	20.00
22. 00	Total reimbursable Program cost (line 20 plus line 21)	W-4, TITIE 10)		47, 132	
23. 00	Allowable bad debts (see instructions)			0	
23. 01	Adjusted reimbursable bad debts (see instructions)			0	
24. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructi ons)		0	
25. 00 25. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	5)		0	l .
25. 99	Demonstration payment adjustment amount before sequestration	-,		0	
26. 00	Net reimbursable amount (see instructions)			47, 132	
26. 01	Sequestration adjustment (see instructions)				26. 01
26. 02 27. 00	Demonstration payment adjustment amount after sequestration Interim payments			0 35, 953	
28. 00	Tentative settlement (for contractor use only)			35, 953	1
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0	02, 27, and 28)		10, 236	
30. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-II,		0	1

	Financial Systems SAINT JAMES HO			u of Form CMS-2	
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-0161	Peri od: From 10/01/2022	Worksheet M-3	
SERVI C	ES	Component CCN: 14-8644	To 09/30/2023	Date/Time Prep 2/21/2024 2:0	
		Title XVIII	RHC VII	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			647, 983	1.00
2. 00 3. 00	Cost of injections/infusions and their administration (from Wk Total allowable cost excluding injections/infusions (line 1 mi			25, 357 622, 626	2. 00 3. 00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)	nus Trne 2)		1, 786	1
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		0	5. 00
6.00	Total adjusted visits (line 4 plus line 5)			1, 786	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	348.61 of limit (1)	7. 00
			Carcaration	or Ermit (1)	
			Rate Period 1		
			(10/01/2022 through	(01/01/2023 through	
			12/31/2022)	09/30/2023)	
			1. 00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	113.00	126.00	
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		113. 00	126. 00	9. 00
10. 00	Program covered visits excluding mental health services (from	contractor records)	0	447	10.00
11. 00	Program cost excluding costs for mental health services (line	9 x line 10)	0	56, 322	11. 00
12.00	Program covered visits for mental health services (from contra	•	0	0	12.00
13. 00 14. 00	Program covered cost from mental health services (line 9 x lir Limit adjustment for mental health services (see instructions)	•	0	0	13. 00 14. 00
15. 00	Graduate Medical Education Pass Through Cost (see instructions)			O .	15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	56, 322	16. 00
16. 01	Total program charges (see instructions)(from contractor's rec	•		127, 671	16. 01
16. 02 16. 03	Total program preventive charges (see instructions)(from provi Total program preventive costs ((line 16.02/line 16.01) times			9, 662 4, 262	16. 02 16. 03
16. 04	Total Program non-preventive costs ((Time 10.02/Time 10.07) times  [Total Program non-preventive costs ((Line 16 minus Lines 16.03)			35, 958	
	(Titles V and XIX see instructions.)	,			
16. 05	Total program cost (see instructions)		0	40, 220	•
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0 7, 113	17. 00 18. 00
10.00	records)	(11 om contractor		7, 113	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		22, 179	19. 00
20.00	Net Medicare cost excluding vaccines (see instructions)			40, 220	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		12, 093	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			52, 313	1
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	23. 00 23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	24. 00
25. 00				0	25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	ı
25. 99 26. 00	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 52, 313	
26. 01	Sequestration adjustment (see instructions)			1, 046	
26. 02	Demonstration payment adjustment amount after sequestration			0	
27. 00	Interim payments			38, 443	
28. 00 29. 00	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 26.0	)2 27 and 28)		0 12, 824	28. 00 29. 00
30. 00	Protested amounts (nonallowable cost report items) in accordan			12, 024	1
	chapter I, §115.2				

