This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0161	Period: From 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/21/2024 2:01 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/21/2024 Time: 2:01 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
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 V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-31,033	-95,868	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/21/2024 2:01 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2500 WEST REYNOLDS STREET	PO Box:			1.00
2.00	City: PONTIAC	State: IL	Zip Code: 61764	County: LIVINGSTON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	SAINT JAMES HOSPITAL	140161	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST JAMES HOSPITAL SWING	14U161	99914		10/10/2002	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	OSF HEALTHCARE- MED GRP- STREATOR	148624	99914		04/05/2021	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	OSF HEALTHCARE- MED GRP- PONTIAC	148654	99914		03/02/2023	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	OSF HEALTHCARE- MED GRP- CULLOM	148640	99914		03/10/2023	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	OSF HEALTHCARE- MED GRP- DWIGHT	148641	99914		03/02/2023	N	O	N	15.03
15.04	Hospital-Based Health Clinic - RHC V	OSF HEALTHCARE- MED GRP- FAIRBURY	148643	99914		03/02/2023	N	O	N	15.04
15.05	Hospital-Based Health Clinic - RHC VI	OSF HEALTHCARE- MED GRP- MINONK	148653	99914		03/02/2023	N	O	N	15.05
15.06	Hospital-Based Health Clinic - RHC VII	OSF HEALTHCARE- MED GRP- FLANAGAN	148644	99914		03/09/2023	N	O	N	15.06
15.07	Hospital-Based Health Clinic - RHC VIII	OSF HEALTHCARE- MED GRP- REYNOLDS	148650	99914		03/02/2023	N	O	N	15.07
15.08	Hospital-Based Health Clinic - RHC IX	OSF HEALTHCARE- MED GRP- EL PASO	148642	99914		03/02/2023	N	O	N	15.08
15.09	Hospital-Based Health Clinic - RHC X	OSF HEALTHCARE- MED GRP- CLINTON	148639	99914		03/02/2023	N	O	N	15.09
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2022	09/30/2023	20.00
21.00	Type of Control (see instructions)	1		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for 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.	Y	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) 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 on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0161	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part I Date/Time Prepared: 2/21/2024 2:01 pm

		1.00	2.00	3.00	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	189	138	0	0	412	17	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	10/01/2022	09/30/2023	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/21/2024 2:01 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	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.			0.00	0.00	61.10
61.20	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.			0.00	0.00	61.20

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/21/2024 2:01 pm

					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.					
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/21/2024 2:01 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

			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 MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?		68.00

		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? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 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)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for 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)			0	76.00

			1.00
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.	N	0	88.00

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		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0	89.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

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				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	295,478	0	430,562	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		Y	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.		Y	N	123.00
	Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00

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		1.00	2.00	
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1728	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS	Contractor's Number: 05901	141.00
142.00	Street: 124 SW ADAMS	PO Box:		142.00
143.00	City: PEORIA	State: IL	Zip Code: 61602	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	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)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

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		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 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 individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 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 reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/21/2023	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	Y	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/14/2023	Y	12/14/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

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		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REBECCA	ROBINSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF HEALTHCARE SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	309-624-7644	REBECCA.C.ROBINSON@OSFHEALTHCARE.ORG	43.00

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		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	STRATEGIC REIMBURSEMENT CONSULTANT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 2/21/2024 2:01 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips 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 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	39	14,235	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		39	14,235	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	3	1,217	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	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	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						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	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC - STREATOR	88.00				0	26.00
26.01	RURAL HEALTH CLINIC - PONTIAC	88.01				0	26.01
26.02	RURAL HEALTH CLINIC - CULLOM	88.02				0	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	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/21/2024 2:01 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	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)	1,531	134	3,168			1.00
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	0	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 beds) (see instructions)	1,637	134	3,394			7.00
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)						12.00
13.00	NURSERY		9	217			13.00
14.00	Total (see instructions)	1,999	189	4,676	0.00	225.09	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						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	HOSPICE						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	1,307	0.00	3.12	26.02
26.03	RURAL HEALTH CLINIC - DWIGHT	372	620	2,675	0.00	5.18	26.03
26.04	RURAL HEALTH CLINIC - FAIRBURY	545	662	3,175	0.00	7.75	26.04
26.05	RURAL HEALTH CLINIC - MINONK	462	608	2,647	0.00	4.29	26.05
26.06	RURAL HEALTH CLINIC - FLANAGAN	447	257	1,786	0.00	4.13	26.06
26.07	RURAL HEALTH CLINIC - REYNOLDS	1,128	1,562	7,270	0.00	13.54	26.07
26.08	RURAL HEALTH CLINIC - EL PASO	547	453	2,958	0.00	7.29	26.08
26.09	RURAL HEALTH CLINIC - CLINTON	1,253	1,975	7,269	0.00	10.06	26.09
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	338.61	27.00
28.00	Observation Bed Days		299	1,589			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	17	21			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
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	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/21/2024 2:01 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid 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)		0	574	40	1,293	1.00
2.00	HMO and other (see instructions)			301	160		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	574	40	1,293	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						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	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC - STREATOR	0.00					26.00
26.01	RURAL HEALTH CLINIC - PONTIAC	0.00					26.01
26.02	RURAL HEALTH CLINIC - CULLOM	0.00					26.02
26.03	RURAL HEALTH CLINIC - DWIGHT	0.00					26.03
26.04	RURAL HEALTH CLINIC - FAIRBURY	0.00					26.04
26.05	RURAL HEALTH CLINIC - MINONK	0.00					26.05
26.06	RURAL HEALTH CLINIC - FLANAGAN	0.00					26.06
26.07	RURAL HEALTH CLINIC - REYNOLDS	0.00					26.07
26.08	RURAL HEALTH CLINIC - EL PASO	0.00					26.08
26.09	RURAL HEALTH CLINIC - CLINTON	0.00					26.09
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
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						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part II | Date/Time Prepared: 2/21/2024 2:01 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	30,802,546	168,449	30,970,995	706,177.00	43.86	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		542,118	0	542,118	4,196.00	129.20	3.00
4.00	Physician-Part A - Administrative		279,023	0	279,023	1,556.00	179.32	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		794,215	0	794,215	3,683.00	215.64	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		11,095,355	-1,666,318	9,429,037	198,079.00	47.60	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		204,443	1,818,101	2,022,544	43,917.00	46.05	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		459,467	0	459,467	4,772.00	96.28	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		15,049	0	15,049	77.00	195.44	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		6,042,072	0	6,042,072	148,287.00	40.75	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,090,574	0	6,090,574			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		624,966	0	624,966			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		85,820	0	85,820			21.00
22.00	Physician Part A - Administrative		33,877	0	33,877			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		80,254	0	80,254			23.00
24.00	Wage-related costs (RHC/FQHC)		2,835,527	0	2,835,527			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		2,490,383	0	2,490,383			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part II Date/Time Prepared: 2/21/2024 2:01 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	315,923	-315,879	44	2.00	22.00	26.00
27.00	Administrative & General	5.00	1,219,327	-44,722	1,174,605	16,295.00	72.08	27.00
28.00	Administrative & General under contract (see inst.)		429,087	0	429,087	2,353.00	182.36	28.00
29.00	Maintenance & Repairs	6.00	255,897	3,438	259,335	9,683.00	26.78	29.00
30.00	Operation of Plant	7.00	420,382	3,850	424,232	14,912.00	28.45	30.00
31.00	Laundry & Linen Service	8.00	30,714	413	31,127	1,622.00	19.19	31.00
32.00	Housekeeping	9.00	672,159	9,031	681,190	34,150.00	19.95	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	514,258	-377,415	136,843	5,844.00	23.42	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	384,324	384,324	17,287.00	22.23	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,031,949	21,850	1,053,799	19,498.00	54.05	38.00
39.00	Central Services and Supply	14.00	111,955	1,504	113,459	5,013.00	22.63	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part III Date/Time Prepared: 2/21/2024 2:01 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		18,799,945	1,834,767	20,634,712	502,572.00	41.06	1.00
2.00	Excluded area salaries (see instructions)		204,443	1,818,101	2,022,544	43,917.00	46.05	2.00
3.00	Subtotal salaries (line 1 minus line 2)		18,595,502	16,666	18,612,168	458,655.00	40.58	3.00
4.00	Subtotal other wages & related costs (see inst.)		6,516,588	0	6,516,588	153,136.00	42.55	4.00
5.00	Subtotal wage-related costs (see inst.)		8,614,834	0	8,614,834	0.00	46.29	5.00
6.00	Total (sum of lines 3 thru 5)		33,726,924	16,666	33,743,590	611,791.00	55.16	6.00
7.00	Total overhead cost (see instructions)		5,001,651	-313,606	4,688,045	126,659.00	37.01	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part IV Date/Time Prepared: 2/21/2024 2:01 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT 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)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	5,495,696	8.02
8.03	Health 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	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,285,471	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	2	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	54,652	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,751,017	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part V Date/Time Prepared: 2/21/2024 2:01 pm

	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	Hospital	459,467	9,751,017	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (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	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	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	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0161 | Component CCN: 14-8624 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			111 SPRING STREET, FL 4		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	STREATOR		IL	61364	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					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 hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	05:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN	
				1.00		2.00	
14.00	RHC/FQHC name, CCN						14.00

		Y/N	V	XVIII	XIX	Total Visits	
		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

			County				
			4.00				
2.00	City, State, ZIP Code, County		LASALLE				2.00

		Tuesday	Wednesday		Thursday		
		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0161
Component CCN: 14-8624

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

Worksheet S-8

Date/Time Prepared:
2/21/2024 2:01 pm

RHC I

Cost

		Friday		Saturday			
		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0161 | Component CCN: 14-8654 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC II | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			2500 W REYNOLDS ST, STE 203,205-207		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	PONTIAC		IL	61764	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					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 hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	05:00	07:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN	
				1.00	2.00	
14.00	RHC/FQHC name, CCN					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		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

			County				
			4.00				
2.00	City, State, ZIP Code, County		LIVINGSTON				2.00
		Tuesday	Wednesday		Thursday		
		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	07:00	05:00	07:00	05:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0161 | Component CCN: 14-8654 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC II | Cost

		Friday		Saturday			
		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0161 | Component CCN: 14-8640 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			105 W HACK ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CULLOM		IL	60929	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					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 hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	05:00	08:00	11.00

	1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0 13.00

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		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

			County				
			4.00				
2.00	City, State, ZIP Code, County		LIVINGSTON				2.00
		Tuesday	Wednesday		Thursday		
		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	08:00	04:30	08:00	04:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0161
Component CCN: 14-8640

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

Worksheet S-8

Date/Time Prepared:
2/21/2024 2:01 pm

RHC III

Cost

		Friday		Saturday			
		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0161 | Component CCN: 14-8641 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			107 WATTERS DR, STE 100		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	DWIGHT		IL	60420	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					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 hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	05:00	07:30	11.00

		1.00	2.00		
12.00	Have you received an approval for an exception to the productivity standard?				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0		13.00

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		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

			County				
			4.00				
2.00	City, State, ZIP Code, County		LIVINGSTON				2.00
		Tuesday	Wednesday		Thursday		
		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	07:45	05:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0161 | Component CCN: 14-8641 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC IV | Cost

		Friday		Saturday			
		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0161 | Component CCN: 14-8643 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC V | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			106 S FIRST ST, STE 100		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FAIRBURY		IL	61739	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					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 hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	05:00	08:00	11.00

		1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0 13.00

				Provider name		CCN	
				1.00		2.00	
14.00	RHC/FQHC name, CCN						14.00

		Y/N	V	XVIII	XIX	Total Visits	
		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

			County				
			4.00				
2.00	City, State, ZIP Code, County		LIVINGSTON				2.00

		Tuesday	Wednesday		Thursday		
		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0161 | Component CCN: 14-8643 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC V | Cost

		Friday		Saturday			
		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0161 | Component CCN: 14-8653 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC VI | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			120 E 7TH ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MINONK		IL	61760	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					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 hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	05:30	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?						12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN	
				1.00		2.00	
14.00	RHC/FQHC name, CCN						14.00

		Y/N	V	XVIII	XIX	Total Visits	
		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

			County				
			4.00				
2.00	City, State, ZIP Code, County		WOODFORD				2.00

		Tuesday	Wednesday		Thursday		
		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0161
Component CCN: 14-8653

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

Worksheet S-8
Date/Time Prepared:
2/21/2024 2:01 pm

RHC VI | Cost

		Friday		Saturday			
		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0161 | Component CCN: 14-8644 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC VII | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			103 W SOUTH ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FLANAGAN		IL	61740	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					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 hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:30	04:30	07:30	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN	
				1.00	2.00	
14.00	RHC/FQHC name, CCN					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		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

			County				
			4.00				
2.00	City, State, ZIP Code, County		LIVINGSTON				2.00
		Tuesday	Wednesday		Thursday		
		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0161
Component CCN: 14-8644

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

Worksheet S-8
Date/Time Prepared:
2/21/2024 2:01 pm

RHC VII

Cost

		Friday		Saturday			
		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0161 | Component CCN: 14-8650 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC VIII | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1506 W REYNOLDS ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	PONTIAC		IL	61764	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					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 hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	05:30	08:00	11.00

	1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0 13.00

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		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

			County				
			4.00				
2.00	City, State, ZIP Code, County		LIVINGSTON				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	05:30	08:00	05:30	08:00	05:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0161
Component CCN: 14-8650

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

Worksheet S-8

Date/Time Prepared:
2/21/2024 2:01 pm

RHC VIII

Cost

		Friday		Saturday			
		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0161 | Component CCN: 14-8642 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC IX | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			100 DELANEY DRIVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	EL PASO		IL	61738	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					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 hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	05:00	08:00	11.00

		1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0 13.00

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		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

			County				
			4.00				
2.00	City, State, ZIP Code, County		WOODFORD				2.00
		Tuesday	Wednesday		Thursday		
		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0161 | Component CCN: 14-8642 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC IX | Cost

		Friday		Saturday			
		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0161 | Component CCN: 14-8639 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC X | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1231 KLEEMANN DR		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CLINTON		IL	61727	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					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 hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	04:00	08:00	11.00

	1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N 0	13.00

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		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

			County				
			4.00				
2.00	City, State, ZIP Code, County		DEWITT				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0161 | Component CCN: 14-8639 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC X | Cost