CALCULATION OF RETIBELISEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FORC   Provider CCN: 14-0161   Port 10/01/2022   To 09/38/2023   Data/Frise Prepare (19/38/2023   Data/Frise Prepare (	Heal th	Financial Systems SAINT JAMES HOS	SPI TAL	In Lie	u of Form CMS-2	2552-10
Determination   Determinatio			Provider CCN: 14-0161	Peri od:		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FORC SERVICES	SERVI C	ES	Component CCN: 14-8650			
DETERMINATION OF RATE FOR HOSPITAL-BASED RINC/FOIG SERVICES			Title XVIII	RHC VIII	Cost	
DETERMINATION OF RATE FOR HOSPITAL-BASED RINC/FOIG SERVICES					1 00	
Total Allowable Cost of hospital-based RHC/FOHC Services (from Wists. M-2, line 20)   2,146,514   1,200   2,000   2,146,514   1,200   2,000   2,000,555   3,00   7,302   4,00   70tal allowable cost excluding injections/infusions (line 1 minus line 2)   2,060,555   3,00   7,302   4,00   70tal vists (from Wists. M-2, column 5, line 9)   7,302   4,00		DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1.00	
Total all owable cost excluding injections/infusions (line 1 minus line 2)   2,060,555   3,	1.00		Wkst. M-2, line 20)		2, 146, 514	1.00
Total Visits (From Wist. M-2, column 5, line 8)   7,392   4,	2.00	Cost of injections/infusions and their administration (from Wks	st. M-4, line 15)		85, 959	2. 00
Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		,	nus line 2)			•
Total adjusted visits (line 4 plus line 5)						•
Adjusted cost per visit (line 3 divided by line 6)   Calculation of Limit (1)		, ,	ine 9)			5. 00 6. 00
Cal Cul attion of Limit (1)   Rate Period 1   Rate Period 2 (10/01/2022 through 12/31/2022)   O(10/01/2023 through 12/3002)   O(10/01/2022)   O(10/01						
Rate Period   Control   Rate Period   Control   Contro	7.00	That district cost per visit (Time 5 divided by Time 6)		Cal cul ati on		7.00
Ret   Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)   113.00   126.00   2.						
through   1/2/31/2022)   09/30/2033   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   2.00   1.00   2.00   2.00   1.00   2.00   2.00   1.00   2.00						
12/31/2022)   09/30/2023					•	
1.00   2.00						
Rate for Program covered visits (see instructions)   113.00   126.00   8,					· · · · · · · · · · · · · · · · · · ·	
Rate for Program covered visits (see instructions)   113.00   126.00   9.	8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.0	6 or your contractor)			8. 00
10.00   Program covered visits excluding mental health services (from contractor records)   0   1,128   10.	9.00	Rate for Program covered visits (see instructions)		113. 00	126. 00	9. 00
11.00   Program cost excluding costs for mental heal th services (line 9 x line 10)   0   142,128   11.						
12.00   Program covered visits for mental health services (from contractor records)   0   0   12.						•
13.00   Program covered cost from mental health services (line 9 x line 12)   0   0   13.						11. 00 12. 00
14.00		,	-	<u> </u>		13.00
15.00 Graduate Medical Education Pass Through Cost (see instructions) 16.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) * 16.01 Total program charges (see instructions) (from contractor's records) 16.02 Total program preventive costs ((line 16.02/line 16.01) times line 16) 16.03 Total program preventive costs ((line 16.02/line 16.01) times line 16) 16.04 Total Program non-preventive costs ((line 16 in lus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.) 16.05 Total program cost (see instructions) 17.00 Primary payer amounts 18.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records) 19.00 Beneficiary coinsurance for RHC/FOHC services (see instructions) (from contractor records) 19.00 Net Medicare cost excluding vaccines (see instructions) 20.00 Net Medicare cost excluding vaccines (see instructions) 21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 22.00 Total reimbursable Program cost (line 20 plus line 21) 23.00 Allowable bad debts (see instructions) 24.00 Allowable bad debts (see instructions) 25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 26.00 Net reimbursable amount (see instructions) 27.00 Ponstration payment adjustment (see instructions) 28.00 Net reimbursable amount (see instructions) 29.01 Net reimbursable amount (see instructions) 20.02 Demonstration payment adjustment amount after sequestration 29.02 Demonstration payment adjustment amount after sequestration 29.03 Demonstration payment adjustment amount after sequestration 29.04 Demonstration payment adjustment amount after sequestration 29.05 Demonstration payment adjustment amount after sequestration 29.06 Demonstration payment adjustment amount after sequestration 29.07 Demonstration payment adjustment amount after sequestration 20.07 Dem		,	•	_		14. 00
16. 01       Total program charges (see instructions) (from contractor's records)       309, 973       16.         16. 02       Total program preventive charges (see instructions) (from provider's records)       9, 076       16.         16. 03       Total program preventive costs ((line 16.02/line 16.01) times line 16)       4, 162       16.         16. 04       Total program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80)       97, 700       16.         16. 05       Total program cost (see instructions.)       0       101, 862       16.         17. 00       Primary payer amounts       0       101, 862       16.         18. 00       Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)       15, 841       18.         19. 00       Beneficiary coinsurance for RHC/FOHC services (see instructions) (from contractor records)       57, 011       19.         20. 00       Net Medicare cost excluding vaccines (see instructions)       101, 522       20.         21. 00       Program cost of vaccines and their administration (from Wkst. M-4, line 16)       18, 931       21.         22. 00       Total reimbursable Program cost (line 20 plus line 21)       120, 453       22.         23. 01       Adjusted reimbursable shad debts (see instructions)       0       23.         24. 00       Allowabl		, ,				15. 00
Total program preventive charges (see instructions) (from provider's records)  16. 03 Total program preventive costs ((line 16. 02/line 16. 01) times line 16)  17. 04 Total Program non-preventive costs ((line 16 minus lines 16. 03 and 18) times .80)  18. 05 Total program cost (see instructions)  19. 00 Primary payer amounts  19. 00 Beneficiary deductible for RHC only (see instructions) (from contractor records)  19. 00 Net Medicare cost excluding vaccines (see instructions)  20. 00 Net Medicare cost excluding vaccines (see instructions)  21. 00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)  22. 00 Total reimbursable Program cost (line 20 plus line 21)  23. 00 Allowable bad debts (see instructions)  24. 00 Allowable bad debts (see instructions)  25. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  26. 00 Net reimbursable amount (see instructions)  27. 00 Demonstration payment adjustment amount after sequestration  28. 29. 00 Demonstration payment adjustment amount after sequestration  29. 20. 01 Interim payments  20. 20. 02. 1nterim payments  20. 20. 21. 22. 23. 24. 26. 26. 27. 20. 1nterim payments  20. 20. 27. 27. 20. 20. 27. 27. 27. 27. 27. 27. 27. 27. 27. 27	16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	and 3) *	0		
16.03 Total program preventive costs ((line 16.02/line 16.01) times line 16) 16.04 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.) 16.05 Total program cost (see instructions) 17.00 Primary payer amounts 18.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records) 19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records) 19.00 Net Medicare cost excluding vaccines (see instructions) (from contractor records) 10.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 11.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 12.00 Allowable bad debts (see instructions) 10.10 Adjusted reimbursable bad debts (see instructions) 10.10 Allowable bad debts for dual eligible beneficiaries (see instructions) 10.10 Contractor records) 10.10 Contractor records) 10.10 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 11.10 Contractor records) 12.10 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 12.10 Contractor records 12.10 Contractor records 13.10 Allowable bad debts (see instructions) 14.10 Allowable bad debts (see instructions) 15.20 Contractor records 16.00 Contractor records 17.00 Contractor records 18.01 From contractor records 18.01 From contractor records 19.02 Contractor records 19.02 Contractor records 19.02 Contractor records 19.02 Contractor records 10.03 Contractor records 10.03 Contractor records 10.04 Con		, , , , , , , , , , , , , , , , , , , ,	•		· ·	1
Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.) Total program cost (see instructions)  Primary payer amounts  Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)  Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)  Net Medicare cost excluding vaccines (see instructions)  Program cost of vaccines and their administration (from Wkst. M-4, line 16) Total reimbursable Program cost (line 20 plus line 21)  Allowable bad debts (see instructions)  Adjusted reimbursable bad debts (see instructions)  Adjusted reimbursable bad debts (see instructions)  Adjusted reimbursable bad debts (see instructions)  Demonstration payment adjustment amount before sequestration  Net reimbursable amount (see instructions)  Demonstration payment adjustment amount after sequestration  Primary payer amounts  101,862 16.03 101,862 16.03 101,862 16.03 101,862 16.03 101,862 16.03 101,862 16.03 101,862 16.03 101,862 16.03 101,862 16.03 101,862 16.03 101,862 16.03 101,862 16.03 101,862 101 101						
(Titles V and XIX see instructions.)  16.05 Total program cost (see instructions)  17.00 Primary payer amounts  Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)  19.00 Beneficiary coinsurance for RHC/FOHC services (see instructions) (from contractor records)  20.00 Net Medicare cost excluding vaccines (see instructions) (from contractor records)  20.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)  21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)  22.00 Total reimbursable Program cost (line 20 plus line 21)  23.00 Allowable bad debts (see instructions)  24.00 Allowable bad debts (see instructions)  25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  25.50 Pioneer ACO demonstration payment adjustment (see instructions)  26.01 Sequestration adjustment (see instructions)  26.02 Demonstration payment adjustment amount after sequestration  101, 862 16.  101, 862 16.  101, 862 16.  101, 862 16.  102, 841 18.  103, 97, 97, 97, 97, 97, 97, 97, 97, 97, 97						16. 03 16. 04
16. 05 Total program cost (see instructions) 17. 00 Primary payer amounts 18. 00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records) 19. 00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records) 19. 00 Program cost of vaccines (see instructions) 20. 00 Net Medicare cost excluding vaccines (see instructions) 21. 00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 22. 00 Total reimbursable Program cost (line 20 plus line 21) 23. 00 Allowable bad debts (see instructions) 24. 00 Allowable bad debts (see instructions) 25. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 26. 00 Demonstration payment adjustment (see instructions) 26. 00 Net reimbursable amount (see instructions) 26. 01 Sequestration adjustment (see instructions) 27. 00 Interim payments 28. 21 Demonstration payment adjustment amount after sequestration 29. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20	10.04		and roy trines . ooy		77, 700	10.04
Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)  19. 00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)  20. 00 Net Medicare cost excluding vaccines (see instructions)  Program cost of vaccines and their administration (from Wkst. M-4, line 16)  101, 522 20.  100 Program cost of vaccines and their administration (from Wkst. M-4, line 16)  110, 522 20.  110, 523 22.  110, 453 22.  110, 453 20.  110, 453 20.  110, 453 26.	16. 05			0	101, 862	16. 05
records)  Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)  20.00 Net Medicare cost excluding vaccines (see instructions)  21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)  22.00 Total reimbursable Program cost (line 20 plus line 21)  23.00 Allowable bad debts (see instructions)  24.00 Allowable bad debts (see instructions)  25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  26.00 Net reimbursable amount (see instructions)  26.00 Net reimbursable amount (see instructions)  26.01 Sequestration adjustment (see instructions)  26.02 Demonstration payment adjustment amount after sequestration  26.02 Demonstration payment adjustment amount after sequestration  27.00 Interim payments	17. 00				340	17. 00
19. 00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records) 20. 00 Net Medicare cost excluding vaccines (see instructions) 21. 00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 22. 00 Total reimbursable Program cost (line 20 plus line 21) 23. 00 Allowable bad debts (see instructions) 23. 01 Adjusted reimbursable bad debts (see instructions) 24. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 25. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 26. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 26. 00 Net reimbursable amount (see instructions) 27. 00 Demonstration adjustment (see instructions) 28. 00 Demonstration payment adjustment amount after sequestration 29. 00 Demonstration payment adjustment amount after sequestration 20. 00 Interim payments 20. 00 Interim payments 20. 00 Interim payments 20. 00 Net reimbursable amount (see instructions) 20. 00 Demonstration payment adjustment amount after sequestration 20. 20. 20. 20. 20. 20. 20. 20. 20. 20.	18. 00		(from contractor		15, 841	18. 00
records)  20.00 Net Medicare cost excluding vaccines (see instructions)  20.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)  21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)  22.00 Total reimbursable Program cost (line 20 plus line 21)  23.00 Allowable bad debts (see instructions)  23.01 Adjusted reimbursable bad debts (see instructions)  24.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  25.50 Pi oneer ACO demonstration payment adjustment (see instructions)  26.00 Net reimbursable amount (see instructions)  26.01 Sequestration adjustment (see instructions)  26.02 Demonstration payment adjustment amount after sequestration  26.02 Demonstration payment adjustment amount after sequestration  27.00 Interim payments	10 00		c) (from contractor		E7 O11	19. 00
20.00 Net Medicare cost excluding vaccines (see instructions)  21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)  22.00 Total reimbursable Program cost (line 20 plus line 21)  23.00 Allowable bad debts (see instructions)  23.01 Adjusted reimbursable bad debts (see instructions)  24.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  25.50 Pioneer ACO demonstration payment adjustment (see instructions)  26.00 Net reimbursable amount (see instructions)  27.00 Interim payments  20.00 Net reimbursable amount digustment amount after sequestration  20.00 Interim payments  20.01 15, 522 20.  18, 931 21.  101, 522 20.  18, 931 21.  120, 453 22.  120, 453 22.  121, 400 25.  122, 400 26.  123, 400 26.  124, 405 26.  125, 407 26.  126, 407 26.  127, 408 26.	19.00	,	s) (ITOIII COITTIACTOI		57,011	19.00
22. 00 Total reimbursable Program cost (line 20 plus line 21)  23. 00 Allowable bad debts (see instructions)  23. 01 Adjusted reimbursable bad debts (see instructions)  24. 00 Allowable bad debts for dual eligible beneficiaries (see instructions)  25. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  26. 50 Pemonstration payment adjustment (see instructions)  26. 00 Net reimbursable amount (see instructions)  27. 00 Interim payments  120, 453 22.  120, 453 22.  120, 453 26.  120, 453 26.  120, 453 26.  120, 453 26.  120, 453 26.  120, 453 26.  120, 453 26.	20.00				101, 522	20. 00
23. 00 Allowable bad debts (see instructions)  23. 01 Adjusted reimbursable bad debts (see instructions)  24. 00 Allowable bad debts for dual eligible beneficiaries (see instructions)  25. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  25. 50 Pi oneer ACO demonstration payment adjustment (see instructions)  26. 00 Net reimbursable amount (see instructions)  26. 01 Sequestration adjustment (see instructions)  26. 02 Demonstration payment adjustment amount after sequestration  26. 02 Interim payments  0 23.  0 24.  0 25.  0 25.  0 26. 01 Sequestration adjustment (see instructions)  27. 00 Interim payments	21. 00	Program cost of vaccines and their administration (from Wkst.!	M-4, line 16)		18, 931	21. 00
23. 01 Adjusted reimbursable bad debts (see instructions) 0 23. 24. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 24. 25. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 25. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 0 25. 25. 99 Demonstration payment adjustment amount before sequestration 0 25. 00 Net reimbursable amount (see instructions) 120, 453 26. 26. 01 Sequestration adjustment (see instructions) 2 2, 409 26. 02 Demonstration payment adjustment amount after sequestration 0 26. 02 Interim payments 98, 211 27.		, , , ,				1
24. 00 Allowable bad debts for dual eligible beneficiaries (see instructions)  0 24. 25. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  25. 50 Pioneer ACO demonstration payment adjustment (see instructions)  0 25. 26. 00 Net reimbursable amount (see instructions)  26. 01 Sequestration adjustment (see instructions)  27. 00 Interim payments  0 24. 25. 26. 27. 00 Interim payment adjustment amount after sequestration  0 25. 27. 00 Interim payments						23. 00
25. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 25. 50 Pioneer ACO demonstration payment adjustment (see instructions) 25. 99 Demonstration payment adjustment amount before sequestration 26. 00 Net reimbursable amount (see instructions) 26. 01 Sequestration adjustment (see instructions) 26. 02 Demonstration payment adjustment amount after sequestration 27. 00 Interim payments 25. 00 Verification payment adjustment (see instructions) 28. 02 Demonstration payment adjustment amount after sequestration 29. 20. 02 Verification payment adjustment amount after sequestration 29. 20. 20. 20. 20. 20. 20. 20. 20. 20. 20		, , , , , , , , , , , , , , , , , , , ,	ustions)			23. 01 24. 00
25. 50 Pi oneer ACO demonstration payment adjustment (see instructions)  25. 99 Demonstration payment adjustment amount before sequestration  26. 00 Net reimbursable amount (see instructions)  26. 01 Sequestration adjustment (see instructions)  26. 02 Demonstration payment adjustment amount after sequestration  27. 00 Interim payments  0 25. 25. 26. 27. 25. 26. 27. 27. 27. 27. 27. 27. 27. 27. 27. 27		· ·	uctions)			1
25. 99 Demonstration payment adjustment amount before sequestration  0 25. 26. 00 Net reimbursable amount (see instructions)  26. 01 Sequestration adjustment (see instructions)  26. 02 Demonstration payment adjustment amount after sequestration  27. 00 Interim payments  0 25. 26. 02 Demonstration payment adjustment amount after sequestration  0 26. 27. 00 Interim payments		L	)			1 .
26.01 Sequestration adjustment (see instructions) 2, 409 26. 26.02 Demonstration payment adjustment amount after sequestration 0 26. 27.00 Interim payments 98, 211 27.		1				1
26.02 Demonstration payment adjustment amount after sequestration 0 26. 27.00 Interim payments 98,211 27.		, , , , , , , , , , , , , , , , , , , ,				
27. 00 Interim payments 98, 211 27.						
		, , ,				1
28.00   Tentative settlement (for contractor use only) 0   28.						27. 00 28. 00
		,	2, 27, and 28)			1
			· ·			1
chapter I, §115.2		chapter I, §115.2				

Heal th	Financial Systems SAINT JAMES HOS	SPI TAL	In Lie	u of Form CMS-2	2552-10
	<del></del>	Provi der CCN: 14-0161	Peri od:	Worksheet M-3	
SERVI C	ES	Component CCN: 14-8642	From 10/01/2022 To 09/30/2023	Date/Time Prep 2/21/2024 2:0	
		Title XVIII	RHC IX	Cost	
				1 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	Wkst. M-2. line 20)		1, 143, 400	1.00
2.00	Cost of injections/infusions and their administration (from Wks			56, 381	2. 00
3.00	Total allowable cost excluding injections/infusions (line 1 min	nus line 2)		1, 087, 019	•
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	0)		3, 108	1
5. 00 6. 00	Physicians visits under agreement (from Wkst. M-2, column 5, li Total adjusted visits (line 4 plus line 5)	i ne 9)		0 3, 108	5. 00 6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			349. 75	
	<u>, , , , , , , , , , , , , , , , , , , </u>		Cal cul ati on		
			Rate Period 1		
			(10/01/2022 through	(01/01/2023 through	
			12/31/2022)	09/30/2023)	
			1. 00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	113.00	126.00	
9. 00	Rate for Program covered visits (see instructions)  CALCULATION OF SETTLEMENT		113. 00	126. 00	9. 00
10.00	Program covered visits excluding mental health services (from o	contractor records)	O	547	10.00
11. 00	Program cost excluding costs for mental health services (line		0	68, 922	1
12.00	Program covered visits for mental health services (from contraction)	ctor records)	0	0	12. 00
13. 00	Program covered cost from mental health services (line 9 x line	e 12)	0	0	13. 00
14. 00 15. 00	Limit adjustment for mental health services (see instructions)	<b>\</b>	0	0	14. 00 15. 00
16. 00	Graduate Medical Education Pass Through Cost (see instructions) Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 a		0	68, 922	1
16. 01	Total program charges (see instructions) (from contractor's reco		Ĭ	169, 254	1
16. 02	Total program preventive charges (see instructions)(from provide			4, 104	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			1, 671	16. 03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03	and 18) times .80)		48, 102	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		o	49, 773	16. 05
17. 00	Pri mary payer amounts			316	1
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		7, 123	18. 00
40.00	records)	> 46		04 (05	40.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructions records)	s) (from contractor		31, 605	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			49, 457	20.00
21. 00	Program cost of vaccines and their administration (from Wkst. !	M-4, line 16)		21, 085	21. 00
22. 00	Total reimbursable Program cost (line 20 plus line 21)			70, 542	1
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		0	23. 01 24. 00
25. 00	,	det1 0113)		0	
25. 50	Pioneer ACO demonstration payment adjustment (see instructions)	)		0	1 .
25. 99	Demonstration payment adjustment amount before sequestration			0	
26. 00	Net reimbursable amount (see instructions)			70, 542	
26. 01 26. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			1, 411 0	26. 01 26. 02
27. 00	Interim payments			48, 226	1
28. 00	1			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.02	· · · · · · · · · · · · · · · · · · ·		20, 905	
30. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-II,		0	30. 00
	chapter I, §115.2		ı	ı	I