		Friday		Saturday			
		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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0161	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/21/2024 2:01 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.240862	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,904,854	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	44,468,970	6.00
7.00	Medicaid cost (line 1 times line 6)	10,710,885	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	6,806,031	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	6,806,031	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	2,789,511	613,035	3,402,546	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	671,887	613,035	1,284,922	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	671,887	613,035	1,284,922	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	2,644,746	26.00
27.00	Medicare reimbursable bad debts (see instructions)	115,122	27.00
27.01	Medicare allowable bad debts (see instructions)	177,111	27.01
28.00	Non-Medicare bad debt amount (see instructions)	2,467,635	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	656,349	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,941,271	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,747,302	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0161	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/21/2024 2:01 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.178480	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	2,789,511	613,035	3,402,546	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	497,872	613,035	1,110,907	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	497,872	613,035	1,110,907	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	2,644,746	26.00
27.00	Medicare reimbursable bad debts (see instructions)	115,122	27.00
27.01	Medicare allowable bad debts (see instructions)	177,111	27.01
28.00	Non-Medicare bad debt amount (see instructions)	2,467,635	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	502,412	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,613,319	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,613,319	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,377,738	1,377,738	66,968	1,444,706	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,077,780	1,077,780	39,425	1,117,205	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	315,923	8,817,372	9,133,295	-112,441	9,020,854	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,219,327	13,997,438	15,216,765	-525,859	14,690,906	5.00
6.00	00600	MAINTENANCE & REPAIRS	255,897	1,209,427	1,465,324	-1,011,497	453,827	6.00
7.00	00700	OPERATION OF PLANT	420,382	722,559	1,142,941	423,159	1,566,100	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,714	135,536	166,250	413	166,663	8.00
9.00	00900	HOUSEKEEPING	672,159	117,549	789,708	9,031	798,739	9.00
10.00	01000	DIETARY	514,258	215,945	730,203	-538,799	191,404	10.00
11.00	01100	CAFETERIA	0	0	0	545,708	545,708	11.00
13.00	01300	NURSING ADMINISTRATION	1,031,949	62,414	1,094,363	21,051	1,115,414	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	111,955	196,013	307,968	65,203	373,171	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	342	342	123,896	124,238	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	619,260	619,260	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	542,118	0	542,118	0	542,118	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,753,417	2,602,666	6,356,083	-653,478	5,702,605	30.00
31.00	03100	INTENSIVE CARE UNIT	614,830	47,902	662,732	13,650	676,382	31.00
43.00	04300	NURSERY	0	0	0	251,682	251,682	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,149,719	1,299,016	2,448,735	-720,030	1,728,705	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	428,657	428,657	52.00
53.00	05300	ANESTHESIOLOGY	955,544	257,968	1,213,512	1,127	1,214,639	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	561,394	27,687	589,081	640,791	1,229,872	54.00
54.10	03630	ULTRA SOUND	284,477	13,946	298,423	3,822	302,245	54.10
54.20	03440	MAMMOGRAPHY	112,015	9,781	121,796	1,466	123,262	54.20
56.00	05600	RADIOISOTOPE	459	201,680	202,139	6	202,145	56.00
57.00	05700	CT SCAN	227,559	242,744	470,303	3,057	473,360	57.00
58.00	05800	MRI	211,717	23,833	235,550	2,585	238,135	58.00
60.00	06000	LABORATORY	1,032,581	962,957	1,995,538	135,830	2,131,368	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	138,342	138,342	0	138,342	63.00
64.00	06400	INTRAVENOUS THERAPY	191,866	25,242	217,108	5,452	222,560	64.00
65.00	06500	RESPIRATORY THERAPY	487,099	123,109	610,208	10,281	620,489	65.00
66.00	06600	PHYSICAL THERAPY	932,803	29,077	961,880	8,138	970,018	66.00
67.00	06700	OCCUPATIONAL THERAPY	241,966	4,537	246,503	40,805	287,308	67.00
68.00	06800	SPEECH PATHOLOGY	136,237	713	136,950	22,695	159,645	68.00
69.00	06900	ELECTROCARDIOLOGY	277,165	12,585	289,750	4,734	294,484	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	123,139	101,370	224,509	2,094	226,603	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	-36,964	-36,964	332,085	295,121	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	348,095	348,095	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	573,705	3,139,783	3,713,488	87,487	3,800,975	73.00
76.00	03950	DIABETES SERVICES	125,974	1,957	127,931	1,693	129,624	76.00
76.97	07697	CARDIAC REHABILITATION	96,727	2,283	99,010	446	99,456	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	3,250,560	1,497,266	4,747,826	-200,654	4,547,172	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	2,344,073	714,971	3,059,044	-747,938	2,311,106	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	267,122	133,633	400,755	-108,615	292,140	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	462,172	380,725	842,897	-213,884	629,013	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	659,383	417,206	1,076,589	-268,450	808,139	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	463,636	223,806	687,442	-185,697	501,745	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	347,290	177,931	525,221	-146,579	378,642	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	1,410,605	676,449	2,087,054	-623,476	1,463,578	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	703,171	251,911	955,082	-252,307	702,775	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	1,187,343	525,533	1,712,876	-450,502	1,262,374	88.09
90.00	09000	CLINIC	73,748	9,120	82,868	1,278	84,146	90.00
91.00	09100	EMERGENCY	2,223,925	2,052,707	4,276,632	-65,277	4,211,355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,598,103	44,223,585	74,821,688	-2,563,413	72,258,275	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,395	10,410	29,805	10,317	40,122	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	161,637	253,693	415,330	2,567,460	2,982,790	192.00
192.01	19201	CARDIAC PHASE III	0	0	0	1,189	1,189	192.01
192.02	19202	FUND DEVELOPMENT	23,411	62,899	86,310	-15,553	70,757	192.02
192.03	19203	PULMONARY FUNCTION	0	0	0	0	0	192.03
192.04	19204	RESEARCH	0	0	0	0	0	192.04

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/21/2024 2:01 pm

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified 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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-139,710	1,304,996		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	969,028	2,086,233		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-33,352	8,987,502		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,638,668	10,052,238		5.00
6.00	00600	MAINTENANCE & REPAIRS	-20,392	433,435		6.00
7.00	00700	OPERATION OF PLANT	-302	1,565,798		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	166,663		8.00
9.00	00900	HOUSEKEEPING	0	798,739		9.00
10.00	01000	DIETARY	-346	191,058		10.00
11.00	01100	CAFETERIA	-149,222	396,486		11.00
13.00	01300	NURSING ADMINISTRATION	870,349	1,985,763		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	373,171		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	67,775	192,013		16.00
17.00	01700	SOCIAL SERVICE	21,406	640,666		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-542,118	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,822,277	3,880,328		30.00
31.00	03100	INTENSIVE CARE UNIT	0	676,382		31.00
43.00	04300	NURSERY	0	251,682		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,728,705		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	428,657		52.00
53.00	05300	ANESTHESIOLOGY	-877,298	337,341		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-31,417	1,198,455		54.00
54.10	03630	ULTRA SOUND	0	302,245		54.10
54.20	03440	MAMMOGRAPHY	0	123,262		54.20
56.00	05600	RADIOISOTOPE	0	202,145		56.00
57.00	05700	CT SCAN	0	473,360		57.00
58.00	05800	MRI	0	238,135		58.00
60.00	06000	LABORATORY	-8,773	2,122,595		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	138,342		63.00
64.00	06400	INTRAVENOUS THERAPY	0	222,560		64.00
65.00	06500	RESPIRATORY THERAPY	0	620,489		65.00
66.00	06600	PHYSICAL THERAPY	-59,272	910,746		66.00
67.00	06700	OCCUPATIONAL THERAPY	876	288,184		67.00
68.00	06800	SPEECH PATHOLOGY	486	160,131		68.00
69.00	06900	ELECTROCARDIOLOGY	-2,100	292,384		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	226,603		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	295,121		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	348,095		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,800,975		73.00
76.00	03950	DIABETES SERVICES	0	129,624		76.00
76.97	07697	CARDIAC REHABILITATION	-6,950	92,506		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - STREATOR	209,321	4,756,493		88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	103,505	2,414,611		88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	0	292,140		88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	30,303	659,316		88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	33,723	841,862		88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	0	501,745		88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	0	378,642		88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	-9,561	1,454,017		88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	0	702,775		88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	0	1,262,374		88.09
90.00	09000	CLINIC	0	84,146		90.00
91.00	09100	EMERGENCY	-1,388,343	2,823,012		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,423,329	64,834,946		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40,122		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,982,790		192.00
192.01	19201	CARDIAC PHASE III	0	1,189		192.01
192.02	19202	FUND DEVELOPMENT	0	70,757		192.02
192.03	19203	PULMONARY FUNCTION	0	0		192.03
192.04	19204	RESEARCH	0	0		192.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-7,423,329	67,929,804		200.00

RECLASSIFICATIONS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/21/2024 2:01 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	106,393	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
	0		0	106,393	
	B - CAFETERIA - DIETARY				
1.00	CAFETERIA	11.00	384,324	161,384	1.00
	0		384,324	161,384	
	C - REHAB ADMIN				
1.00	OCCUPATIONAL THERAPY	67.00	25,486	2,142	1.00
2.00	SPEECH PATHOLOGY	68.00	14,160	1,190	2.00
	0		39,646	3,332	
	D - NON-ALLOWABLE CARDIAC PHASE III COST				
1.00	CARDIAC PHASE III	192.01	1,162	27	1.00
	0		1,162	27	
	E - IMPLANT DEVICE				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	348,095	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
	0		0	348,095	
	F - MED SUPPLIES CHARGED TO PATIENTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	429,134	1.00
	0		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	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
	0		0	4,763	
	I - ALTERNATIVE BIRTHING CTR				
1.00	NURSERY	43.00	237,830	13,852	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	405,064	23,593	2.00
	0		642,894	37,445	
	J - HTM SERVICE COST				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	633,400	1.00
2.00	LABORATORY	60.00	0	122,012	2.00
3.00	OPERATION OF PLANT	7.00	0	441,920	3.00
	0		0	1,197,332	
	K - MINISTRY ALLOCATION				
1.00	MAINTENANCE & REPAIRS	6.00	0	182,397	1.00
2.00	SOCIAL SERVICE	17.00	0	619,260	2.00
3.00	PHYSICAL THERAPY	66.00	0	37,672	3.00
4.00	OCCUPATIONAL THERAPY	67.00	0	9,654	4.00
5.00	SPEECH PATHOLOGY	68.00	0	5,364	5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	75,016	6.00
7.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	351,700	7.00
	0		0	1,281,063	
	L - CONTRACT ADMIN FEES				
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	63,699	1.00
	TOTALS		0	63,699	
	M - OSFMG HOSPITALIST AND PALL				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10,098	1.00
2.00	ADULTS & PEDIATRICS	30.00	19,618	0	2.00
	0		19,618	10,098	
	N - STD & OTHER BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	17,778	0	2.00
3.00	MAINTENANCE & REPAIRS	6.00	3,438	0	3.00
4.00	OPERATION OF PLANT	7.00	5,648	1,798	4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	413	0	5.00
6.00	HOUSEKEEPING	9.00	9,031	0	6.00
7.00	DIETARY	10.00	6,909	0	7.00
8.00	NURSING ADMINISTRATION	13.00	21,850	0	8.00
9.00	CENTRAL SERVICE & SUPPLY	14.00	1,504	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	63,553	4,280	10.00
11.00	INTENSIVE CARE UNIT	31.00	13,650	0	11.00
12.00	OPERATING ROOM	50.00	26,654	682	12.00

RECLASSIFICATIONS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/21/2024 2:01 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
13.00	ANESTHESIOLOGY	53.00	20,122	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	7,543	3,896	14.00
15.00	ULTRA SOUND	54.10	3,822	0	15.00
16.00	MAMMOGRAPHY	54.20	1,505	0	16.00
17.00	RADIOISOTOPE	56.00	6	0	17.00
18.00	CT SCAN	57.00	3,057	705	18.00
19.00	MRI	58.00	2,844	0	19.00
20.00	LABORATORY	60.00	13,873	0	20.00
21.00	INTRAVENOUS THERAPY	64.00	5,452	0	21.00
22.00	RESPIRATORY THERAPY	65.00	10,281	0	22.00
23.00	PHYSICAL THERAPY	66.00	13,006	0	23.00
24.00	OCCUPATIONAL THERAPY	67.00	3,251	0	24.00
25.00	SPEECH PATHOLOGY	68.00	1,830	0	25.00
26.00	ELECTROCARDIOLOGY	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	DIABETES SERVICES	76.00	1,693	0	29.00
30.00	CARDIAC REHABILITATION	76.97	1,300	0	30.00
31.00	RURAL HEALTH CLINIC - STREATOR	88.00	43,672	0	31.00
32.00	RURAL HEALTH CLINIC - PONTIAC	88.01	31,493	0	32.00
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 - FLANAGAN	88.06	4,666	0	37.00
38.00	RURAL HEALTH CLINIC - REYNOLDS	88.07	18,952	1,980	38.00
39.00	RURAL HEALTH CLINIC - EL PASO	88.08	9,447	0	39.00
40.00	RURAL HEALTH CLINIC - CLINTON	88.09	15,952	0	40.00
41.00	CLINIC	90.00	1,278	0	41.00
42.00	EMERGENCY	91.00	49,483	0	42.00
43.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	586	0	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		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
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	976,221	
	P - PHYSICIAN EXPENSE				
1.00	ADULTS & PEDIATRICS	30.00	62,500	0	1.00
	0		62,500	0	
	Q - FOUNDATION EXPENSE				
1.00	PHYSICAL THERAPY	66.00	0	911	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0	272	2.00
3.00	SPEECH PATHOLOGY	68.00	0	151	3.00
4.00	CARDIAC REHABILITATION	76.97	0	335	4.00
5.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	10,057	5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4,142	6.00
7.00	FUND DEVELOPMENT	192.02	0	3,795	7.00
	0		0	19,663	
	R - MEDICAL RECORDS & LIBRARY				
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	123,896	1.00
	0		0	123,896	

RECLASSIFICATIONS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/21/2024 2:01 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	T - CABLE TV					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	26,803		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	26,803		
	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		500.00

RECLASSIFICATIONS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/21/2024 2:01 pm

		Decreases					
	Cost Center	Line #	Salary	Other	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	ADMINISTRATIVE & GENERAL	5.00	0	11	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	6,849	0		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	12,297	0		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	21,736	0		5.00
	0		0	106,393			
	B - CAFETERIA - DIETARY						
1.00	DIETARY	10.00	384,324	161,384	0		1.00
	0		384,324	161,384			
	C - REHAB ADMIN						
1.00	PHYSICAL THERAPY	66.00	39,646	3,332	0		1.00
2.00		0.00	0	0	0		2.00
	0		39,646	3,332			
	D - NON-ALLOWABLE CARDIAC PHASE III COST						
1.00	CARDIAC REHABILITATION	76.97	1,162	27	0		1.00
	0		1,162	27			
	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	ELECTROCARDIOLOGY	69.00	0	140	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	407	0		4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	33,350	0		5.00
	0		0	348,095			
	F - MED SUPPLIES CHARGED TO PATIENTS						
1.00	OPERATING ROOM	50.00	0	429,134	0		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	RADIOLOGY-DIAGNOSTIC	54.00	0	152	0		2.00
3.00	MAMMOGRAPHY	54.20	0	39	0		3.00
4.00	MRI	58.00	0	259	0		4.00
5.00	LABORATORY	60.00	0	55	0		5.00
	0		0	4,763			
	I - ALTERNATIVE BIRTHING CTR						
1.00	ADULTS & PEDIATRICS	30.00	642,894	37,445	0		1.00
2.00		0.00	0	0	0		2.00
	0		642,894	37,445			
	J - HTM SERVICE COST						
1.00	MAINTENANCE & REPAIRS	6.00	0	1,197,332	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	1,197,332			
	K - MINISTRY ALLOCATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,281,063	0		1.00
2.00		0.00	0	0	0		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						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	63,699	0		1.00
	TOTALS		0	63,699			
	M - OSFMG HOSPITALIST AND PALL						
1.00	ADULTS & PEDIATRICS	30.00	0	29,716	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	29,716			
	N - STD & OTHER BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	315,880	158,360	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,394	0		2.00
3.00	OPERATION OF PLANT	7.00	1,798	0	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	799	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	4,280	765	0		5.00
6.00	OPERATING ROOM	50.00	682	55	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	3,896	0	0		7.00
8.00	CT SCAN	57.00	705	0	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	473	0		9.00
10.00	RURAL HEALTH CLINIC - REYNOLDS	88.07	1,980	0	0		10.00

RECLASSIFICATIONS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/21/2024 2:01 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
11.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	326	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
33.00		0.00	0	0	0		33.00
34.00		0.00	0	0	0		34.00
35.00		0.00	0	0	0		35.00
36.00		0.00	0	0	0		36.00
37.00		0.00	0	0	0		37.00
38.00		0.00	0	0	0		38.00
39.00		0.00	0	0	0		39.00
40.00		0.00	0	0	0		40.00
41.00		0.00	0	0	0		41.00
42.00		0.00	0	0	0		42.00
43.00		0.00	0	0	0		43.00
44.00		0.00	0	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	ANESTHESIOLOGY	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	0	113,799	0		4.00
5.00	RURAL HEALTH CLINIC - PONTIAC	88.01	0	144,933	0		5.00
6.00	RURAL HEALTH CLINIC - CULLOM	88.02	0	19,093	0		6.00
7.00	RURAL HEALTH CLINIC - DWIGHT	88.03	0	33,736	0		7.00
8.00	RURAL HEALTH CLINIC - FAIRBURY	88.04	0	36,922	0		8.00
9.00	RURAL HEALTH CLINIC - MINONK	88.05	0	30,393	0		9.00
10.00	RURAL HEALTH CLINIC - FLANAGAN	88.06	0	24,360	0		10.00
11.00	RURAL HEALTH CLINIC - REYNOLDS	88.07	0	99,553	0		11.00
12.00	RURAL HEALTH CLINIC - EL PASO	88.08	0	40,628	0		12.00
13.00	RURAL HEALTH CLINIC - CLINTON	88.09	0	81,561	0		13.00
	0		0	976,221			
	P - PHYSICIAN EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	62,500	0	0		1.00
	0		62,500	0			
	Q - FOUNDATION EXPENSE						
1.00	FUND DEVELOPMENT	192.02	0	19,663	0		1.00
2.00		0.00	0	0	0		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	19,663			