	Financial Systems SAINT JAMES HO		In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-0161	Peri od: From 10/01/2022	Worksheet M-3	
SERVI C	ES	Component CCN: 14-8639	To 09/30/2023	Date/Time Prep 2/21/2024 2:0	
		Title XVIII	RHC X	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			1, 970, 070	•
2.00	Cost of injections/infusions and their administration (from Wk			87, 586	2.00
3. 00 4. 00	Total allowable cost excluding injections/infusions (line 1 mi Total Visits (from Wkst. M-2, column 5, line 8)	nus line 2)		1, 882, 484 7, 269	3. 00 4. 00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	,		7, 269	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			258. 97	7. 00
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(10/01/2022	(01/01/2023	
			through 12/31/2022)	through 09/30/2023)	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	113.00	126. 00	8. 00
9. 00	Rate for Program covered visits (see instructions)		113.00	126. 00	9. 00
10. 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from	contractor records)	0	1, 253	10.00
11. 00	Program cost excluding costs for mental health services (line		Ö	157, 878	
12.00	Program covered visits for mental health services (from contra	•	0	0	12. 00
13.00	Program covered cost from mental health services (line 9 x lin	•	0	0	13.00
14. 00 15. 00	Limit adjustment for mental health services (see instructions) Graduate Medical Education Pass Through Cost (see instructions		0	0	14. 00 15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	157, 878	1
16. 01	Total program charges (see instructions)(from contractor's rec	•		359, 626	ı
16. 02	Total program preventive charges (see instructions) (from provi			1, 415	1
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.03			621 108, 798	16. 03 16. 04
	(Titles V and XIX see instructions.)	and 10) trimos 100)		.00, 770	10.0.
16. 05	Total program cost (see instructions)		0	109, 419	•
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		101 21, 259	17. 00 18. 00
10.00	records)	(11 oiii contractor		21, 234	18.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	s) (from contractor		67, 390	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			109, 318	20.00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		21, 136	1
22. 00 23. 00	Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions)			130, 454 0	22. 00 23. 00
23. 00	Adjusted reimbursable bad debts (see instructions)			0	23. 00
24. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	24. 00
25. 00				0	
25. 50 25. 99	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	ı
26. 00	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			130, 454	ı
26. 01	Sequestration adjustment (see instructions)			2, 609	26. 01
26. 02	Demonstration payment adjustment amount after sequestration			0	ı
27. 00 28. 00	Interim payments Tentative settlement (for contractor use only)			105, 646 0	27. 00 28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0	2, 27, and 28)		22, 199	
30. 00	Protested amounts (nonallowable cost report items) in accordan			0	
	chapter I, §115.2				l

Heal th	Financial Systems SAINT JAMES	S HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	CN: 14-0161	Peri od:	Worksheet M-4	
		Component C	CCN: 14-8624	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/21/2024 2:0	
			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 care staff time	2, 771, 218 0. 002646	2, 771, 2° 0. 0081		2, 771, 218 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	7, 333	22, 63	1, 139	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	135, 434	49, 40	0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	142, 767	72, 09		0	5. 00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3, 386, 461	3, 386, 46	3, 386, 461	3, 386, 461	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	4, 193, 732	4, 193, 73			
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 042158			0.000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	176, 799	89, 28		0	
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	319, 566	161, 38		0	
11. 00	Total number of injections/infusions (from your records)	650	2, 00		0	
12. 00	Cost per injection/infusion (line 10/line 11)	491. 64	80. 4			12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	190	7:	31 45	0	
	administered to MA enrollees			0	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)	93, 412	58, 80	09 1, 135	0	14. 00
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI ON	
1E 00	Total cost of injections/infusions and their administration	a costs (sum of	columns 1	1. 00	2. 00 483, 497	15. 00
	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)				
16.00	Total Program cost of injections/infusions and their admini	stration costs	(sum of		153, 356	16.00

	Financial Systems SAINT JAMES ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	CN: 14-0161	Peri od:	w of Form CMS-2 Worksheet M-4	
		Component C	CCN: 14-8654	From 10/01/2022 To 09/30/2023	Date/Time Prep 2/21/2024 2:0	
			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	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 447, 780 0. 001264	1, 447, 78 0. 00264		1, 447, 780 0. 000000	
. 00	Injection/infusion health care staff cost (line 1 x line 2)	1, 830	3, 82	25 0	0	3. 0
. 00	Injections/infusions and related medical supplies costs (from your records)	46, 464	11, 49	92 0	0	4. 0
5. 00 5. 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)	48, 294 1, 633, 450	15, 31 1, 633, 45		0 1, 633, 450	5. 0 6. 0
. 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)	2, 170, 331 0. 029566	2, 170, 33 0. 00937		2, 170, 331 0. 000000	7. 0 8. 0
. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	64, 168 112, 462	20, 35 35, 66		0	9. 0 10. 0
1. 00 2. 00 3. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program beneficiaries	223 504. 31 26	46 76. 5 10	0.00	0 0. 00 0	12. 0
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			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)	13, 112	8, 19	90 0	0	14.0
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				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,		148, 130	15. C
6.00 Total Program cost of injections/infusions and their administration costs (sum of					21, 302	16 (

	Financial Systems SAINT JAMES ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provi der CO	CN: 14-0161	Peri od:	eu of Form CMS-2 Worksheet M-4	
			CCN: 14-8640	From 10/01/2022 To 09/30/2023		pared:
		Title	XVIII	RHC III	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 care staff time	130, 042 0. 000907	130, 0 0. 0034			1. 00 2. 00
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	118	4	50 0	0	3.00
1. 00	Injections/infusions and related medical supplies costs (from your records)	5, 626	·		0	4.00
5. 00 5. 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)	5, 744 169, 035			0 169, 035	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)	305, 872 0. 033981				7. 00 8. 00
0. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	10, 394 16, 138			0	9. 00 10. 00
1. 00 2. 00 3. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	27 597. 70 2	81.	03 0 56 0.00 30 0		12.00
3. 01	beneficiaries Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 0 <sup>-</sup>
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1, 195	2, 4	47 O	0	14. 00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				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.		24, 539	15. 00		
6.00						16.0

	Financial Systems SAINT JAMES ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	S HOSPITAL Provider CO	N. 14 01/1	Period:	u of Form CMS-2	
COMPUI	ATTON OF HOSPITAL-RASED KHC/FORC VACCINE COST	Provider CC	N: 14-0161	From 10/01/2022	Worksheet M-4	
		Component C		To 09/30/2023	Date/Time Prep 2/21/2024 2:0	
		Title		RHC IV	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 care staff time	294, 824 0. 001401	294, 82 0. 00172		294, 824 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	413	50	0 8	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	10, 001	1, 45		0	4.00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	10, 414	1, 96		0	5.00
5. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	347, 046	347, 04	347, 046	347, 046	6.00
7. 00 8. 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)	617, 298 0. 030008	617, 29 0. 00569		617, 298 0. 000000	
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration	18, 524 28, 938	3, 49 5, 45		0	1
11. 00 12. 00 13. 00	costs (sum of lines 5 and 9) Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program beneficiaries	48 602. 88 6	92. 4	59 0 14 0.00 13 0	0 0. 00 0	12.00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 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)	3, 617	1, 20	02 0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				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.		col umns 1,		34, 392	15. 00
16. 00	Total Program cost of injections/infusions and their admini		4 810	16.00		

	Financial Systems SAINT JAMES ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co	CN: 14-0161	Peri od:	worksheet M-4	
		·	CCN: 14-8643	From 10/01/2022 To 09/30/2023	Date/Time Prep 2/21/2024 2:0	
			XVIII	RHC V	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	Health care staff cost (from Wkst. M-1, col. 7, line 10)	382, 861			382, 861	1. 00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 001917			0.000000	2.00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	734	1, 14	45 O	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	22, 711			0	4.00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	23, 445		37 0	0	5. 0
5. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	504, 476	504, 47	76 504, 476	504, 476	6. 00
7. 00	Total overhead (from Wkst. M-2, line 19)	925, 649	925, 64	19 925, 649	925, 649	7.00
3. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 046474	0. 0105	0. 000000	0.000000	8. 00
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	43, 019			0	9. 00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	66, 464	15, 12	29 0	0	10. 00
11.00	Total number of injections/infusions (from your records)	109	17	70 21	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	609. 76	88. 9	0.00	0.00	
13. 00	Number of injection/infusion administered to Program beneficiaries	16	4	12 4	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 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)	9, 756	3, 73	0	0	14. 0
					COST OF INJECTIONS /	
					INFUSIONS AND ADMINISTRATION	
				1. 00	2.00	

81, 593 15. 00

15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)

16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

Title XVIII   RHC VI   RHC V		u of Form CMS-2 Worksheet M-4	eri od:	Pe	:N: 14-0161	Provider C	Financial Systems SAINT JAME TATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST		
Title XVIII   RHC VI   PNEUMOCOCCAL   INFLUENZA   COVID-19   MONOCOL   ANTIBE   VACCINES   VACCINES   VACCINES   ANTIBE   VACCINES   VACCINES   VACCINES   VACCINES   ANTIBE   VACCINES   VACCINES   VACCINES   VACCINES   VACCINES   ANTIBE   VACCINES   VACCIN		Date/Time Pre	om 10/01/2022	Fr			ATTOM OF HOSPITAL BROLD KNOT VIOLENE GOOT		
PNEUMOCOCCAL   INFLUENZA   COVID-19   MONOCLE   ANTIBE		2/21/2024 2:0	0 77 307 2023	10	CON. 14-0033	Component			
VACCINES   VACCINES   VACCINES   ANTI BE PRODUCE		Cost		Ц,					
1.00	'	MONOCLONAL ANTI BODY PRODUCTS							
Ratio of injection/infusion staff time to total health   0.001448   0.005219   0.000000   0.000000   0.0000000   0.00000000		2. 02							
2,   1   1,000   1,0		268, 732 0. 000000		-			Ratio of injection/infusion staff time to total health		
(from your records) Direct cost of injections/infusions (line 3 plus line 4) 5.00 Total direct cost of the hospital-based RHC/FQHC (from 339, 980 349, 980, 980, 980, 980, 980, 980, 980, 98	0	0	0	403	1, 4	389			
Total direct cost of the hospital-based RHC/FOHC (from Worksheet M-1, col. 7, line 22)   Worksheet M-1, col. 7, line 22)   Total overhead (from Wkst. M-2, line 19)   450,114	0		0				(from your records)		
Total overhead (from Wkst. M-2, line 19)  Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)  Overhead cost - injection/infusion (line 7 x line 8)  Total injection/infusion costs and their administration costs (sum of lines 5 and 9)  Total number of injections/infusions (from your records)  Cost per injection/infusion (line 10/line 11)  Number of injection/infusion administered to Program beneficiaries  Number of COVID-19 vaccine injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)  Cost Total cost of injections/infusions and their administration costs (sum of columns 1,	980	-	0 339, 980				Total direct cost of the hospital-based RHC/FQHC (from		
Overhead cost - injection/infusion (line 7 x line 8)  Total injection/infusion costs and their administration costs (sum of lines 5 and 9)  Total number of injections/infusions (from your records)  Cost per injection/infusion (line 10/line 11)  Number of injections/infusion administered to Program beneficiaries  Number of COVID-19 vaccine injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)  Cost per injections/infusion administered to Program 12 51 0 obtained to MA enrollees  14.00 Program cost of injections/infusions and their 3 and 13.01, as applicable)  Cost per injections/infusions (line 10/line 11) 499.81 72.91 0.00  Double of COVID-19 vaccine injections/infusions and their 5, 998 3, 718 0 obtained to MA enrollees  Cost Injections/infusions and their administration costs (sum of columns 1, 1.00 2.00							Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct		
1.00 Total number of injections/infusions (from your records) 2.00 Cost per injection/infusion (line 10/line 11) 3.00 Number of injection/infusion administered to Program beneficiaries 3.01 Number of COVID-19 vaccine injections/infusions administered to MA enrollees 4.00 Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)  COST INJECTIC INFUSION ADMINISTED 1.00 2.00  5.00 Total cost of injections/infusions and their administration costs (sum of columns 1,	0 0 1	-	۳				Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration		
3.01 Number of COVID-19 vaccine injections/infusions administered to MA enrollees 4.00 Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)  COST INJECTION ADMINISTRET TO SET OF TOTAL COST OF	0 1 0 00 1 0 1	0. 00	٧,	91	72.	499. 81	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program		
administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)  COST INJECTION INFUSION ADMINISTRATION 2.00  Total cost of injections/infusions and their administration costs (sum of columns 1,	0 1		0	718	3 7	5 998	Number of COVID-19 vaccine injections/infusions administered to MA enrollees		
INJECTION INFUSION ADMINISTRE 1.00 2.00 5.00 Total cost of injections/infusions and their administration costs (sum of columns 1,			J	, 10	3, 7	5,776	administration costs (line 12 times the sum of lines 13		
1.00 2.00 Total cost of injections/infusions and their administration costs (sum of columns 1,	AND	COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION							
		2. 00							
	227 1	44, 227							
2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) 6.00 Total Program cost of injections/infusions and their administration costs (sum of	716 1	9, 716			(sum of				