RECLASSIFICATIONS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/21/2024 2:01 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	R - MEDICAL RECORDS & LIBRARY						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	123,896	0		1.00
	0		0	123,896			
	T - CABLE TV						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,394	0		1.00
2.00	OPERATION OF PLANT	7.00	0	24,409	0		2.00
	TOTALS		0	26,803			
	U - NON-ALLOWABLE RHC						
1.00	RURAL HEALTH CLINIC - PONTIAC	88.01	475,615	158,883	0		1.00
2.00	RURAL HEALTH CLINIC - CULLOM	88.02	63,415	29,696	0		2.00
3.00	RURAL HEALTH CLINIC - DWIGHT	88.03	101,751	84,606	0		3.00
4.00	RURAL HEALTH CLINIC - FAIRBURY	88.04	147,675	92,712	0		4.00
5.00	RURAL HEALTH CLINIC - MINONK	88.05	111,798	49,735	0		5.00
6.00	RURAL HEALTH CLINIC - FLANAGAN	88.06	87,345	39,540	0		6.00
7.00	RURAL HEALTH CLINIC - REYNOLDS	88.07	392,553	150,322	0		7.00
8.00	RURAL HEALTH CLINIC - EL PASO	88.08	165,146	55,980	0		8.00
9.00	RURAL HEALTH CLINIC - CLINTON	88.09	268,108	116,785	0		9.00
	TOTALS		1,813,406	778,259			
500.00	Grand Total: Decreases		3,273,153	5,749,397			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/21/2024 2:01 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	600,013	0	0	0	0	1.00
2.00	Land Improvements	2,301,596	0	0	0	0	2.00
3.00	Buildings and Fixtures	38,997,628	773,864	0	773,864	0	3.00
4.00	Building Improvements	7,095	0	0	0	0	4.00
5.00	Fixed Equipment	23,848,989	1,130,774	0	1,130,774	214,060	5.00
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

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 2/21/2024 2:01 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,377,738	0	0	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

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	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)	0	2,455,518	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part III | Date/Time Prepared: 2/21/2024 2:01 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	42,080,182	0	42,080,182	0.629440	41,228	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24,773,230	0	24,773,230	0.370560	24,272	2.00
3.00	Total (sum of lines 1-2)	66,853,412	0	66,853,412	1.000000	65,500	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	25,740	0	66,968	1,238,028	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,153	0	39,425	2,046,808	0	2.00
3.00	Total (sum of lines 1-2)	40,893	0	106,393	3,284,836	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	41,228	25,740	0	1,304,996	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	24,272	15,153	0	2,086,233	2.00
3.00	Total (sum of lines 1-2)	0	65,500	40,893	0	3,391,229	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/21/2024 2:01 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-33,636	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,100,972			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-298,628			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-143,060	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-80	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	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)	B	-10,696	ADMINISTRATIVE & GENERAL	5.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	162,477	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	197,200	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist	A	-542,118	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER REVENUES - DIETARY	B	-346	DIETARY	10.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/21/2024 2:01 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	LOBBYING DUES	A	-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 SERVICES	B	-32,042	EMERGENCY	91.00	0	36.00
37.00	LAB NON PATIENT CARE	B	-805	LABORATORY	60.00	0	37.00
38.00	CARDIAC REHAB	B	-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 - SALARIED	A	-149,385	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.01
40.00	HOSPITAL ADMIN - FARM INCOME	B	-37,000	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	RENTAL INCOME AND OTHER	B	-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	B	-8,481	RURAL HEALTH CLINIC - STREATOR	88.00	0	43.00
44.00	DIABETES SERVICES	B	0	DIABETES SERVICES	76.00	0	44.00
45.00	OTHER REVENUE - PT	B	-62,691	PHYSICAL THERAPY	66.00	0	45.00
46.00	MEDICAID ASSESSMENT TAX EXPENSE	A	-2,761,004	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.00	REVENUE CYCLE ADMINISTRATION	B	-417	ADMINISTRATIVE & GENERAL	5.00	0	47.00
49.00	RECRUITING	A	-2,257	ADMINISTRATIVE & GENERAL	5.00	0	49.00
49.01	RECRUITING	A	-17,888	ADULTS & PEDIATRICS	30.00	0	49.01
49.02	RECRUITING	A	-400	ELECTROCARDIOLOGY	69.00	0	49.02
49.03	RECRUITING	A	-1,000	LABORATORY	60.00	0	49.03
49.04	RECRUITING	A	-1,000	EMERGENCY	91.00	0	49.04
49.05	RECRUITING	A	-2,400	RURAL HEALTH CLINIC - STREATOR	88.00	0	49.05
49.06	RECRUITING	A	-9,561	RURAL HEALTH CLINIC - REYNOLDS	88.07	0	49.06
49.07	MARKETING & ADVERTISING	A	-415	ADULTS & PEDIATRICS	30.00	0	49.07
49.08	OUTSIDE TRAINING SESSION	A	-1,574	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 - STREATOR	88.00	0	49.10
49.11	PONTIAC RHC- MISSING SALARIES	A	103,505	RURAL HEALTH CLINIC - PONTIAC	88.01	0	49.11
49.12	DWIGHT RHC- MISSING SALARIES	A	30,303	RURAL HEALTH CLINIC - DWIGHT	88.03	0	49.12
49.13	FAIRBURY RHC- MISSING SALARIES	A	33,723	RURAL HEALTH CLINIC - FAIRBURY	88.04	0	49.13
49.14	RHC MISSING BENEFITS	A	69,910	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.14
49.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.15
49.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.16
49.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.17
49.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.18
49.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.19
49.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,423,329				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/21/2024 2:01 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	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	PHYSICAL 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	0	4.02
4.04	6.00	MAINTENANCE & REPAIRS	PCI HTM - ENGINEERING	421,528	441,920	4.04
4.05	54.00	RADIOLOGY-DIAGNOSTIC	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	RADIOLOGY-DIAGNOSTIC	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			0	0	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
4.15	0.00			0	0	4.15
4.16	0.00			0	0	4.16
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			15,172,438	15,471,066	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B	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 non-financial) specify:					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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/21/2024 2:01 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-302,187	9		1.00
2.00	771,828	9		2.00
3.00	0	0		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	0		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	0		4.02
4.04	-20,392	0		4.04
4.05	-29,227	0		4.05
4.06	-5,630	0		4.06
4.07	0	0		4.07
4.08	-2,190	0		4.08
4.09	-302	0		4.09
4.10	0	0		4.10
4.11	-1,215	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		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 RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the 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			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 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/21/2024 2:01 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	32,340	32,340	0	211,500	0	1.00
2.00	13.00	NURSING ADMINISTRATION	30,595	30,595	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	1,803,974	1,803,974	0	197,500	0	3.00
4.00	53.00	ANESTHESIOLOGY	991,680	877,298	114,382	239,400	1,084	4.00
5.00	60.00	LABORATORY	1,338	1,338	0	260,300	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	1,700	1,700	0	260,300	0	6.00
7.00	91.00	EMERGENCY	1,353,727	1,353,727	0	211,500	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,215,354	4,100,972	114,382		1,084	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	124,764	6,238	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			124,764	6,238	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	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	ANESTHESIOLOGY	0	124,764	0	877,298		4.00
5.00	60.00	LABORATORY	0	0	0	1,338		5.00
6.00	69.00	ELECTROCARDIOLOGY	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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,304,996	1,304,996				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,086,233		2,086,233			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,987,502	0	0	8,987,502		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,052,238	240,141	992,606	346,422	11,631,407	5.00
6.00	00600	MAINTENANCE & REPAIRS	433,435	8,791	1,408	78,650	522,284	6.00
7.00	00700	OPERATION OF PLANT	1,565,798	62,876	78,575	128,660	1,835,909	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	166,663	0	0	9,440	176,103	8.00
9.00	00900	HOUSEKEEPING	798,739	9,261	13,667	206,589	1,028,256	9.00
10.00	01000	DIETARY	191,058	3,596	5,428	41,501	241,583	10.00
11.00	01100	CAFETERIA	396,486	10,642	1,837	116,557	525,522	11.00
13.00	01300	NURSING ADMINISTRATION	1,985,763	2,405	45,348	319,593	2,353,109	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	373,171	0	0	34,410	407,581	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	192,013	11,119	0	0	203,132	16.00
17.00	01700	SOCIAL SERVICE	640,666	0	0	0	640,666	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	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	31.00
43.00	04300	NURSERY	251,682	5,510	839	72,128	330,159	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	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	1,429	122,847	562,320	52.00
53.00	05300	ANESTHESIOLOGY	337,341	0	39,087	64,838	441,266	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,198,455	33,545	42,123	171,364	1,445,487	54.00
54.10	03630	ULTRA SOUND	302,245	2,363	46,533	87,434	438,575	54.10
54.20	03440	MAMMOGRAPHY	123,262	0	47,212	34,428	204,902	54.20
56.00	05600	RADIOISOTOPE	202,145	400	549	141	203,235	56.00
57.00	05700	CT SCAN	473,360	4,914	138,503	69,727	686,504	57.00
58.00	05800	MRI	238,135	7,943	51,564	65,071	362,713	58.00
60.00	06000	LABORATORY	2,122,595	17,498	28,089	317,365	2,485,547	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	138,342	0	0	0	138,342	63.00
64.00	06400	INTRAVENOUS THERAPY	222,560	0	0	59,842	282,402	64.00
65.00	06500	RESPIRATORY THERAPY	620,489	4,346	5,538	150,844	781,217	65.00
66.00	06600	PHYSICAL THERAPY	910,746	54,134	14,025	274,818	1,253,723	66.00
67.00	06700	OCCUPATIONAL THERAPY	288,184	15,844	1,332	82,098	387,458	67.00
68.00	06800	SPEECH PATHOLOGY	160,131	8,805	2,583	46,167	217,686	68.00
69.00	06900	ELECTROCARDIOLOGY	292,384	1,893	42,241	85,536	422,054	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	226,603	0	17,947	37,980	282,530	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	295,121	18,255	0	0	313,376	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	348,095	0	0	0	348,095	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,800,975	6,954	7,171	176,329	3,991,429	73.00
76.00	03950	DIABETES SERVICES	129,624	855	0	38,718	169,197	76.00
76.97	07697	CARDIAC REHABILITATION	92,506	11,126	9,200	29,377	142,209	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - 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	1,241	576,211	3,019,418	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	292,140	9,751	1,131	62,868	365,890	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	659,316	0	27,851	111,190	798,357	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	841,862	41,593	2,039	157,876	1,043,370	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	501,745	9,380	1,928	108,593	621,646	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	378,642	17,526	954	80,250	477,372	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	1,454,017	0	7,251	313,899	1,775,167	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	702,775	17,519	5,071	166,036	891,401	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	1,262,374	20,064	1,630	283,621	1,567,689	88.09
90.00	09000	CLINIC	84,146	6,933	0	22,754	113,833	90.00
91.00	09100	EMERGENCY	2,823,012	47,446	32,570	689,472	3,592,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	64,834,946	1,068,170	2,084,554	8,374,111	63,983,050	118.00
		NONREIMBURSABLE COST CENTERS						
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
192.01	19201	CARDIAC PHASE III	1,189	112	0	352	1,653	192.01
192.02	19202	FUND DEVELOPMENT	70,757	6,667	0	7,196	84,620	192.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
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					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	67,929,804	1,304,996	2,086,233	8,987,502	67,929,804	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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	11,631,407					5.00
6.00	00600	MAINTENANCE & REPAIRS	107,905	630,189				6.00
7.00	00700	OPERATION OF PLANT	379,304	37,521	2,252,734			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,383	0	0	212,486		8.00
9.00	00900	HOUSEKEEPING	212,441	5,526	21,005	0	1,267,228	9.00
10.00	01000	DIETARY	49,912	2,146	8,157	0	4,632	10.00
11.00	01100	CAFETERIA	108,574	6,350	24,138	0	13,706	11.00
13.00	01300	NURSING ADMINISTRATION	486,159	1,435	5,454	0	3,097	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	84,207	0	0	0	0	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	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,037,658	48,008	182,479	47,414	103,616	30.00
31.00	03100	INTENSIVE CARE UNIT	191,905	4,522	17,189	10,874	9,760	31.00
43.00	04300	NURSERY	68,212	3,288	12,498	2,286	7,097	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	502,026	63,457	241,201	31,992	136,960	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	116,177	5,602	21,291	3,895	12,090	52.00
53.00	05300	ANESTHESIOLOGY	91,167	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	298,642	20,017	76,086	28,947	43,203	54.00
54.10	03630	ULTRA SOUND	90,611	1,410	5,359	0	3,043	54.10
54.20	03440	MAMMOGRAPHY	42,333	0	0	0	0	54.20
56.00	05600	RADIOISOTOPE	41,989	238	906	0	515	56.00
57.00	05700	CT SCAN	141,834	2,933	11,147	0	6,329	57.00
58.00	05800	MRI	74,938	4,740	18,016	0	10,230	58.00
60.00	06000	LABORATORY	513,521	10,442	39,689	0	22,536	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	28,582	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	58,345	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	161,402	2,594	9,859	0	5,598	65.00
66.00	06600	PHYSICAL THERAPY	259,023	32,304	122,787	4,546	69,721	66.00
67.00	06700	OCCUPATIONAL THERAPY	80,050	9,454	35,936	0	20,405	67.00
68.00	06800	SPEECH PATHOLOGY	44,975	5,254	19,972	0	11,340	68.00
69.00	06900	ELECTROCARDIOLOGY	87,198	1,130	4,293	0	2,438	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	58,372	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,744	10,893	41,406	0	23,511	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	71,917	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	824,641	4,150	15,774	0	8,957	73.00
76.00	03950	DIABETES SERVICES	34,957	510	1,940	0	1,102	76.00
76.97	07697	CARDIAC REHABILITATION	29,381	6,639	25,235	0	14,329	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	1,214,648	73,773	280,413	0	159,225	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	623,821	16,323	62,045	46	35,231	88.01
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	08804	RURAL HEALTH CLINIC - FAIRBURY	215,563	24,820	94,340	353	53,569	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	128,434	5,597	21,275	8	12,081	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	98,626	10,458	39,752	0	22,572	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	366,755	0	0	0	0	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	45,508	0	25,841	88.09
90.00	09000	CLINIC	23,518	4,137	15,726	0	8,930	90.00
91.00	09100	EMERGENCY	742,221	28,313	107,618	79,678	61,108	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,815,995	488,865	1,715,567	210,554	962,214	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,831	9,500	36,111	0	20,505	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	784,756	127,779	485,680	1,932	275,778	192.00
192.01	19201	CARDIAC PHASE III	342	67	254	0	144	192.01
192.02	19202	FUND DEVELOPMENT	17,483	3,978	15,122	0	8,587	192.02
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	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,631,407	630,189	2,252,734	212,486	1,267,228	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	MEDICAL RECORDS & LIBRARY	
			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						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	306,430					10.00
11.00	01100	CAFETERIA	0	678,290				11.00
13.00	01300	NURSING ADMINISTRATION	0	30,569	2,879,823			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	7,812	0	499,600		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	291,274	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	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						
50.00	05000	OPERATING ROOM	10,919	38,414	405,488	17,558	21,351	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,622	0	0	0	740	52.00
53.00	05300	ANESTHESIOLOGY	0	13,777	0	5,403	2,919	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,275	0	1,653	9,277	54.00
54.10	03630	ULTRA SOUND	0	9,887	0	2,469	7,217	54.10
54.20	03440	MAMMOGRAPHY	0	5,219	0	901	3,745	54.20
56.00	05600	RADIOISOTOPE	0	0	0	282	4,648	56.00
57.00	05700	CT SCAN	0	8,947	0	15,990	33,629	57.00
58.00	05800	MRI	0	8,428	0	5,042	9,739	58.00
60.00	06000	LABORATORY	0	55,011	0	12,502	52,694	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	943	63.00
64.00	06400	INTRAVENOUS THERAPY	0	6,710	0	5,036	1,230	64.00
65.00	06500	RESPIRATORY THERAPY	0	18,024	0	23,405	4,276	65.00
66.00	06600	PHYSICAL THERAPY	0	35,140	0	1,873	5,512	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,628	0	244	2,405	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,062	0	0	927	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,119	0	2,157	9,932	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,187	0	1,069	1,678	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	121,549	914	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	95,255	2,326	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,889	0	2,903	31,081	73.00
76.00	03950	DIABETES SERVICES	0	4,214	44,484	0	165	76.00
76.97	07697	CARDIAC REHABILITATION	0	5,025	0	227	671	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	0	0	0	18,592	10,006	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	0	56,276	0	10,150	6,590	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	0	0	0	2,671	789	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	0	0	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	0	0	0	4,423	1,674	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	0	0	0	9,006	3,781	88.09
90.00	09000	CLINIC	0	4,020	0	155	206	90.00
91.00	09100	EMERGENCY	0	78,773	831,508	56,071	30,844	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	306,430	609,857	2,879,823	497,388	291,274	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	584	0	170	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	66,455	0	2,042	0	192.00
192.01	19201	CARDIAC PHASE III	0	65	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	0	1,329	0	0	0	192.02
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	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/21/2024 2:01 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	MEDICAL RECORDS & LIBRARY	
		10.00	11.00	13.00	14.00	16.00	
202.00	TOTAL (sum lines 118 through 201)	306,430	678,290	2,879,823	499,600	291,274	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		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						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	773,030					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	550,328	0	8,720,770	0	8,720,770	30.00
31.00	03100	INTENSIVE CARE UNIT	185,006	0	1,642,707	0	1,642,707	31.00
43.00	04300	NURSERY	37,696	0	556,907	0	556,907	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	3,899,271	0	3,899,271	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	726,737	0	726,737	52.00
53.00	05300	ANESTHESIOLOGY	0	0	554,532	0	554,532	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,946,587	0	1,946,587	54.00
54.10	03630	ULTRA SOUND	0	0	558,571	0	558,571	54.10
54.20	03440	MAMMOGRAPHY	0	0	257,100	0	257,100	54.20
56.00	05600	RADIOISOTOPE	0	0	251,813	0	251,813	56.00
57.00	05700	CT SCAN	0	0	907,313	0	907,313	57.00
58.00	05800	MRI	0	0	493,846	0	493,846	58.00
60.00	06000	LABORATORY	0	0	3,191,942	0	3,191,942	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	167,867	0	167,867	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	353,723	0	353,723	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,006,375	0	1,006,375	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,784,629	0	1,784,629	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	545,580	0	545,580	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	306,216	0	306,216	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	540,321	0	540,321	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	348,836	0	348,836	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	576,393	0	576,393	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	517,593	0	517,593	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,895,824	0	4,895,824	73.00
76.00	03950	DIABETES SERVICES	0	0	256,569	0	256,569	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	223,716	0	223,716	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	0	0	7,635,851	0	7,635,851	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	0	0	3,829,900	0	3,829,900	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	0	0	485,440	0	485,440	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	0	0	967,809	0	967,809	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	0	0	1,436,806	0	1,436,806	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	0	0	798,223	0	798,223	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	0	0	651,374	0	651,374	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	0	0	2,153,152	0	2,153,152	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	0	0	1,154,417	0	1,154,417	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	0	0	1,987,687	0	1,987,687	88.09
90.00	09000	CLINIC	0	0	170,525	0	170,525	90.00
91.00	09100	EMERGENCY	0	0	5,608,634	0	5,608,634	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID 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	62,111,556	0	62,111,556	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	141,804	0	141,804	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	5,542,800	0	5,542,800	192.00
192.01	19201	CARDIAC PHASE III	0	0	2,525	0	2,525	192.01
192.02	19202	FUND DEVELOPMENT	0	0	131,119	0	131,119	192.02
192.03	19203	PULMONARY FUNCTION	0	0	0	0	0	192.03
192.04	19204	RESEARCH	0	0	0	0	0	192.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/21/2024 2:01 pm

	Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		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	0	201.00
202.00	TOTAL (sum lines 118 through 201)	773,030	0	67,929,804	0	67,929,804	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		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	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,136	240,141	992,606	1,262,883	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	8,791	1,408	10,199	0	6.00
7.00	00700	OPERATION OF PLANT	8,682	62,876	78,575	150,133	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	9,261	13,667	22,928	0	9.00
10.00	01000	DIETARY	0	3,596	5,428	9,024	0	10.00
11.00	01100	CAFETERIA	0	10,642	1,837	12,479	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,405	45,348	47,753	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,119	0	11,119	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,014	80,452	75,461	189,927	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,149	7,578	54,294	63,021	0	31.00
43.00	04300	NURSERY	0	5,510	839	6,349	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,998	106,341	238,299	351,638	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,387	1,429	10,816	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	39,087	39,087	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,545	42,123	75,668	0	54.00
54.10	03630	ULTRA SOUND	0	2,363	46,533	48,896	0	54.10
54.20	03440	MAMMOGRAPHY	0	0	47,212	47,212	0	54.20
56.00	05600	RADIOISOTOPE	0	400	549	949	0	56.00
57.00	05700	CT SCAN	0	4,914	138,503	143,417	0	57.00
58.00	05800	MRI	0	7,943	51,564	59,507	0	58.00
60.00	06000	LABORATORY	31,175	17,498	28,089	76,762	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	32,904	4,346	5,538	42,788	0	65.00
66.00	06600	PHYSICAL THERAPY	0	54,134	14,025	68,159	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,844	1,332	17,176	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,805	2,583	11,388	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,893	42,241	44,134	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	72,600	0	17,947	90,547	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	18,255	0	18,255	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45	6,954	7,171	14,170	0	73.00
76.00	03950	DIABETES SERVICES	0	855	0	855	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	11,126	9,200	20,326	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - 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 - 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	88.06
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
90.00	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		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		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
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,921	0	15,921	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	96,645	214,126	1,679	312,450	0	192.00
192.01	19201	CARDIAC PHASE III	0	112	0	112	0	192.01
192.02	19202	FUND DEVELOPMENT	0	6,667	0	6,667	0	192.02
192.03	19203	PULMONARY FUNCTION	0	0	0	0	0	192.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			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	0	201.00
202.00		TOTAL (sum lines 118 through 201)	577,108	1,304,996	2,086,233	3,968,337	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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	1,262,883					5.00
6.00	00600	MAINTENANCE & REPAIRS	11,716	21,915				6.00
7.00	00700	OPERATION OF PLANT	41,183	1,305	192,621			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,950	0	0	3,950		8.00
9.00	00900	HOUSEKEEPING	23,066	192	1,796	0	47,982	9.00
10.00	01000	DIETARY	5,419	75	697	0	175	10.00
11.00	01100	CAFETERIA	11,789	221	2,064	0	519	11.00
13.00	01300	NURSING ADMINISTRATION	52,785	50	466	0	117	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	9,143	0	0	0	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	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	112,664	1,669	15,603	881	3,923	30.00
31.00	03100	INTENSIVE CARE UNIT	20,836	157	1,470	202	370	31.00
43.00	04300	NURSERY	7,406	114	1,069	42	269	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,508	2,207	20,624	595	5,186	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,614	195	1,821	72	458	52.00
53.00	05300	ANESTHESIOLOGY	9,898	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,425	696	6,506	538	1,636	54.00
54.10	03630	ULTRA SOUND	9,838	49	458	0	115	54.10
54.20	03440	MAMMOGRAPHY	4,596	0	0	0	0	54.20
56.00	05600	RADIOISOTOPE	4,559	8	77	0	19	56.00
57.00	05700	CT SCAN	15,400	102	953	0	240	57.00
58.00	05800	MRI	8,136	165	1,540	0	387	58.00
60.00	06000	LABORATORY	55,756	363	3,394	0	853	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,103	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	6,335	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	17,524	90	843	0	212	65.00
66.00	06600	PHYSICAL THERAPY	28,124	1,123	10,499	85	2,640	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,691	329	3,073	0	773	67.00
68.00	06800	SPEECH PATHOLOGY	4,883	183	1,708	0	429	68.00
69.00	06900	ELECTROCARDIOLOGY	9,468	39	367	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	07200	IMPL. DEV. CHARGED TO PATIENTS	7,808	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	89,536	144	1,349	0	339	73.00
76.00	03950	DIABETES SERVICES	3,795	18	166	0	42	76.00
76.97	07697	CARDIAC REHABILITATION	3,190	231	2,158	0	543	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	131,879	2,565	23,977	0	6,029	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	67,732	568	5,305	1	1,334	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	8,208	202	1,891	0	476	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	17,909	0	0	10	0	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	23,405	863	8,067	7	2,028	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	13,945	195	1,819	0	457	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	10,708	364	3,399	0	855	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	39,821	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	19,996	364	3,398	0	854	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	35,166	416	3,891	0	978	88.09
90.00	09000	CLINIC	2,554	144	1,345	0	338	90.00
91.00	09100	EMERGENCY	80,587	985	9,202	1,481	2,314	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,174,350	17,001	146,691	3,914	36,432	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,393	330	3,088	0	776	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	85,205	4,444	41,527	36	10,444	192.00
192.01	19201	CARDIAC PHASE III	37	2	22	0	5	192.01
192.02	19202	FUND DEVELOPMENT	1,898	138	1,293	0	325	192.02
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	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,262,883	21,915	192,621	3,950	47,982	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	MEDICAL RECORDS & LIBRARY	
			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						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	15,390					10.00
11.00	01100	CAFETERIA	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	MEDICAL RECORDS & LIBRARY	0	0	0	0	18,605	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,429	4,959	46,621	920	1,092	30.00
31.00	03100	INTENSIVE CARE UNIT	3,045	766	7,202	176	184	31.00
43.00	04300	NURSERY	136	320	3,005	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	0	0	47	52.00
53.00	05300	ANESTHESIOLOGY	0	550	0	102	186	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	929	0	31	591	54.00
54.10	03630	ULTRA SOUND	0	395	0	47	460	54.10
54.20	03440	MAMMOGRAPHY	0	208	0	17	239	54.20
56.00	05600	RADIOISOTOPE	0	0	0	5	296	56.00
57.00	05700	CT SCAN	0	357	0	303	2,143	57.00
58.00	05800	MRI	0	336	0	95	621	58.00
60.00	06000	LABORATORY	0	2,196	0	237	3,404	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	60	63.00
64.00	06400	INTRAVENOUS THERAPY	0	268	0	95	78	64.00
65.00	06500	RESPIRATORY THERAPY	0	719	0	443	272	65.00
66.00	06600	PHYSICAL THERAPY	0	1,403	0	35	351	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	384	0	5	153	67.00
68.00	06800	SPEECH PATHOLOGY	0	242	0	0	59	68.00
69.00	06900	ELECTROCARDIOLOGY	0	444	0	41	633	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	207	0	20	107	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,301	58	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,803	148	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	674	0	55	1,980	73.00
76.00	03950	DIABETES SERVICES	0	168	1,582	0	10	76.00
76.97	07697	CARDIAC REHABILITATION	0	201	0	4	43	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	0	0	0	352	638	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	0	2,246	0	192	420	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	0	0	0	51	50	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	0	0	0	49	89	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	0	0	0	60	103	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	0	0	0	148	88	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	0	0	0	33	54	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	0	0	0	143	234	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	0	0	0	84	107	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	0	0	0	170	241	88.09
90.00	09000	CLINIC	0	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	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,390	24,341	102,391	9,413	18,605	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23	0	3	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,652	0	39	0	192.00
192.01	19201	CARDIAC PHASE III	0	3	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	0	53	0	0	0	192.02
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	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/21/2024 2:01 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	MEDICAL RECORDS & LIBRARY	
		10.00	11.00	13.00	14.00	16.00	
202.00	TOTAL (sum lines 118 through 201)	15,390	27,072	102,391	9,455	18,605	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		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						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	14,371					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,231		399,919	0	399,919	30.00
31.00	03100	INTENSIVE CARE UNIT	3,439		100,868	0	100,868	31.00
43.00	04300	NURSERY	701		19,439	0	19,439	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		452,948	0	452,948	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		26,255	0	26,255	52.00
53.00	05300	ANESTHESIOLOGY	0		49,823	0	49,823	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		119,020	0	119,020	54.00
54.10	03630	ULTRA SOUND	0		60,258	0	60,258	54.10
54.20	03440	MAMMOGRAPHY	0		52,272	0	52,272	54.20
56.00	05600	RADIOISOTOPE	0		5,913	0	5,913	56.00
57.00	05700	CT SCAN	0		162,915	0	162,915	57.00
58.00	05800	MRI	0		70,787	0	70,787	58.00
60.00	06000	LABORATORY	0		142,965	0	142,965	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		3,163	0	3,163	63.00
64.00	06400	INTRAVENOUS THERAPY	0		6,776	0	6,776	64.00
65.00	06500	RESPIRATORY THERAPY	0		62,891	0	62,891	65.00
66.00	06600	PHYSICAL THERAPY	0		112,419	0	112,419	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		30,584	0	30,584	67.00
68.00	06800	SPEECH PATHOLOGY	0		18,892	0	18,892	68.00
69.00	06900	ELECTROCARDIOLOGY	0		55,218	0	55,218	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		97,219	0	97,219	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		32,453	0	32,453	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		9,759	0	9,759	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		108,247	0	108,247	73.00
76.00	03950	DIABETES SERVICES	0		6,636	0	6,636	76.00
76.97	07697	CARDIAC REHABILITATION	0		26,696	0	26,696	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	0		298,587	0	298,587	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	0		111,419	0	111,419	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	0		22,523	0	22,523	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	0		187,719	0	187,719	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	0		79,628	0	79,628	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	0		29,206	0	29,206	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	0		34,960	0	34,960	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	0		190,920	0	190,920	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	0		-4,459	0	-4,459	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	0		65,842	0	65,842	88.09
90.00	09000	CLINIC	0		11,490	0	11,490	90.00
91.00	09100	EMERGENCY	0		217,281	0	217,281	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,371	0	3,479,451	0	3,479,451	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		21,534	0	21,534	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		456,797	0	456,797	192.00
192.01	19201	CARDIAC PHASE III	0		181	0	181	192.01
192.02	19202	FUND DEVELOPMENT	0		10,374	0	10,374	192.02
192.03	19203	PULMONARY FUNCTION	0		0	0	0	192.03
192.04	19204	RESEARCH	0		0	0	0	192.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/21/2024 2:01 pm

	Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		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	0	201.00
202.00	TOTAL (sum lines 118 through 201)	14,371	0	3,968,337	0	3,968,337	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	186,151					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,046,810				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	29,634,616			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	34,255	973,849	1,142,263	-11,631,407	56,298,397	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,254	1,381	259,335	0	522,284	6.00
7.00	00700	OPERATION OF PLANT	8,969	77,090	424,232	0	1,835,909	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	31,127	0	176,103	8.00
9.00	00900	HOUSEKEEPING	1,321	13,409	681,190	0	1,028,256	9.00
10.00	01000	DIETARY	513	5,325	136,843	0	241,583	10.00
11.00	01100	CAFETERIA	1,518	1,802	384,324	0	525,522	11.00
13.00	01300	NURSING ADMINISTRATION	343	44,491	1,053,799	0	2,353,109	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	113,459	0	407,581	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,586	0	0	0	203,132	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	640,666	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,476	74,035	3,251,914	0	5,022,472	30.00
31.00	03100	INTENSIVE CARE UNIT	1,081	53,268	628,480	0	928,858	31.00
43.00	04300	NURSERY	786	823	237,830	0	330,159	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,169	233,796	1,175,691	0	2,429,905	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,339	1,402	405,064	0	562,320	52.00
53.00	05300	ANESTHESIOLOGY	0	38,348	213,791	0	441,266	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,785	41,327	565,041	0	1,445,487	54.00
54.10	03630	ULTRA SOUND	337	45,654	288,299	0	438,575	54.10
54.20	03440	MAMMOGRAPHY	0	46,320	113,520	0	204,902	54.20
56.00	05600	RADIOISOTOPE	57	539	465	0	203,235	56.00
57.00	05700	CT SCAN	701	135,886	229,911	0	686,504	57.00
58.00	05800	MRI	1,133	50,590	214,561	0	362,713	58.00
60.00	06000	LABORATORY	2,496	27,558	1,046,454	0	2,485,547	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	138,342	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	197,318	0	282,402	64.00
65.00	06500	RESPIRATORY THERAPY	620	5,433	497,380	0	781,217	65.00
66.00	06600	PHYSICAL THERAPY	7,722	13,760	906,163	0	1,253,723	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,260	1,307	270,703	0	387,458	67.00
68.00	06800	SPEECH PATHOLOGY	1,256	2,534	152,227	0	217,686	68.00
69.00	06900	ELECTROCARDIOLOGY	270	41,443	282,039	0	422,054	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	17,608	125,233	0	282,530	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,604	0	0	0	313,376	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	348,095	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	992	7,035	581,413	0	3,991,429	73.00
76.00	03950	DIABETES SERVICES	122	0	127,667	0	169,197	76.00
76.97	07697	CARDIAC REHABILITATION	1,587	9,026	96,865	0	142,209	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	17,635	0	3,294,232	0	5,879,194	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	3,902	1,218	1,899,951	0	3,019,418	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	1,391	1,110	207,296	0	365,890	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	0	27,325	366,630	0	798,357	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	5,933	2,000	520,567	0	1,043,370	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	1,338	1,892	358,067	0	621,646	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	2,500	936	264,611	0	477,372	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	0	7,114	1,035,024	0	1,775,167	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	2,499	4,975	547,472	0	891,401	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	2,862	1,599	935,187	0	1,567,689	88.09
90.00	09000	CLINIC	989	0	75,026	0	113,833	90.00
91.00	09100	EMERGENCY	6,768	31,955	2,273,408	0	3,592,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	152,369	2,045,163	27,612,072	-11,631,407	52,351,643	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,271	0	19,981	0	62,103	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	30,544	1,647	1,977,675	0	3,798,378	192.00
192.01	19201	CARDIAC PHASE III	16	0	1,162	0	1,653	192.01
192.02	19202	FUND DEVELOPMENT	951	0	23,726	0	84,620	192.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (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 II)			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 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		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						5.00
6.00	00600	MAINTENANCE & REPAIRS	150,642					6.00
7.00	00700	OPERATION OF PLANT	8,969	141,673				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	186,374			8.00
9.00	00900	HOUSEKEEPING	1,321	1,321	0	140,352		9.00
10.00	01000	DIETARY	513	513	0	513	16,839	10.00
11.00	01100	CAFETERIA	1,518	1,518	0	1,518	0	11.00
13.00	01300	NURSING ADMINISTRATION	343	343	0	343	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,586	1,586	0	1,586	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,476	11,476	41,587	11,476	12,504	30.00
31.00	03100	INTENSIVE CARE UNIT	1,081	1,081	9,538	1,081	3,332	31.00
43.00	04300	NURSERY	786	786	2,005	786	149	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,169	15,169	28,061	15,169	600	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,339	1,339	3,416	1,339	254	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,785	4,785	25,390	4,785	0	54.00
54.10	03630	ULTRA SOUND	337	337	0	337	0	54.10
54.20	03440	MAMMOGRAPHY	0	0	0	0	0	54.20
56.00	05600	RADIOISOTOPE	57	57	0	57	0	56.00
57.00	05700	CT SCAN	701	701	0	701	0	57.00
58.00	05800	MRI	1,133	1,133	0	1,133	0	58.00
60.00	06000	LABORATORY	2,496	2,496	0	2,496	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	620	620	0	620	0	65.00
66.00	06600	PHYSICAL THERAPY	7,722	7,722	3,987	7,722	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,260	2,260	0	2,260	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,256	1,256	0	1,256	0	68.00
69.00	06900	ELECTROCARDIOLOGY	270	270	0	270	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,604	2,604	0	2,604	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	992	992	0	992	0	73.00
76.00	03950	DIABETES SERVICES	122	122	0	122	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,587	1,587	0	1,587	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	17,635	17,635	0	17,635	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	3,902	3,902	40	3,902	0	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	1,391	1,391	0	1,391	0	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	0	0	452	0	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	7	1,338	0	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	2,500	2,500	0	2,500	0	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	0	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	2,499	2,499	0	2,499	0	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	2,862	2,862	0	2,862	0	88.09
90.00	09000	CLINIC	989	989	0	989	0	90.00
91.00	09100	EMERGENCY	6,768	6,768	69,886	6,768	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	116,860	107,891	184,679	106,570	16,839	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,271	2,271	0	2,271	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	30,544	30,544	1,695	30,544	0	192.00
192.01	19201	CARDIAC PHASE III	16	16	0	16	0	192.01
192.02	19202	FUND DEVELOPMENT	951	951	0	951	0	192.02
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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			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, Part I)	630,189	2,252,734	212,486	1,267,228	306,430	202.00
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, Part II)	21,915	192,621	3,950	47,982	15,390	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.145477	1.359617	0.021194	0.341869	0.913950	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 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
			11.00	13.00	14.00	16.00	17.00	
		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						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	20,924					11.00
13.00	01300	NURSING ADMINISTRATION	943	8,416				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	241	0	1,825,723			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	257,871,630		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	4,450	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	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
31.00	03100	INTENSIVE CARE UNIT	592	592	34,028	2,550,111	1,065	31.00
43.00	04300	NURSERY	247	247	0	383,520	217	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,185	1,185	64,162	18,894,658	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	654,637	0	52.00
53.00	05300	ANESTHESIOLOGY	425	0	19,746	2,582,890	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	718	0	6,040	8,209,836	0	54.00
54.10	03630	ULTRA SOUND	305	0	9,023	6,387,023	0	54.10
54.20	03440	MAMMOGRAPHY	161	0	3,294	3,314,180	0	54.20
56.00	05600	RADIOISOTOPE	0	0	1,031	4,113,029	0	56.00
57.00	05700	CT SCAN	276	0	58,434	29,759,951	0	57.00
58.00	05800	MRI	260	0	18,424	8,618,243	0	58.00
60.00	06000	LABORATORY	1,697	0	45,687	46,738,865	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	834,699	0	63.00
64.00	06400	INTRAVENOUS THERAPY	207	0	18,403	1,088,554	0	64.00
65.00	06500	RESPIRATORY THERAPY	556	0	85,529	3,783,678	0	65.00
66.00	06600	PHYSICAL THERAPY	1,084	0	6,845	4,877,915	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	297	0	890	2,128,521	0	67.00
68.00	06800	SPEECH PATHOLOGY	187	0	0	820,698	0	68.00
69.00	06900	ELECTROCARDIOLOGY	343	0	7,883	8,789,085	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	160	0	3,908	1,485,137	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	444,190	809,077	0	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	0	10,608	27,505,390	0	73.00
76.00	03950	DIABETES SERVICES	130	130	0	145,712	0	76.00
76.97	07697	CARDIAC REHABILITATION	155	0	828	593,467	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	0	0	67,942	8,854,856	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	1,736	0	37,092	5,831,731	0	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	0	0	9,760	698,436	0	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	0	0	9,492	1,236,278	0	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	0	0	11,589	1,433,997	0	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	0	0	28,530	1,217,170	0	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	0	0	6,398	746,387	0	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	0	0	27,629	3,246,945	0	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	0	0	16,164	1,481,525	0	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	0	0	32,910	3,346,009	0	88.09
90.00	09000	CLINIC	124	0	565	181,976	0	90.00
91.00	09100	EMERGENCY	2,430	2,430	204,905	27,295,274	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,813	8,416	1,817,639	257,871,630	4,450	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18	0	622	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,050	0	7,462	0	0	192.00
192.01	19201	CARDIAC PHASE III	2	0	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	41	0	0	0	0	192.02
192.03	19203	PULMONARY FUNCTION	0	0	0	0	0	192.03
192.04	19204	RESEARCH	0	0	0	0	0	192.04

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
			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, Part I)	678,290	2,879,823	499,600	291,274	773,030	202.00
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, Part II)	27,072	102,391	9,455	18,605	14,371	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.293825	12.166231	0.005179	0.000072	3.229438	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 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		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		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	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	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.10	03630	ULTRA SOUND	0	54.10
54.20	03440	MAMMOGRAPHY	0	54.20
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
60.00	06000	LABORATORY	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03950	DIABETES SERVICES	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	78.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC - STREATOR	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	0	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	0	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	0	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	0	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	0	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	0	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	0	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	0	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	0	88.09
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM	0	102.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	CARDIAC PHASE III	0	192.01
192.02	19202	FUND DEVELOPMENT	0	192.02
192.03	19203	PULMONARY FUNCTION	0	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 | Worksheet B-1 | Date/Time Prepared: 2/21/2024 2:01 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			19.00		
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/21/2024 2:01 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,720,770		8,720,770	0	8,720,770	30.00
31.00	03100	INTENSIVE CARE UNIT	1,642,707		1,642,707	0	1,642,707	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	0	3,899,271	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	726,737		726,737	0	726,737	52.00
53.00	05300	ANESTHESIOLOGY	554,532		554,532	0	554,532	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,946,587		1,946,587	0	1,946,587	54.00
54.10	03630	ULTRA SOUND	558,571		558,571	0	558,571	54.10
54.20	03440	MAMMOGRAPHY	257,100		257,100	0	257,100	54.20
56.00	05600	RADIOISOTOPE	251,813		251,813	0	251,813	56.00
57.00	05700	CT SCAN	907,313		907,313	0	907,313	57.00
58.00	05800	MRI	493,846		493,846	0	493,846	58.00
60.00	06000	LABORATORY	3,191,942		3,191,942	0	3,191,942	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	167,867		167,867	0	167,867	63.00
64.00	06400	INTRAVENOUS THERAPY	353,723		353,723	0	353,723	64.00
65.00	06500	RESPIRATORY THERAPY	1,006,375	0	1,006,375	0	1,006,375	65.00
66.00	06600	PHYSICAL THERAPY	1,784,629	0	1,784,629	0	1,784,629	66.00
67.00	06700	OCCUPATIONAL THERAPY	545,580	0	545,580	0	545,580	67.00
68.00	06800	SPEECH PATHOLOGY	306,216	0	306,216	0	306,216	68.00
69.00	06900	ELECTROCARDIOLOGY	540,321		540,321	0	540,321	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	348,836		348,836	0	348,836	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	576,393		576,393	0	576,393	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	517,593		517,593	0	517,593	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,895,824		4,895,824	0	4,895,824	73.00
76.00	03950	DIABETES SERVICES	256,569		256,569	0	256,569	76.00
76.97	07697	CARDIAC REHABILITATION	223,716		223,716	0	223,716	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	7,635,851		7,635,851	0	7,635,851	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	3,829,900		3,829,900	0	3,829,900	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	485,440		485,440	0	485,440	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	967,809		967,809	0	967,809	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	1,436,806		1,436,806	0	1,436,806	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	798,223		798,223	0	798,223	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	651,374		651,374	0	651,374	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	2,153,152		2,153,152	0	2,153,152	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	1,154,417		1,154,417	0	1,154,417	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	1,987,687		1,987,687	0	1,987,687	88.09
90.00	09000	CLINIC	170,525		170,525	0	170,525	90.00
91.00	09100	EMERGENCY	5,608,634		5,608,634	0	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	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	65,024,590	0	65,024,590	0	65,024,590	200.00
201.00		Less Observation Beds	2,913,034		2,913,034		2,913,034	201.00
202.00		Total (see instructions)	62,111,556	0	62,111,556	0	62,111,556	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/21/2024 2:01 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,670,932		9,670,932			30.00
31.00	03100	INTENSIVE CARE UNIT	2,550,111		2,550,111			31.00
43.00	04300	NURSERY	383,520		383,520			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,575,413	16,319,245	18,894,658	0.206369	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	607,065	47,572	654,637	1.110137	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	491,205	2,091,685	2,582,890	0.214694	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	743,776	7,466,060	8,209,836	0.237104	0.000000	54.00
54.10	03630	ULTRA SOUND	396,472	5,990,551	6,387,023	0.087454	0.000000	54.10
54.20	03440	MAMMOGRAPHY	1,717	3,312,463	3,314,180	0.077576	0.000000	54.20
56.00	05600	RADIOISOTOPE	260,398	3,852,631	4,113,029	0.061223	0.000000	56.00
57.00	05700	CT SCAN	3,780,976	25,978,975	29,759,951	0.030488	0.000000	57.00
58.00	05800	MRI	632,236	7,986,007	8,618,243	0.057302	0.000000	58.00
60.00	06000	LABORATORY	7,278,705	39,460,160	46,738,865	0.068293	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	246,674	588,025	834,699	0.201111	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	720	1,087,834	1,088,554	0.324948	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,379,628	1,404,050	3,783,678	0.265978	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	533,267	4,344,648	4,877,915	0.365859	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	352,270	1,776,251	2,128,521	0.256319	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	121,959	698,739	820,698	0.373117	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,354,556	7,434,529	8,789,085	0.061476	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	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
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	722,827	1,335,992	2,058,819	0.251403	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,580,562	21,924,828	27,505,390	0.177995	0.000000	73.00
76.00	03950	DIABETES SERVICES	0	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	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	0	8,854,856	8,854,856			88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	0	5,831,731	5,831,731			88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	0	698,436	698,436			88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	0	1,236,278	1,236,278			88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	0	1,433,997	1,433,997			88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	0	1,217,170	1,217,170			88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	0	746,387	746,387			88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	0	3,246,945	3,246,945			88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	0	1,481,525	1,481,525			88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	0	3,346,009	3,346,009			88.09
90.00	09000	CLINIC	0	181,976	181,976	0.937074	0.000000	90.00
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	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	46,465,728	211,405,902	257,871,630			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	46,465,728	211,405,902	257,871,630			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient 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	0.206369		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.110137		52.00
53.00	05300	ANESTHESIOLOGY	0.214694		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237104		54.00
54.10	03630	ULTRA SOUND	0.087454		54.10
54.20	03440	MAMMOGRAPHY	0.077576		54.20
56.00	05600	RADIOISOTOPE	0.061223		56.00
57.00	05700	CT SCAN	0.030488		57.00
58.00	05800	MRI	0.057302		58.00
60.00	06000	LABORATORY	0.068293		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.201111		63.00
64.00	06400	INTRAVENOUS THERAPY	0.324948		64.00
65.00	06500	RESPIRATORY THERAPY	0.265978		65.00
66.00	06600	PHYSICAL THERAPY	0.365859		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.256319		67.00
68.00	06800	SPEECH PATHOLOGY	0.373117		68.00
69.00	06900	ELECTROCARDIOLOGY	0.061476		69.00
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
73.00	07300	DRUGS CHARGED TO PATIENTS	0.177995		73.00
76.00	03950	DIABETES SERVICES	1.760795		76.00
76.97	07697	CARDIAC REHABILITATION	0.376965		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			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	0.937074		90.00
91.00	09100	EMERGENCY	0.205480		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.529410		92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID 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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/21/2024 2:01 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,720,770		8,720,770	0	8,720,770	30.00
31.00	03100	INTENSIVE CARE UNIT	1,642,707		1,642,707	0	1,642,707	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	0	3,899,271	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	726,737		726,737	0	726,737	52.00
53.00	05300	ANESTHESIOLOGY	554,532		554,532	0	554,532	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,946,587		1,946,587	0	1,946,587	54.00
54.10	03630	ULTRA SOUND	558,571		558,571	0	558,571	54.10
54.20	03440	MAMMOGRAPHY	257,100		257,100	0	257,100	54.20
56.00	05600	RADIOISOTOPE	251,813		251,813	0	251,813	56.00
57.00	05700	CT SCAN	907,313		907,313	0	907,313	57.00
58.00	05800	MRI	493,846		493,846	0	493,846	58.00
60.00	06000	LABORATORY	3,191,942		3,191,942	0	3,191,942	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	167,867		167,867	0	167,867	63.00
64.00	06400	INTRAVENOUS THERAPY	353,723		353,723	0	353,723	64.00
65.00	06500	RESPIRATORY THERAPY	1,006,375	0	1,006,375	0	1,006,375	65.00
66.00	06600	PHYSICAL THERAPY	1,784,629	0	1,784,629	0	1,784,629	66.00
67.00	06700	OCCUPATIONAL THERAPY	545,580	0	545,580	0	545,580	67.00
68.00	06800	SPEECH PATHOLOGY	306,216	0	306,216	0	306,216	68.00
69.00	06900	ELECTROCARDIOLOGY	540,321		540,321	0	540,321	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	348,836		348,836	0	348,836	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	576,393		576,393	0	576,393	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	517,593		517,593	0	517,593	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,895,824		4,895,824	0	4,895,824	73.00
76.00	03950	DIABETES SERVICES	256,569		256,569	0	256,569	76.00
76.97	07697	CARDIAC REHABILITATION	223,716		223,716	0	223,716	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	7,635,851		7,635,851	0	7,635,851	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	3,829,900		3,829,900	0	3,829,900	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	485,440		485,440	0	485,440	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	967,809		967,809	0	967,809	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	1,436,806		1,436,806	0	1,436,806	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	798,223		798,223	0	798,223	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	651,374		651,374	0	651,374	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	2,153,152		2,153,152	0	2,153,152	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	1,154,417		1,154,417	0	1,154,417	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	1,987,687		1,987,687	0	1,987,687	88.09
90.00	09000	CLINIC	170,525		170,525	0	170,525	90.00
91.00	09100	EMERGENCY	5,608,634		5,608,634	0	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	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	65,024,590	0	65,024,590	0	65,024,590	200.00
201.00		Less Observation Beds	2,913,034		2,913,034		2,913,034	201.00
202.00		Total (see instructions)	62,111,556	0	62,111,556	0	62,111,556	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/21/2024 2:01 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,670,932		9,670,932			30.00
31.00	03100	INTENSIVE CARE UNIT	2,550,111		2,550,111			31.00
43.00	04300	NURSERY	383,520		383,520			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,575,413	16,319,245	18,894,658	0.206369	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	607,065	47,572	654,637	1.110137	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	491,205	2,091,685	2,582,890	0.214694	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	743,776	7,466,060	8,209,836	0.237104	0.000000	54.00
54.10	03630	ULTRA SOUND	396,472	5,990,551	6,387,023	0.087454	0.000000	54.10
54.20	03440	MAMMOGRAPHY	1,717	3,312,463	3,314,180	0.077576	0.000000	54.20
56.00	05600	RADIOISOTOPE	260,398	3,852,631	4,113,029	0.061223	0.000000	56.00
57.00	05700	CT SCAN	3,780,976	25,978,975	29,759,951	0.030488	0.000000	57.00
58.00	05800	MRI	632,236	7,986,007	8,618,243	0.057302	0.000000	58.00
60.00	06000	LABORATORY	7,278,705	39,460,160	46,738,865	0.068293	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	246,674	588,025	834,699	0.201111	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	720	1,087,834	1,088,554	0.324948	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,379,628	1,404,050	3,783,678	0.265978	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	533,267	4,344,648	4,877,915	0.365859	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	352,270	1,776,251	2,128,521	0.256319	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	121,959	698,739	820,698	0.373117	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,354,556	7,434,529	8,789,085	0.061476	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	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
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	722,827	1,335,992	2,058,819	0.251403	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,580,562	21,924,828	27,505,390	0.177995	0.000000	73.00
76.00	03950	DIABETES SERVICES	0	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	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	0	8,854,856	8,854,856	0.862335	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	0	5,831,731	5,831,731	0.656735	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	0	698,436	698,436	0.695039	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	0	1,236,278	1,236,278	0.782841	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	0	1,433,997	1,433,997	1.001959	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	0	1,217,170	1,217,170	0.655802	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	0	746,387	746,387	0.872703	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	0	3,246,945	3,246,945	0.663132	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	0	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
90.00	09000	CLINIC	0	181,976	181,976	0.937074	0.000000	90.00
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	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	46,465,728	211,405,902	257,871,630			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	46,465,728	211,405,902	257,871,630			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/21/2024 2:01 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient 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	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.10	03630	ULTRA SOUND	0.000000		54.10
54.20	03440	MAMMOGRAPHY	0.000000		54.20
56.00	05600	RADIOISOTOPE	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	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL 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	ELECTROCARDIOLOGY	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	DIABETES SERVICES	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	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	CLINIC	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			
102.00	10200	OPIOID 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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part I Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	399,919	0	399,919	4,757	84.07	30.00
31.00	INTENSIVE CARE UNIT	100,868		100,868	1,065	94.71	31.00
43.00	NURSERY	19,439		19,439	217	89.58	43.00
200.00	Total (lines 30 through 199)	520,226		520,226	6,039		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,531	128,711				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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	452,948	18,894,658	0.023972	942,042	22,583	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,255	654,637	0.040106	0	0	52.00
53.00	05300	ANESTHESIOLOGY	49,823	2,582,890	0.019290	151,109	2,915	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,020	8,209,836	0.014497	341,382	4,949	54.00
54.10	03630	ULTRA SOUND	60,258	6,387,023	0.009434	172,120	1,624	54.10
54.20	03440	MAMMOGRAPHY	52,272	3,314,180	0.015772	0	0	54.20
56.00	05600	RADIOISOTOPE	5,913	4,113,029	0.001438	158,787	228	56.00
57.00	05700	CT SCAN	162,915	29,759,951	0.005474	1,620,414	8,870	57.00
58.00	05800	MRI	70,787	8,618,243	0.008214	327,544	2,690	58.00
60.00	06000	LABORATORY	142,965	46,738,865	0.003059	3,078,872	9,418	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,163	834,699	0.003789	62,844	238	63.00
64.00	06400	INTRAVENOUS THERAPY	6,776	1,088,554	0.006225	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	62,891	3,783,678	0.016622	1,045,036	17,371	65.00
66.00	06600	PHYSICAL THERAPY	112,419	4,877,915	0.023047	241,046	5,555	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,584	2,128,521	0.014369	144,592	2,078	67.00
68.00	06800	SPEECH PATHOLOGY	18,892	820,698	0.023019	61,402	1,413	68.00
69.00	06900	ELECTROCARDIOLOGY	55,218	8,789,085	0.006283	702,635	4,415	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	97,219	1,485,137	0.065461	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,453	809,077	0.040111	99,707	3,999	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,759	2,058,819	0.004740	404,839	1,919	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	108,247	27,505,390	0.003935	2,394,729	9,423	73.00
76.00	03950	DIABETES SERVICES	6,636	145,712	0.045542	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	26,696	593,467	0.044983	13,221	595	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	298,587	8,854,856	0.033720	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	111,419	5,831,731	0.019106	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	22,523	698,436	0.032248	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	187,719	1,236,278	0.151842	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	79,628	1,433,997	0.055529	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	29,206	1,217,170	0.023995	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	34,960	746,387	0.046839	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	190,920	3,246,945	0.058800	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	-4,459	1,481,525	-0.003010	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	65,842	3,346,009	0.019678	0	0	88.09
90.00	09000	CLINIC	11,490	181,976	0.063140	0	0	90.00
91.00	09100	EMERGENCY	217,281	27,295,274	0.007960	1,725,901	13,738	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	133,586	5,502,419	0.024278	927,337	22,514	92.00
200.00		Total (lines 50 through 199)	3,092,811	245,267,067		14,615,559	136,535	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part III Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,757	0.00	1,531	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,065	0.00	362	31.00
43.00	04300	NURSERY		0	217	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	6,039		1,893	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/21/2024 2:01 pm