	Financial Systems SAINT JAMES TATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provi der CO	CN: 14-0161	Period:	eu of Form CMS-2 Worksheet M-4	1002 10
			CCN: 14-8644	From 10/01/2022 To 09/30/2023		
		Title	XVIII	RHC VII	Cost	т рііі
		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	182, 277 0. 000700	182, 2 0. 0030			1. 00 2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	128	5	59 0	0	3. 00
1. 00	Injections/infusions and related medical supplies costs (from your records)	5, 001	2, 5		0	4. 00
5. 00 5. 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)	5, 129 211, 514			0 211, 514	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)	436, 469 0. 024249				7. 00 8. 00
0. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	10, 584 15, 713			ı	9. 00 10. 00
1. 00 2. 00 3. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	24 654. 71 13	91.	05 0 85 0.00 39 0	ı	11. 00 12. 00 13. 00
3. 01	beneficiaries Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 0 <sup>-</sup>
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	8, 511	3, 5	82 0	0	14. 00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				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.		col umns 1,		25, 357	15. 00
6. 00	5.00 Total Program cost of injections/infusions and their administration costs (sum of					16.00

	Financial Systems SAINT JAMES ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider Co	CN: 14-0161	Peri od:	wof Form CMS-2 Worksheet M-4	
		Component (	CCN: 14-8650	From 10/01/2022 To 09/30/2023	Date/Time Prep 2/21/2024 2:0	
			XVIII	RHC VIII	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	Health care staff cost (from Wkst. M-1, col. 7, line 10)	799, 536				1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 001188			0. 000000	2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	950	3, 02	29 0	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	24, 378	9, 19	98 0	0	4.00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	25, 328	12, 22	27 0	0	5.00
5. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	937, 802	937, 80	937, 802	937, 802	6. 00
7. 00	Total overhead (from Wkst. M-2, line 19)	1, 208, 712	1, 208, 7			7.00
3. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 027008	0. 01303	0. 000000	0.000000	8. 00
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	32, 645			0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	57, 973			0	10.00
11. 00	Total number of injections/infusions (from your records)	117			0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	495. 50	l .			
13. 00	Number of injection/infusion administered to Program beneficiaries	27	7	74 0	0	13.00
13. 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)	13, 379	5, 55	52 0	0	14. 00
		•			COST OF INJECTIONS /	
					INFUSIONS AND	
				1. 00	ADMI NI STRATI ON 2. 00	
				1.00	2.00	

85, 959 15. 00

15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)

16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

	Financial Systems SAINT JAMES		N 44 04/4		eu of Form CMS-2	
COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CO	JN: 14-0161	Peri od: From 10/01/2022	Worksheet M-4	
		,	CCN: 14-8642	To 09/30/2023	Date/Time Pre 2/21/2024 2:0	
			XVIII	RHC I X	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	Health care staff cost (from Wkst. M-1, col. 7, line 10)	387, 122				
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 001535	0. 0024	0. 000000	0.000000	2.00
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	594	9!	57 0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	18, 752	3, 5	76 0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	19, 346	4, 53	33 0	0	
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	484, 263	484, 20	484, 263	484, 263	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	659, 137	659, 13	37 659, 137	659, 137	7. 00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 039949	0. 00936	0. 000000	0.000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	26, 332			0	
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	45, 678	10, 70	0	0	10. 00
11.00	Total number of injections/infusions (from your records)	90		45 0	0	
12.00	Cost per injection/infusion (line 10/line 11)	507. 53	73.8	0.00	0.00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	35	4	45 O	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	17, 764	3, 32	21 0	0	14. 00
	<u>  απα 13.01, α3 αμμίτοαμίθ</u>				COST OF	
					INJECTIONS /	
					ADMI NI STRATI ON	
				1. 00	2. 00	
4- 00	I T				F ( 001	1 45 22

56, 381 15. 00 21, 085 16. 00

15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)

16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

	Financial Systems SAINT JAMES ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC	CN: 14-0161	Peri od:	w of Form CMS-2 Worksheet M-4	
		Component C	CCN: 14-8639	From 10/01/2022 To 09/30/2023	Date/Time Prep 2/21/2024 2:0	
			XVIII	RHC X	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	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	716, 606 0. 001645	716, 60 0. 00529		716, 606 0. 000000	
. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	1, 179	3, 79	97 0	0	3. 0
. 00	Injections/infusions and related medical supplies costs (from your records)	24, 586	9, 37	71 0	0	4. 0
. 00 . 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)	25, 765 875, 723	13, 16 875, 72		0 875, 723	5. 0 6. 0
. 00 . 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)	1, 094, 347 0. 029421	1, 094, 34 0. 01503		1, 094, 347 0. 000000	7. 0 8. 0
0. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	32, 197 57, 962	16, 45 29, 62		0 0	9. 0 10. 0
1. 00 2. 00 3. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program beneficiaries	118 491. 20 27	38 77. 9 10		0 0. 00 0	12. 0
3. 01 4. 00	Number of COVID-19 vaccine injections/infusions administered to MA enrollees Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13	13, 262	7, 87	0 0	0	13. 0 14. 0
	and 13.01, as applicable)				COST OF I NJECTIONS / I NFUSIONS AND ADMINISTRATION	
F 00	Tatal and of initialization (infliction and their state of the state o	( 6	1	1. 00	2. 00	15.0
	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			87, 586	
6. 00	Total Program cost of injections/infusions and their admin columns 1, 2, 2.01, and 2.02, line 14) (transfer this amounts)				21, 136	16. C

Health Financial Systems	SAINT JAMES	S HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RESERVICES RENDERED TO PROGRAM BENEFICIARIE		Provider CCN: 14-0161 Component CCN: 14-8624	From 10/01/2022	Worksheet M-5 Date/Time Prepared: 2/21/2024 2:01 pm

		Component CCN: 14-8624	10 09/30/2023	2/21/2024 2: 01	
			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
0	Total interim payments paid to hospital-based RHC/FQHC			719, 243	1.
0	Interim payments payable on individual bills, either submitt the contractor for services rendered in the cost reporting p "NONE" or enter a zero	period. If none, write		0	2.
0	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1) Program to Provider				3
1	Program to Provider			0	3
)1 )2				0	3
				0	
13				- 1	3
14				0	3
15				0	3
_	Provider to Program				۔ ا
0				0	3
1				0	3
2				0	3
3				0	3
4				0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9			0	3
0	Total interim payments (sum of lines 1, 2, and 3.99) (transf	fer to Worksheet M-3, line		719, 243	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				
0	List separately each tentative settlement payment after desk each payment. If none, write "NONE" or enter a zero. (1)	c review. Also show date o	f		5
	Program to Provider				
11				0	5
12				0	5
13				0	5
	Provider to Program				
0				0	5
1				0	5
2				0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5
0					6
1	SETTLEMENT TO PROVIDER			284, 352	6
2	SETTLEMENT TO PROGRAM			0	6
0	Total Medicare program liability (see instructions)			1, 003, 595	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	