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.10	03630	ULTRA SOUND	0	0	0	0	0	54.10
54.20	03440	MAMMOGRAPHY	0	0	0	0	0	54.20
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETES SERVICES	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	0	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	0	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	0	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	0	0	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	0	0	0	0	0	88.09
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/21/2024 2:01 pm

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		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	18,894,658	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	654,637	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,582,890	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,209,836	0.000000	54.00
54.10	03630	ULTRA SOUND	0	0	0	6,387,023	0.000000	54.10
54.20	03440	MAMMOGRAPHY	0	0	0	3,314,180	0.000000	54.20
56.00	05600	RADIOISOTOPE	0	0	0	4,113,029	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	29,759,951	0.000000	57.00
58.00	05800	MRI	0	0	0	8,618,243	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	46,738,865	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	834,699	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,088,554	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,783,678	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,877,915	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,128,521	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	820,698	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,789,085	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,485,137	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	809,077	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,058,819	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	27,505,390	0.000000	73.00
76.00	03950	DIABETES SERVICES	0	0	0	145,712	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	593,467	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	0	0	0	8,854,856	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	0	0	0	5,831,731	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	0	0	0	698,436	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	0	0	0	1,236,278	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	0	0	0	1,433,997	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	0	0	0	1,217,170	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	0	0	0	746,387	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	0	0	0	3,246,945	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	0	0	0	1,481,525	0.000000	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	0	0	0	3,346,009	0.000000	88.09
90.00	09000	CLINIC	0	0	0	181,976	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	27,295,274	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,502,419	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	245,267,067		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/21/2024 2:01 pm

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		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	942,042	0	3,237,671	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	151,109	0	366,594	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	341,382	0	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	RADIOISOTOPE	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	INTRAVENOUS 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	PHYSICAL THERAPY	0.000000	241,046	0	18,485	0	66.00
67.00	06700	OCCUPATIONAL 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	ELECTROCARDIOLOGY	0.000000	702,635	0	2,552,693	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	99,707	0	10,531	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	404,839	0	244,459	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,394,729	0	328,846	0	73.00
76.00	03950	DIABETES SERVICES	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	13,221	0	176,599	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - STREATOR	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	0.000000	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	0.000000	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	0.000000	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	0.000000	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	0.000000	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	0.000000	0	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	0.000000	0	0	0	0	88.09
90.00	09000	CLINIC	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	0	529,695	0	92.00
200.00		Total (lines 50 through 199)		14,615,559	0	35,235,304	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/21/2024 2:01 pm

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		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.206369	3,237,671	0	0	668,155	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.110137	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.214694	366,594	0	0	78,706	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237104	1,731,262	0	0	410,489	54.00
54.10	03630	ULTRA SOUND	0.087454	1,039,384	0	0	90,898	54.10
54.20	03440	MAMMOGRAPHY	0.077576	0	0	0	0	54.20
56.00	05600	RADIOISOTOPE	0.061223	1,250,376	0	0	76,552	56.00
57.00	05700	CT SCAN	0.030488	13,890,362	0	28,742	423,489	57.00
58.00	05800	MRI	0.057302	1,708,739	0	0	97,914	58.00
60.00	06000	LABORATORY	0.068293	3,013,872	435	0	205,826	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.201111	94,252	0	0	18,955	63.00
64.00	06400	INTRAVENOUS THERAPY	0.324948	435,137	0	0	141,397	64.00
65.00	06500	RESPIRATORY THERAPY	0.265978	422,704	0	0	112,430	65.00
66.00	06600	PHYSICAL THERAPY	0.365859	18,485	0	0	6,763	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.256319	228	0	0	58	67.00
68.00	06800	SPEECH PATHOLOGY	0.373117	5,088	0	0	1,898	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061476	2,552,693	0	0	156,929	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.234885	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.712408	10,531	0	0	7,502	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.251403	244,459	0	0	61,458	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.177995	328,846	0	0	58,533	73.00
76.00	03950	DIABETES SERVICES	1.760795	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.376965	176,599	0	0	66,572	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - 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	0.937074	35,825	0	0	33,571	90.00
91.00	09100	EMERGENCY	0.205480	4,142,502	0	0	851,201	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.529410	529,695	0	0	280,426	92.00
200.00		Subtotal (see instructions)		35,235,304	435	28,742	3,849,722	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		35,235,304	435	28,742	3,849,722	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/21/2024 2:01 pm

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.10	03630	ULTRA SOUND	0	0		54.10
54.20	03440	MAMMOGRAPHY	0	0		54.20
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	876		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	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	DIABETES SERVICES	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
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	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	30	876		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	30	876		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/21/2024 2:01 pm

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	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,983	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,757	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,168	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	226	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,531	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	106	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	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 December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,720,770	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	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 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	8,720,770	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,833.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,806,706	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,806,706	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,642,707	1,065	1,542.45	362	558,367	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	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 (Wkst. D-3, col. 3, line 200)	2,542,579	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	5,907,652	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	162,996	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	136,535	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	299,531	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,608,121	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,589	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,833.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,913,034	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (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	0.045858	2,913,034	133,586	90.00
91.00	Nursing Program cost	0	8,720,770	0.000000	2,913,034	0	91.00
92.00	Allied health cost	0	8,720,770	0.000000	2,913,034	0	92.00
93.00	All other Medical Education	0	8,720,770	0.000000	2,913,034	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,977,364		30.00
31.00	03100	INTENSIVE CARE UNIT		1,768,060		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.206369	942,042	194,408	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.110137	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.214694	151,109	32,442	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237104	341,382	80,943	54.00
54.10	03630	ULTRA SOUND	0.087454	172,120	15,053	54.10
54.20	03440	MAMMOGRAPHY	0.077576	0	0	54.20
56.00	05600	RADIOISOTOPE	0.061223	158,787	9,721	56.00
57.00	05700	CT SCAN	0.030488	1,620,414	49,403	57.00
58.00	05800	MRI	0.057302	327,544	18,769	58.00
60.00	06000	LABORATORY	0.068293	3,078,872	210,265	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.201111	62,844	12,639	63.00
64.00	06400	INTRAVENOUS THERAPY	0.324948	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.265978	1,045,036	277,957	65.00
66.00	06600	PHYSICAL THERAPY	0.365859	241,046	88,189	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.256319	144,592	37,062	67.00
68.00	06800	SPEECH PATHOLOGY	0.373117	61,402	22,910	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061476	702,635	43,195	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.234885	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.712408	99,707	71,032	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.251403	404,839	101,778	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.177995	2,394,729	426,250	73.00
76.00	03950	DIABETES SERVICES	1.760795	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.376965	13,221	4,984	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - STREATOR	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	0.000000		0	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	0.000000		0	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	0.000000		0	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	0.000000		0	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	0.000000		0	88.09
90.00	09000	CLINIC	0.937074	0	0	90.00
91.00	09100	EMERGENCY	0.205480	1,725,901	354,638	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.529410	927,337	490,941	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		14,615,559	2,542,579	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		14,615,559		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0161 | Component CCN: 14-U161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		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	0.206369	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.110137	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.214694	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237104	4,476	1,061	54.00
54.10	03630	ULTRA SOUND	0.087454	2,327	204	54.10
54.20	03440	MAMMOGRAPHY	0.077576	0	0	54.20
56.00	05600	RADIOISOTOPE	0.061223	0	0	56.00
57.00	05700	CT SCAN	0.030488	0	0	57.00
58.00	05800	MRI	0.057302	4,276	245	58.00
60.00	06000	LABORATORY	0.068293	11,796	806	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.201111	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.324948	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.265978	5,832	1,551	65.00
66.00	06600	PHYSICAL THERAPY	0.365859	35,924	13,143	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.256319	36,833	9,441	67.00
68.00	06800	SPEECH PATHOLOGY	0.373117	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061476	377	23	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.234885	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.712408	2,734	1,948	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.251403	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.177995	22,877	4,072	73.00
76.00	03950	DIABETES SERVICES	1.760795	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.376965	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - STREATOR	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC - PONTIAC	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC - CULLOM	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC - DWIGHT	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC - FAIRBURY	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC - MINONK	0.000000		0	88.05
88.06	08806	RURAL HEALTH CLINIC - FLANAGAN	0.000000		0	88.06
88.07	08807	RURAL HEALTH CLINIC - REYNOLDS	0.000000		0	88.07
88.08	08808	RURAL HEALTH CLINIC - EL PASO	0.000000		0	88.08
88.09	08809	RURAL HEALTH CLINIC - CLINTON	0.000000		0	88.09
90.00	09000	CLINIC	0.937074	0	0	90.00
91.00	09100	EMERGENCY	0.205480	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.529410	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		127,452	32,494	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		127,452		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0161	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part A Date/Time Prepared: 2/21/2024 2:01 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
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 instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,750,795	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	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	Outlier payments for discharges occurring prior to October 1 (see instructions)	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	301	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
	Indirect Medical Education Adjustment		
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 new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
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 cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for 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).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
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 instructions)	0.00	8.21
9.00	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 minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	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.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
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 instructions)	0.00	25.00
26.00	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	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
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	20.27	32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.94	33.00
34.00	Disproportionate share adjustment (see instructions)	70,549	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E Part A Date/Time Prepared: 2/21/2024 2:01 pm

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	6,874,403,459	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000065867	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	0	452,796	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	0	452,796	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	452,796		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	5,274,441		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	6,187,081		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		6,187,081	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		355,374	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		27,740	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		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 intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		6,570,195	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,570,195	61.00
62.00	Deductibles billed to program beneficiaries		642,808	62.00
63.00	Coinsurance billed to program beneficiaries		0	63.00
64.00	Allowable bad debts (see instructions)		95,655	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		62,176	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		88,920	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		5,989,563	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		0	70.93
70.94	HRR adjustment amount (see instructions)		-15,769	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E Part A | Date/Time Prepared: 2/21/2024 2:01 pm

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2023	1,047,749	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,021,543	71.00
71.01	Sequestration adjustment (see instructions)		140,431	71.01
71.02	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, 72, and 73)		-31,033	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		111,716	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		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 Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	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 demonstration period)			
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) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/21/2024 2:01 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,750,795	0		4,750,795	4,750,795	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	301	0		301	301	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0594	0.0594	0.0594	0.0594		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	70,549	0	0	70,549	70,549	11.00
11.01	Uncompensated care payments	36.00	452,796	0	0	452,796	452,796	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	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 (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	6,187,081	0	0	6,187,081	6,187,081	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,187,081	0	0	6,187,081	6,187,081	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	355,374	0	0	355,374	355,374	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/21/2024 2:01 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	27,740	0	0	27,740	27,740	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	6,570,195	6,570,195	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
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	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	355,374	0	0	355,374	355,374	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.159470		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				1,047,749	1,047,749	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/21/2024 2:01 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,750,795		4,750,795	4,750,795	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	301		301	301	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0594	0.0594	0.0594		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	70,549	0	70,549	70,549	11.00
11.01	Uncompensated care payments	36.00	452,796	0	452,796	452,796	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	5,274,441	0	5,274,441	5,274,441	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	6,187,081	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,187,081	0	6,187,081	6,187,081	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	355,374	0	355,374	355,374	16.00
17.00	Special add-on payments for new technologies	54.00	27,740	0	27,740	27,740	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	6,570,195	6,570,195	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/21/2024 2:01 pm

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		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	0	355,374	355,374	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	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	0	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	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	355,374	0	355,374	355,374	26.00
		Wkst. E, Pt. A, line	(Amt. from 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	28.00
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	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-15,769	0	-15,769	-15,769	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0161	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/21/2024 2:01 pm
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	906	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,849,722	2.00
3.00	OPPS or REH payments	4,640,590	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	906	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	29,177	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	29,177	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	29,177	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	28,271	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	906	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	4,640,590	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	870,056	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,771,440	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	3,771,440	30.00
31.00	Primary payer payments	379	31.00
32.00	Subtotal (line 30 minus line 31)	3,771,061	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	81,456	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	52,946	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	79,117	36.00
37.00	Subtotal (see instructions)	3,824,007	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,824,007	40.00
40.01	Sequestration adjustment (see instructions)	76,480	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,843,395	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-95,868	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	9,450	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0161	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/21/2024 2:01 pm
	Title XVIII	Hospital	PPS

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part 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		6,912,145		3,811,095	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	06/07/2023	32,300	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		32,300	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,912,145		3,843,395	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		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 Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0161 | Component CCN: 14-U161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part 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		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		56,824		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		56,824		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0161	Period: From 10/01/2022 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/21/2024 2:01 pm
	Title XVIII	Hospital	PPS

			1.00
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	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 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
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		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-0161 | Component CCN: 14-U161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-2 | Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	61,784	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0	0	3.00
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 program (see instructions)		0.00	4.00
5.00	Program days	106	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		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	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 physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	61,784	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,800	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	57,984	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
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			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	56,824	0	20.00
20.01	Interim payments-PARHM			20.01
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, chapter 1, §115.2	0	0	23.00
	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 Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 14-0161	Period: From 10/01/2022 To 09/30/2023	Worksheet E-5 Date/Time Prepared: 2/21/2024 2:01 pm
	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 instructions)	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 instructions)	0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	0	4.00
5.00	The rate used to calculate the time value of money (see instructions)	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 instructions)	0	7.00

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 10/01/2022 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/21/2024 2:01 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	70,759,232	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	28,973,489	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-19,066,332	0	0	0	6.00
7.00	Inventory	882,553	0	0	0	7.00
8.00	Prepaid expenses	4,063	0	0	0	8.00
9.00	Other current assets	255,516	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	81,808,521	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	600,013	0	0	0	12.00
13.00	Land improvements	2,301,596	0	0	0	13.00
14.00	Accumulated depreciation	-2,208,963	0	0	0	14.00
15.00	Buildings	40,649,652	0	0	0	15.00
16.00	Accumulated depreciation	-27,185,456	0	0	0	16.00
17.00	Leasehold improvements	7,095	0	0	0	17.00
18.00	Accumulated depreciation	-7,095	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	24,773,230	0	0	0	23.00
24.00	Accumulated depreciation	-18,403,352	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	1,155,925	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	21,682,645	0	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	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,011,797	506,094	918,867	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	104,502,963	506,094	918,867	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	649,381	0	0	0	37.00
38.00	Salaries, wages, and fees payable	32,387	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	122,262	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,131,526	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,935,556	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	458,473	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	458,473	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,394,029	0	0	0	51.00
	CAPITAL 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, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	101,108,934	506,094	918,867	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	104,502,963	506,094	918,867	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/21/2024 2:01 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		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		-132,262		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 sheet (line 11 minus line 18)		101,108,934		506,094		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	922,908		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		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	-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 sheet (line 11 minus line 18)	918,867		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 2/21/2024 2:01 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	10,054,452		10,054,452	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	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	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	2,550,111		2,550,111	16.00
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	20.02
20.03	RURAL HEALTH CLINIC - DWIGHT	0	1,236,278	1,236,278	20.03
20.04	RURAL HEALTH CLINIC - FAIRBURY	0	1,433,997	1,433,997	20.04
20.05	RURAL HEALTH CLINIC - MINONK	0	1,217,170	1,217,170	20.05
20.06	RURAL HEALTH CLINIC - FLANAGAN	0	746,387	746,387	20.06
20.07	RURAL HEALTH CLINIC - REYNOLDS	0	3,246,945	3,246,945	20.07
20.08	RURAL HEALTH CLINIC - EL PASO	0	1,481,525	1,481,525	20.08
20.09	RURAL HEALTH CLINIC - CLINTON	0	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	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	5,639,872	5,639,872	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	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)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		75,353,133		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0161	Period: From 10/01/2022 To 09/30/2023	Worksheet G-3 Date/Time Prepared: 2/21/2024 2:01 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	263,331,882	1.00
2.00	Less contractual allowances and discounts on patients' accounts	184,463,900	2.00
3.00	Net patient revenues (line 1 minus line 2)	78,867,982	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	75,353,133	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,514,849	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	392,757	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	143,406	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	80	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	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	COVID-19 PHE Funding	0	24.50
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	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	127,304	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,387,723	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0161	Period: From 10/01/2022 To 09/30/2023	Worksheet L Parts I-III Date/Time Prepared: 2/21/2024 2:01 pm
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		355,374	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		11.65	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		355,374	12.00
			1.00	
	PART II - PAYMENT UNDER REASONABLE COST			
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
			1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Component CCN: 14-8624 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	631,735	0	631,735	8,487	640,222	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	981,228	0	981,228	13,183	994,411	3.00
4.00	Visiting Nurse	0	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	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	1,146,053	0	1,146,053	15,397	1,161,450	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,759,016	0	2,759,016	37,067	2,796,083	10.00
11.00	Physician Services Under Agreement	0	258,517	258,517	0	258,517	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	258,517	258,517	0	258,517	14.00
15.00	Medical Supplies	0	330,571	330,571	0	330,571	15.00
16.00	Transportation (Health Care Staff)	0	3,252	3,252	0	3,252	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	6,487	6,487	0	6,487	18.00
19.00	Other Health Care Costs	0	16,416	16,416	0	16,416	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	356,726	356,726	0	356,726	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,759,016	615,243	3,374,259	37,067	3,411,326	22.00
	COSTS OTHER THAN RHC/FQHC 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	Telehealth	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	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	93,983	93,983	0	93,983	29.00
30.00	Administrative Costs	491,545	788,040	1,279,585	-237,722	1,041,863	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	491,545	882,023	1,373,568	-237,722	1,135,846	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,250,561	1,497,266	4,747,827	-200,655	4,547,172	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Component CCN: 14-8624 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-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 Technician	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	0	16,416		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	356,726		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-24,865	3,386,461		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	24,865	24,865		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 through 27)	24,865	24,865		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	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 30)	209,321	1,345,167		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	209,321	4,756,493		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Component CCN: 14-8654 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	653,016	0	653,016	11,007	664,023	1.00
2.00	Physician Assistant	1,641	0	1,641	28	1,669	2.00
3.00	Nurse Practitioner	241,281	0	241,281	4,067	245,348	3.00
4.00	Visiting Nurse	0	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	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	538,873	0	538,873	9,083	547,956	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,434,811	0	1,434,811	24,185	1,458,996	10.00
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	142,574	142,574	0	142,574	15.00
16.00	Transportation (Health Care Staff)	0	10,046	10,046	0	10,046	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	4,437	4,437	0	4,437	18.00
19.00	Other Health Care Costs	0	28,613	28,613	0	28,613	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	185,670	185,670	0	185,670	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,434,811	185,670	1,620,481	24,185	1,644,666	22.00
	COSTS OTHER THAN RHC/FQHC 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	Telehealth	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	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	8,567	8,567	0	8,567	29.00
30.00	Administrative Costs	433,646	361,851	795,497	-137,624	657,873	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	433,646	370,418	804,064	-137,624	666,440	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,868,457	556,088	2,424,545	-113,439	2,311,106	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1

Component CCN: 14-8654 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-8,212	655,811		1.00
2.00	Physician Assistant	0	1,669		2.00
3.00	Nurse Practitioner	-732	244,616		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 Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	-2,272	545,684		9.00
10.00	Subtotal (sum of lines 1 through 9)	-11,216	1,447,780		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	142,574		15.00
16.00	Transportation (Health Care Staff)	0	10,046		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	4,437		18.00
19.00	Other Health Care Costs	0	28,613		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	185,670		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-11,216	1,633,450		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	11,216	11,216		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 through 27)	11,216	11,216		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	8,567		29.00
30.00	Administrative Costs	103,505	761,378		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	103,505	769,945		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	103,505	2,414,611		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Component CCN: 14-8640 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	63,014	0	63,014	1,110	64,124	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	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	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	68,461	0	68,461	1,206	69,667	9.00
10.00	Subtotal (sum of lines 1 through 9)	131,475	0	131,475	2,316	133,791	10.00
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	24,683	24,683	0	24,683	15.00
16.00	Transportation (Health Care Staff)	0	583	583	0	583	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	13,727	13,727	0	13,727	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	38,993	38,993	0	38,993	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	131,475	38,993	170,468	2,316	172,784	22.00
	COSTS OTHER THAN RHC/FQHC 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	Telehealth	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	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	4,100	4,100	0	4,100	29.00
30.00	Administrative Costs	72,232	60,844	133,076	-17,820	115,256	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	72,232	64,944	137,176	-17,820	119,356	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	203,707	103,937	307,644	-15,504	292,140	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1

Component CCN: 14-8640 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	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 Technician	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		18.00
19.00	Other Health Care Costs	0	13,727		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	38,993		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-3,749	169,035		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	3,749	3,749		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 through 27)	3,749	3,749		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	4,100		29.00
30.00	Administrative Costs	0	115,256		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	119,356		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	292,140		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Component CCN: 14-8641 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC IV | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	129,990	0	129,990	2,239	132,229	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	39,462	0	39,462	680	40,142	3.00
4.00	Visiting Nurse	0	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	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	121,605	0	121,605	2,095	123,700	9.00
10.00	Subtotal (sum of lines 1 through 9)	291,057	0	291,057	5,014	296,071	10.00
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	29,596	29,596	0	29,596	15.00
16.00	Transportation (Health Care Staff)	0	3,718	3,718	0	3,718	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	17,649	17,649	0	17,649	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	52,222	52,222	0	52,222	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	291,057	52,222	343,279	5,014	348,293	22.00
	COSTS OTHER THAN RHC/FQHC 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	Telehealth	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	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	131,145	131,145	0	131,145	29.00
30.00	Administrative Costs	69,365	112,751	182,116	-32,541	149,575	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	69,365	243,896	313,261	-32,541	280,720	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	360,422	296,118	656,540	-27,527	629,013	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Component CCN: 14-8641 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-971	131,258		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-58	40,084		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 Technician	0	0		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	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	29,596		15.00
16.00	Transportation (Health Care Staff)	0	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)	0	52,222		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-1,247	347,046		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	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 through 27)	1,247	1,247		28.00
	FACILITY OVERHEAD				
29.00	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)	30,303	311,023		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	30,303	659,316		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Component CCN: 14-8643 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC V | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	119,126	0	119,126	2,062	121,188	1.00
2.00	Physician Assistant	9,149	0	9,149	158	9,307	2.00
3.00	Nurse Practitioner	72,831	0	72,831	1,261	74,092	3.00
4.00	Visiting Nurse	0	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	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	177,557	0	177,557	3,074	180,631	9.00
10.00	Subtotal (sum of lines 1 through 9)	378,663	0	378,663	6,555	385,218	10.00
11.00	Physician Services Under Agreement	0	30,393	30,393	0	30,393	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	30,393	30,393	0	30,393	14.00
15.00	Medical Supplies	0	65,816	65,816	0	65,816	15.00
16.00	Transportation (Health Care Staff)	0	1,953	1,953	0	1,953	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	956	956	0	956	18.00
19.00	Other Health Care Costs	0	22,497	22,497	0	22,497	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	91,222	91,222	0	91,222	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	378,663	121,615	500,278	6,555	506,833	22.00
	COSTS OTHER THAN RHC/FQHC 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	Telehealth	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	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	15,237	15,237	0	15,237	29.00
30.00	Administrative Costs	133,046	187,642	320,688	-34,619	286,069	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	133,046	202,879	335,925	-34,619	301,306	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	511,709	324,494	836,203	-28,064	808,139	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Component CCN: 14-8643 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC V | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-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	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 Technician	0	0		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	382,861		10.00
11.00	Physician Services Under Agreement	0	30,393		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	30,393		14.00
15.00	Medical Supplies	0	65,816		15.00
16.00	Transportation (Health Care Staff)	0	1,953		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	956		18.00
19.00	Other Health Care Costs	0	22,497		19.00
20.00	Allowable GME Costs				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 lines 10, 14, and 21)	-2,357	504,476		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	2,357	2,357		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 through 27)	2,357	2,357		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	15,237		29.00
30.00	Administrative Costs	33,723	319,792		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	33,723	335,029		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	33,723	841,862		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Component CCN: 14-8653 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC VI | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	122,813	0	122,813	2,174	124,987	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	63,732	0	63,732	1,128	64,860	3.00
4.00	Visiting Nurse	0	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	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	80,950	0	80,950	1,433	82,383	9.00
10.00	Subtotal (sum of lines 1 through 9)	267,495	0	267,495	4,735	272,230	10.00
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	51,904	51,904	0	51,904	15.00
16.00	Transportation (Health Care Staff)	0	1,428	1,428	0	1,428	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	1,136	1,136	0	1,136	18.00
19.00	Other Health Care Costs	0	16,780	16,780	0	16,780	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	71,248	71,248	0	71,248	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	267,495	71,248	338,743	4,735	343,478	22.00
	COSTS OTHER THAN RHC/FQHC 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	Telehealth	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	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	8,346	8,346	0	8,346	29.00
30.00	Administrative Costs	84,344	94,476	178,820	-28,899	149,921	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	84,344	102,822	187,166	-28,899	158,267	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	351,839	174,070	525,909	-24,164	501,745	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1

Component CCN: 14-8653 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC VI | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-2,339	122,648		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-322	64,538		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 Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	-837	81,546		9.00
10.00	Subtotal (sum of lines 1 through 9)	-3,498	268,732		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	51,904		15.00
16.00	Transportation (Health 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 Health Care Costs	0	16,780		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	71,248		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-3,498	339,980		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	3,498	3,498		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 through 27)	3,498	3,498		28.00
	FACILITY OVERHEAD				
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)	0	158,267		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	501,745		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Component CCN: 14-8644 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC VII | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	51,108	0	51,108	917	52,025	1.00
2.00	Physician Assistant	64,444	0	64,444	1,157	65,601	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	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	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	64,598	0	64,598	1,160	65,758	9.00
10.00	Subtotal (sum of lines 1 through 9)	180,150	0	180,150	3,234	183,384	10.00
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	19,798	19,798	0	19,798	15.00
16.00	Transportation (Health Care Staff)	0	1,807	1,807	0	1,807	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	332	332	0	332	18.00
19.00	Other Health Care Costs	0	7,300	7,300	0	7,300	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29,237	29,237	0	29,237	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	180,150	29,237	209,387	3,234	212,621	22.00
	COSTS OTHER THAN RHC/FQHC 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	Telehealth	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	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	15,321	15,321	0	15,321	29.00
30.00	Administrative Costs	79,795	93,833	173,628	-22,928	150,700	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	79,795	109,154	188,949	-22,928	166,021	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	259,945	138,391	398,336	-19,694	378,642	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1