Health Financial Systems	SAINT JAMES H	OSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC. SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0161 Component CCN: 14-8654	From 10/01/2022	Date/Time Prepared:
		Component Con. 14-8654	10 09/30/2023	2/21/2024 2:01 nm

		Component CCN: 14-8654	To 09/30/2023	3 Date/Time Prep 2/21/2024 2:0	
			RHC I I	Cost	
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
00	Total interim payments paid to hospital-based RHC/FQHC			202, 336	1.0
00	Interim payments payable on individual bills, either submit			0	2.0
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount				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				
01				0	
02				0	3.0
03				0	3. (
04				0	3.
05				0	3. (
	Provider to Program				
50				0	3.
51				0	3.
52				0	3.
53				0	3.
54				0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		202, 336	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
21				0	5.
02				0	5.
03				0	5.
	Provider to Program				
50				0	5.
51				0	5.
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.
00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6.
01	SETTLEMENT TO PROVI DER			25, 123	6.
02	SETTLEMENT TO PROGRAM			0	6.
00	Total Medicare program liability (see instructions)			227, 459	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1 00	0 00	
00	Name of Contractor	U	1. 00	2. 00	8.

Health Financial Systems	SAINT J	AMES HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI		Provi der CCN: 14-0161	Peri od: From 10/01/2022	Worksheet M-5
SERVICES RENDERED TO PROGRAM DENEFTICIARI	£3	Component CCN: 14-8640		Date/Time Prepared: 2/21/2024 2:01 pm

	Component CCN: 14-8640	10 09/30/2023	2/21/2024 2:01	
		RHC III	Cost	
			rt B	
		mm/dd/yyyy	Amount	
		1. 00	2.00	
Total interim payments paid to hospital-based RHC/FQHC			13, 182	1
Interim payments payable on individual bills, either submitte			0	2
the contractor for services rendered in the cost reporting pe	eriod. If none, write			
"NONE" or enter a zero				_
List separately each retroactive lump sum adjustment amount I revision of the interim rate for the cost reporting period.				3
payment. If none, write "NONE" or enter a zero. (1)	ALSO SHOW date of each			
Program to Provider				
I			0	3
			l ol	3
3			l ol	3
1			l ol	3
			0	3
Provider to Program				
			0	3
			0	3
2			0	,
3			0	;
4			0	:
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98			0	3
Total interim payments (sum of lines 1, 2, and 3.99) (transfe 27)	er to worksneet M-3, line		13, 182	4
TO BE COMPLETED BY CONTRACTOR				
List separately each tentative settlement payment after desk	review. Also show date o	f		5
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
			0	5
2			0	5
			0	Ę
Provider to Program			1 0	5
) 				5
				5
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.96	8)			-
Determined net settlement amount (balance due) based on the cost report. (1)				ě
SETTLEMENT TO PROVIDER			4, 074	6
SETTLEMENT TO PROGRAM			0	6
Total Medicare program liability (see instructions)			17, 256	7
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1. 00	2. 00	
Name of Contractor		1	1	8

Health Financial Systems	SAINT JAMES	S HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 14-0161	Peri od: From 10/01/2022	Worksheet M-5
		Component CCN: 14-8641	To 09/30/2023	Date/Time Prepared: 2/21/2024 2:01 pm

	Component Con. 14-8641	10 07/30/2023	2/21/2024 2: 01	
		RHC IV	Cost	
		Par	rt B	
		mm/dd/yyyy	Amount	
		1. 00	2, 00	
O Total interim payments paid to hospital-based RHC/FQHC			31, 541	
O Interim payments payable on individual bills, either submitte	ed or to be submitted to		0.,0	
the contractor for services rendered in the cost reporting pe				
"NONE" or enter a zero	0.1.04. 1.1.1.01.0, 11.1.1.0			
O List separately each retroactive lump sum adjustment amount b	based on subsequent			
revision of the interim rate for the cost reporting period. A				
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider			•	
1			0	1
2			0	
3			o	
4			0	
5				
Provider to Program				
0			0	1
1				
2				
3				
4				
9   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98	0)			
O Total interim payments (sum of lines 1, 2, and 3.99) (transfe			31, 541	
27)	er to worksheet M-3, Title		31, 341	
TO BE COMPLETED BY CONTRACTOR				
Uist separately each tentative settlement payment after desk	review Also show date o	f		1
each payment. If none, write "NONE" or enter a zero. (1)	Townson This show date s			
Program to Provider				
1			0	1
2			o	
3			o	
Provider to Program				1
0			0	1
1			0	
2			0	
9   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98	8)		0	
O Determined net settlement amount (balance due) based on the c				
1 SETTLEMENT TO PROVIDER			5, 363	
2 SETTLEMENT TO PROGRAM			0	
O Total Medicare program liability (see instructions)			36, 904	
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
			2.00	
	0	1. 00	2.00	

Health Financial Systems	SAINT JAMES	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R		Provider CCN: 14-0161	Peri od: From 10/01/2022	Worksheet M-5
SERVICES RENDERED TO PROGRAM BENEFICIARI	E2	Component CCN: 14-8643		Date/Time Prepared: 2/21/2024 2:01 pm

		Component CCN: 14-8643	To 09/30/2023	Date/Time Prep 2/21/2024 2:01	
			RHC V	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
	im payments paid to hospital-based RHC/FQHC			46, 511	1
the contrac	ments payable on individual bills, either su tor for services rendered in the cost report nter a zero			0	2
revision of payment. If	tely each retroactive lump sum adjustment am the interim rate for the cost reporting per none, write "NONE" or enter a zero. (1)				3
Program to	Provi der				_
01				0	3
)2				0	3
13				- 1	3
4   5				0	3
Provider to	Drogram			<u> </u>	3
0	Fi Ogi alli			0	3
1					3
2					3
3					3
4					3
	um of lines 3.01-3.49 minus sum of lines 3.5	0-3 98)			3
,	im payments (sum of lines 1, 2, and 3.99) (t	*		46, 511	4
	ETED BY CONTRACTOR				
	tely each tentative settlement payment after	desk review Also show date of	=		5
	t. If none, write "NONE" or enter a zero. (1				
Program to		,			
1	1011401			0	5
12				o	5
3				o	5
Provi der to	Program				
0	-			0	5
1				0	5
2				0	5
	um of lines 5.01-5.49 minus sum of lines 5.5			0	5
1	net settlement amount (balance due) based on	the cost report. (1)			6
1 SETTLEMENT				14, 107	6
2 SETTLEMENT				0	6
00 Total Medic	are program liability (see instructions)			60, 618	7
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1. 00	2. 00	
	tractor				8

Health Financial Systems	SAINT JAMES HO	SPI TAL		In Lie	eu of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED	RHC/FQHC PROVIDER FOR	Provider CCN:	14-0161	Peri od:	Worksheet M-5
SERVICES RENDERED TO PROGRAM BENEFICIAR	I ES			From 10/01/2022	
		Component CCN:	: 14-8653	To 09/30/2023	Date/Time Prepared:
		•			2/21/2024 2·01 nm

		Component CCN: 14-8653	10 09/30/2023	2/21/2024 2: 01	
			RHC VI	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			35, 953	1. 0
2.00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting   "NONE" or enter a zero			0	2. 0
3. 00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)				3. 0
	Program to Provider				
3. 01				0	3. 0
3.02				0	3. 0
3. 03				0	3. 0
3.04				0	3. 0
3. 05	Duran di dana da Duranyana			0	3. 0
3. 50	Provider to Program			0	3. 5
3. 50 3. 51				0	3. 5
3. 52				o o	3. !
3. 53				0	3. !
3. 54				o	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3.
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans- 27)	fer to Worksheet M-3, line		35, 953	4. (
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after desleach payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date o	f		5. 0
	Program to Provider				
5. 01				0	5.0
5. 02				0	5. (
5. 03				0	5. (
0	Provider to Program				
5. 50 5. 51				0	5. 5 5. 5
5. 51 5. 52				0	5. S
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	08)		0	5. 9
o. 00	Determined net settlement amount (balance due) based on the				6. (
5. 01	SETTLEMENT TO PROVIDER	opo. c. (1)		10, 236	6. (
5. 02	SETTLEMENT TO PROGRAM			0	6. (
7. 00	Total Medicare program liability (see instructions)			46, 189	7. 0
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
8.00	Name of Contractor				8. 0

Health Financial Systems	SAINT JAMES	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0161 Component CCN: 14-8644	From 10/01/2022	Worksheet M-5 Date/Time Prepared: 2/21/2024 2:01 pm

		Component Con. 14-8044	10 077 307 2023		
			RHC VII	Cost	
			Par	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
			mm/dd/yyyy	Amount	
			1, 00	2, 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC	-		38, 443	1. 00
2.00	Interim payments payable on individual bills, either submit	ted or to be submitted to		l ol	2. 00
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero	•			
3.00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.00
	revision of the interim rate for the cost reporting period.				
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01					3. 0
3.02					3. 02
3.03					3. 03
3.04				0	3. 04
3.05				0	3. 05
	Provider to Program				
3.50					3. 50
3. 51					3. 5
3.52					3. 5
3. 53					3. 5
3.54					3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			_	3. 9
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		38, 443	4. 0
	27)				
г оо	TO BE COMPLETED BY CONTRACTOR		e		F 0/
5. 00	List separately each tentative settlement payment after deseach payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date of	I		5. 00
	Program to Provider				
5. 01	Frogram to Frovider				5. 0
5. 02				- 1	5. 0
5. 02					5. 02
5.05	Provider to Program				3.00
5. 50	1 TOVI doi: 10 Trogram			0	5. 50
5. 51				_	5. 5
5. 52					5. 5
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)			5. 9
6. 00	Determined net settlement amount (balance due) based on the			Ĭ	6. 0
6. 01	SETTLEMENT TO PROVIDER	, edg. 1 eps. 1. (1)		12 824	6. 0
6. 02	SETTLEMENT TO PROGRAM				6. 0
7.00	Total Medicare program liability (see instructions)			_	7. 0
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
8. 00	Name of Contractor				8. 0
	•	•			

Health Financial Systems	SAINT JAMES HO	OSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RESERVICES RENDERED TO PROGRAM BENEFICIARIE		Provider CCN: 14-0161	Peri od: From 10/01/2022	Worksheet M-5
		Component CCN: 14-8650	To 09/30/2023	Date/Time Prepared: 2/21/2024 2:01 pm

		Component CCN: 14-8650	10 09/30/2023	2/21/2024 2: 01	
			RHC VIII	Cost	. p
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			98, 211	1. 0
2. 00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero	period. If none, write		0	2. 0
. 00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)  Program to Provider				3. 0
. 01	1 Togram to 11 ovi dei			0	3. 0
. 02				o	3. 0
. 03				o o	3. 0
. 04				ő	3. 0
. 05				0	3. 0
. 00	Provider to Program			0	J. C
. 50	Trovidor to trogram			0	3. 5
51				o	3.
52				0	3.
53				o	3.
54				0	3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3. (
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)	fer to Worksheet M-3, line		98, 211	4. (
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after deseach payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date o	f		5. 0
	Program to Provider				
. 01				0	5. (
. 02				0	5. (
. 03				0	5. (
F0	Provider to Program			0	
50				0	5. !
51				0	5.
52	Cultural (	00)		0	5. 5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	
00	Determined net settlement amount (balance due) based on the	cost report. (1)		10 000	6.
01	SETTLEMENT TO PROVIDER			19, 833	6.
02	SETTLEMENT TO PROGRAM			119 044	6. 7.
. 00	Total Medicare program liability (see instructions)		Contractor	118, 044 NPR Date	7.
			Number	(Mo/Day/Yr)	
			Nullibel	(WO/Day/TI)	
		0	1. 00	2. 00	

Health Financial Systems	SAINT JAMES	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/ SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0161 Component CCN: 14-8642	From 10/01/2022	Worksheet M-5 Date/Time Prepared: 2/21/2024 2:01 pm

		Component Con. 14-8042	10 077 307 2023		
			RHC I X	Cost	
	·		Par	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
			mm/dd/yyyy	Amount	
			1, 00	2, 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC	-		48, 226	1. (
2. 00	Interim payments payable on individual bills, either submit	ted or to be submitted to			2.0
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero	, , , , , , , , , , , , , , , , , , , ,			
. 00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.0
	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				[
. 01				0	3.0
. 02				0	3. (
. 03				0	3. (
04				0	3.
. 05				0	3.
	Provider to Program				
50				0	3.
51				0	3.
52				0	3.
53				0	3.
54				0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		48, 226	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider			1 _	_
01					5.
02					5.
03				0	5.
	Provider to Program				_
50				-	5.
51					5.
52		00)			5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5.
00	Determined net settlement amount (balance due) based on the	e cost report. (I)		00.005	6.
01	SETTLEMENT TO PROVIDER				6.
02	SETTLEMENT TO PROGRAM				6.
00	Total Medicare program liability (see instructions)				7.
			Contractor		
		0	Number		
00	Nome of Contractor	0	1. 00	2. 00	_
. 00	Name of Contractor	l			8.

Health Financial Systems	SAINT JAMES	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RESERVICES RENDERED TO PROGRAM BENEFICIARIE		Provider CCN: 14-0161 Component CCN: 14-8639	From 10/01/2022	Worksheet M-5 Date/Time Prepared: 2/21/2024 2:01 pm

		Component Con. 14-8039	10 07/30/2023		
			RHC X	Cost	
				Part B  mm/dd/yyyy	
			mm/dd/yyyy	Amount	
				2, 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC	-		105, 646	1. 00
2. 00	Interim payments payable on individual bills, either submit	ted or to be submitted to			2. 00
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero	•			
3.00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.00
	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				
3. 01					3. 0
3. 02					3. 02
3. 03					3. 03
3.04				0	3. 04
3.05				0	3. 05
	Provider to Program				
3. 50					3. 50
3. 51					3. 5
3. 52					3. 5
3. 53					3. 5
3.54					3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			_	3. 9
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		105, 646	4. 0
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after des	sk roviou. Also show data o	f		5. 0
3.00	each payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date of	!		5. 0
	Program to Provider				
5. 01	i rogram to rrovider			0	5. 0
5. 02				- 1	5. 0.
5. 03					5. 0
0.00	Provider to Program				0. 0.
5. 50				0	5. 5
5. 51				0	5. 5
5. 52				l ol	5. 5
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5. 9
5. 00	Determined net settlement amount (balance due) based on the				6. 0
5. 01	SETTLEMENT TO PROVIDER			22, 199	6. 0
6. 02	SETTLEMENT TO PROGRAM				6. 0
7. 00	Total Medicare program liability (see instructions)			127, 845	7. 0
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8. 00
		·			