Component CCN: 14-8644 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC VII | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-385	51,640		1.00
2.00	Physician Assistant	-372	65,229		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 Technician	0	0		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	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	19,798		15.00
16.00	Transportation (Health Care Staff)	0	1,807		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	332		18.00
19.00	Other Health Care Costs	0	7,300		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29,237		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-1,107	211,514		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	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 through 27)	1,107	1,107		28.00
	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 30)	0	166,021		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	378,642		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Component CCN: 14-8650 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC VIII | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	404,111	0	404,111	7,523	411,634	1.00
2.00	Physician Assistant	22,419	0	22,419	417	22,836	2.00
3.00	Nurse Practitioner	189,441	0	189,441	3,527	192,968	3.00
4.00	Visiting Nurse	0	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	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	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	787,771	14,665	802,436	10.00
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 lines 10, 14, and 21)	787,771	138,266	926,037	14,665	940,702	22.00
	COSTS OTHER THAN RHC/FQHC 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	Telehealth	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	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	121,913	121,913	0	121,913	29.00
30.00	Administrative Costs	230,281	265,948	496,229	-95,266	400,963	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	230,281	387,861	618,142	-95,266	522,876	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,018,052	526,127	1,544,179	-80,601	1,463,578	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Component CCN: 14-8650 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC VIII | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-653	410,981		1.00
2.00	Physician Assistant	-83	22,753		2.00
3.00	Nurse Practitioner	-1,236	191,732		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 Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	-928	174,070		9.00
10.00	Subtotal (sum of lines 1 through 9)	-2,900	799,536		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	86,507		15.00
16.00	Transportation (Health Care Staff)	0	538		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	49,962		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	138,266		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-2,900	937,802		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	2,900	2,900		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 through 27)	2,900	2,900		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	121,913		29.00
30.00	Administrative Costs	-9,561	391,402		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-9,561	513,315		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-9,561	1,454,017		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Component CCN: 14-8642 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC IX | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	118,597	0	118,597	2,082	120,679	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	120,031	0	120,031	2,108	122,139	3.00
4.00	Visiting Nurse	0	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	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	146,399	0	146,399	2,571	148,970	9.00
10.00	Subtotal (sum of lines 1 through 9)	385,027	0	385,027	6,761	391,788	10.00
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	1,123	1,123	0	1,123	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	1,123	1,123	0	1,123	14.00
15.00	Medical Supplies	0	55,144	55,144	0	55,144	15.00
16.00	Transportation (Health Care Staff)	0	5,656	5,656	0	5,656	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	1,017	1,017	0	1,017	18.00
19.00	Other Health Care Costs	0	34,201	34,201	0	34,201	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	96,018	96,018	0	96,018	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	385,027	97,141	482,168	6,761	488,929	22.00
	COSTS OTHER THAN RHC/FQHC 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	Telehealth	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	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	-32,445	-32,445	0	-32,445	29.00
30.00	Administrative Costs	152,998	131,234	284,232	-37,941	246,291	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	152,998	98,789	251,787	-37,941	213,846	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	538,025	195,930	733,955	-31,180	702,775	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1

Component CCN: 14-8642 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC IX | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-3,149	117,530		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-428	121,711		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 Technician	0	0		8.00
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		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	1,123		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	1,123		14.00
15.00	Medical Supplies	0	55,144		15.00
16.00	Transportation (Health Care Staff)	0	5,656		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	1,017		18.00
19.00	Other Health Care Costs	0	34,201		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	96,018		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-4,666	484,263		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	4,666	4,666		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 through 27)	4,666	4,666		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	-32,445		29.00
30.00	Administrative Costs	0	246,291		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	213,846		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	702,775		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Component CCN: 14-8639 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC X | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	461,884	0	461,884	8,015	469,899	1.00
2.00	Physician Assistant	55,063	0	55,063	956	56,019	2.00
3.00	Nurse Practitioner	69,697	0	69,697	1,209	70,906	3.00
4.00	Visiting Nurse	0	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	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	125,436	0	125,436	2,177	127,613	9.00
10.00	Subtotal (sum of lines 1 through 9)	712,080	0	712,080	12,357	724,437	10.00
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	94,069	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	17.00
18.00	Professional Liability Insurance	0	2,506	2,506	0	2,506	18.00
19.00	Other Health Care Costs	0	59,319	59,319	0	59,319	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	159,117	159,117	0	159,117	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	712,080	159,117	871,197	12,357	883,554	22.00
	COSTS OTHER THAN RHC/FQHC 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	Telehealth	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	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	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)	207,156	249,630	456,786	-77,966	378,820	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	919,236	408,747	1,327,983	-65,609	1,262,374	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0161 | Component CCN: 14-8639 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 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	Physician	-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 Technician	0	0		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		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		17.00
18.00	Professional Liability Insurance	0	2,506		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 lines 10, 14, and 21)	-7,831	875,723		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	7,831	7,831		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 through 27)	7,831	7,831		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	12,571		29.00
30.00	Administrative Costs	0	366,249		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	378,820		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,262,374		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0161 | Component CCN: 14-8624 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.85	6,614	4,200	7,770		1.00
2.00	Physician Assistant	0.03	86	2,100	63		2.00
3.00	Nurse Practitioner	7.22	21,284	2,100	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 only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	9.10	27,984			27,984	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					3,386,461	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					24,865	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,411,326	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.992711	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,345,167	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,879,358	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,224,525	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					4,224,525	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					4,193,732	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					7,580,193	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0161 | Component CCN: 14-8654 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.65	7,177	4,200	6,930		1.00
2.00	Physician Assistant	0.01	102	2,100	21		2.00
3.00	Nurse Practitioner	1.35	6,889	2,100	2,835		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.01	14,168		9,786	14,168	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)	3.01	14,168			14,168	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,633,450	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					11,216	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,644,666	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.993180	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					769,945	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,415,289	15.00
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
18.00	Enter the amount from line 16					2,185,234	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,170,331	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,803,781	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0161 | Component CCN: 14-8640 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	0	0		1.00
2.00	Physician Assistant	0.44	1,307	2,100	924		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.44	1,307		924	1,307	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)	0.44	1,307			1,307	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					169,035	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					3,749	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					172,784	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.978302	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					119,356	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					193,300	15.00
16.00	Total overhead (sum of lines 14 and 15)					312,656	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					312,656	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					305,872	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					474,907	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0161 | Component CCN: 14-8641 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.53	1,970	4,200	2,226		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.30	705	2,100	630		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
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					347,046	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,247	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					348,293	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.996420	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					311,023	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					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/FQHC services (line 13 x line 18)					617,298	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					964,344	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0161 | Component CCN: 14-8643 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC V | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.33	1,077	4,200	1,386		1.00
2.00	Physician Assistant	0.08	328	2,100	168		2.00
3.00	Nurse Practitioner	0.54	1,770	2,100	1,134		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.95	3,175		2,688	3,175	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)	0.95	3,175			3,175	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					504,476	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					2,357	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					506,833	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.995350	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					335,029	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					594,944	15.00
16.00	Total overhead (sum of lines 14 and 15)					929,973	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					929,973	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					925,649	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,430,125	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0161 | Component CCN: 14-8653 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC VI | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.36	1,209	4,200	1,512		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.42	1,438	2,100	882		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.78	2,647		2,394	2,647	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)	0.78	2,647			2,647	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					339,980	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					3,498	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					343,478	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.989816	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					158,267	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					296,478	15.00
16.00	Total overhead (sum of lines 14 and 15)					454,745	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					454,745	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					450,114	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					790,094	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0161 | Component CCN: 14-8644 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC VII | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.18	666	4,200	756		1.00
2.00	Physician Assistant	0.38	1,120	2,100	798		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.56	1,786		1,554	1,786	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)	0.56	1,786			1,786	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC 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)					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
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					647,983	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0161 | Component CCN: 14-8650 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC VIII | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.00	3,422	4,200	4,200		1.00
2.00	Physician Assistant	0.26	347	2,100	546		2.00
3.00	Nurse Practitioner	1.26	3,501	2,100	2,646		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.52	7,270		7,392	7,392	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)	2.52	7,270			7,392	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					937,802	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					2,900	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					940,702	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.996917	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					513,315	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					699,135	15.00
16.00	Total overhead (sum of lines 14 and 15)					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/FQHC services (line 13 x line 18)					1,208,712	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,146,514	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0161 | Component CCN: 14-8642 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC IX | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.34	1,226	4,200	1,428		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.80	1,732	2,100	1,680		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.14	2,958		3,108	3,108	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)	1.14	2,958			3,108	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					484,263	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					4,666	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					488,929	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.990457	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					213,846	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					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/FQHC services (line 13 x line 18)					659,137	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,143,400	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0161 | Component CCN: 14-8639 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/21/2024 2:01 pm

RHC X | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.94	4,387	4,200	3,948		1.00
2.00	Physician Assistant	0.39	1,456	2,100	819		2.00
3.00	Nurse Practitioner	0.53	1,426	2,100	1,113		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			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)	1.86	7,269			7,269	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					875,723	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					7,831	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					883,554	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.991137	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					378,820	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					725,313	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,104,133	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,104,133	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,094,347	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,970,070	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0161 Component CCN: 14-8624	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/21/2024 2:01 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			7,580,193	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			483,497	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			7,096,696	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			27,984	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			27,984	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			253.60	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 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
	CALCULATION OF SETTLEMENT				
10.00	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 9 x line 10)	315,975	952,083		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,268,058		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,670,207		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		15,097		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		11,462		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		859,259		16.04
16.05	Total program cost (see instructions)	0	870,721		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		182,522		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		294,349		19.00
20.00	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		21.00
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	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		1,024,077		26.00
26.01	Sequestration adjustment (see instructions)		20,482		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		719,243		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		284,352		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0161 Component CCN: 14-8654	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/21/2024 2:01 pm
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,803,781	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			148,130	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			3,655,651	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			14,168	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			14,168	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			258.02	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 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
	CALCULATION OF SETTLEMENT				
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 9 x line 10)	0	292,950		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	292,950		16.00
16.01	Total program charges (see instructions)(from contractor's records)		669,381		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		27,413		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		11,997		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		198,802		16.04
16.05	Total program cost (see instructions)	0	210,799		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		32,450		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		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		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		232,101		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	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		232,101		26.00
26.01	Sequestration adjustment (see instructions)		4,642		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		202,336		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		25,123		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0161 Component CCN: 14-8640	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/21/2024 2:01 pm
	Title XVIII	RHC III	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			474,907	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			24,539	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			450,368	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,307	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			1,307	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			344.58	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 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
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	164		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	20,664		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	20,664		16.00
16.01	Total program charges (see instructions)(from contractor's records)		60,129		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,422		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,520		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		12,446		16.04
16.05	Total program cost (see instructions)	0	13,966		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		3,587		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		10,424		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		13,966		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,642		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		17,608		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	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		17,608		26.00
26.01	Sequestration adjustment (see instructions)		352		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		13,182		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		4,074		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0161 Component CCN: 14-8641	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/21/2024 2:01 pm
	Title XVIII	RHC IV	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			964,344	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			34,392	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			929,952	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,856	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			2,856	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			325.61	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 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
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	372		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	46,872		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	46,872		16.00
16.01	Total program charges (see instructions)(from contractor's records)		104,088		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,122		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,856		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		30,982		16.04
16.05	Total program cost (see instructions)	0	32,838		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,288		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		18,736		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		32,838		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,819		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		37,657		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	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		37,657		26.00
26.01	Sequestration adjustment (see instructions)		753		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		31,541		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		5,363		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0161 Component CCN: 14-8643	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/21/2024 2:01 pm
	Title XVIII	RHC V	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,430,125	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			81,593	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,348,532	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,175	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3,175	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			424.73	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 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
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	545		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	68,670		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	68,670		16.00
16.01	Total program charges (see instructions)(from contractor's records)		164,023		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,500		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,884		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		46,477		16.04
16.05	Total program cost (see instructions)	0	48,361		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,690		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		30,167		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		48,361		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		13,494		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		61,855		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	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		61,855		26.00
26.01	Sequestration adjustment (see instructions)		1,237		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		46,511		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		14,107		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0161 Component CCN: 14-8653	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/21/2024 2:01 pm
	Title XVIII	RHC VI	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			790,094	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			44,227	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			745,867	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,647	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			2,647	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			281.78	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 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
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	462		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	58,212		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	58,212		16.00
16.01	Total program charges (see instructions)(from contractor's records)		127,694		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,171		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,357		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		35,059		16.04
16.05	Total program cost (see instructions)	0	37,416		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		12,031		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		22,098		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		37,416		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		9,716		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		47,132		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	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		47,132		26.00
26.01	Sequestration adjustment (see instructions)		943		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		35,953		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		10,236		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0161 Component CCN: 14-8644	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/21/2024 2:01 pm
	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 Wkst. M-2, line 20)			647,983	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			25,357	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			622,626	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,786	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			1,786	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			348.61	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 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
	CALCULATION OF SETTLEMENT				
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 contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	56,322		16.00
16.01	Total program charges (see instructions)(from contractor's records)		127,671		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		9,662		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,262		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		35,958		16.04
16.05	Total program cost (see instructions)	0	40,220		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		7,113		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		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		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		52,313		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	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		52,313		26.00
26.01	Sequestration adjustment (see instructions)		1,046		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		38,443		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		12,824		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0161 Component CCN: 14-8650	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/21/2024 2:01 pm
	Title XVIII	RHC VIII	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,146,514	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			85,959	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,060,555	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,392	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			7,392	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			278.75	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 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
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,128		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	142,128		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	142,128		16.00
16.01	Total program charges (see instructions)(from contractor's records)		309,973		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		9,076		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,162		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		97,700		16.04
16.05	Total program cost (see instructions)	0	101,862		16.05
17.00	Primary payer amounts		340		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		15,841		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		57,011		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		101,522		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		18,931		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		120,453		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	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		120,453		26.00
26.01	Sequestration adjustment (see instructions)		2,409		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		98,211		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		19,833		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0161 Component CCN: 14-8642	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/21/2024 2:01 pm
	Title XVIII	RHC IX	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
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 Wkst. M-4, line 15)			56,381	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,087,019	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,108	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3,108	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			349.75	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 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
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	547		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	68,922		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	68,922		16.00
16.01	Total program charges (see instructions)(from contractor's records)		169,254		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,104		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,671		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		48,102		16.04
16.05	Total program cost (see instructions)	0	49,773		16.05
17.00	Primary payer amounts		316		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		7,123		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		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		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	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		70,542		26.00
26.01	Sequestration adjustment (see instructions)		1,411		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		48,226		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		20,905		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0161 Component CCN: 14-8639	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/21/2024 2:01 pm
	Title XVIII	RHC X	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,970,070	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			87,586	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,882,484	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,269	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			7,269	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			258.97	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 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
	CALCULATION OF SETTLEMENT				
10.00	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 9 x line 10)	0	157,878		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	157,878		16.00
16.01	Total program charges (see instructions)(from contractor's records)		359,626		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,415		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		621		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		108,798		16.04
16.05	Total program cost (see instructions)	0	109,419		16.05
17.00	Primary payer amounts		101		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		21,259		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		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		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		130,454		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	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		130,454		26.00
26.01	Sequestration adjustment (see instructions)		2,609		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		105,646		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		22,199		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0161 | Component CCN: 14-8624 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,771,218	2,771,218	2,771,218	2,771,218	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002646	0.008166	0.000411	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	7,333	22,630	1,139	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	135,434	49,468	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	142,767	72,098	1,139	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	3,386,461	3,386,461	3,386,461	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	4,193,732	4,193,732	4,193,732	4,193,732	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.042158	0.021290	0.000336	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	176,799	89,285	1,409	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	319,566	161,383	2,548	0	10.00
11.00	Total number of injections/infusions (from your records)	650	2,006	101	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	491.64	80.45	25.23	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	190	731	45	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)	93,412	58,809	1,135	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
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)		483,497	15.00
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)		153,356	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0161 | Component CCN: 14-8654 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,447,780	1,447,780	1,447,780	1,447,780	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001264	0.002642	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,830	3,825	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	46,464	11,492	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	48,294	15,317	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,633,450	1,633,450	1,633,450	1,633,450	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,170,331	2,170,331	2,170,331	2,170,331	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.029566	0.009377	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	64,168	20,351	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	112,462	35,668	0	0	10.00
11.00	Total number of injections/infusions (from your records)	223	466	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	504.31	76.54	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	26	107	0	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)	13,112	8,190	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
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)		148,130	15.00
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)		21,302	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0161 | Component CCN: 14-8640 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | RHC III | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	130,042	130,042	130,042	130,042	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000907	0.003460	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	118	450	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	5,626	2,540	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	5,744	2,990	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	169,035	169,035	169,035	169,035	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	305,872	305,872	305,872	305,872	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.033981	0.017689	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	10,394	5,411	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	16,138	8,401	0	0	10.00
11.00	Total number of injections/infusions (from your records)	27	103	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	597.70	81.56	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	30	0	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)	1,195	2,447	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
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)		24,539	15.00
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)		3,642	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0161 | Component CCN: 14-8641 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | RHC IV | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	294,824	294,824	294,824	294,824	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001401	0.001722	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	413	508	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	10,001	1,455	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	10,414	1,963	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	347,046	347,046	347,046	347,046	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	617,298	617,298	617,298	617,298	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.030008	0.005656	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	18,524	3,491	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	28,938	5,454	0	0	10.00
11.00	Total number of injections/infusions (from your records)	48	59	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	602.88	92.44	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	6	13	0	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)	3,617	1,202	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
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)		34,392	15.00
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)		4,819	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0161 | Component CCN: 14-8643 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | RHC V | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY 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	382,861	382,861	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001917	0.002990	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	734	1,145	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	22,711	4,192	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	23,445	5,337	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	504,476	504,476	504,476	504,476	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	925,649	925,649	925,649	925,649	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.046474	0.010579	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	43,019	9,792	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	66,464	15,129	0	0	10.00
11.00	Total number of injections/infusions (from your records)	109	170	21	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	609.76	88.99	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	16	42	4	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)	9,756	3,738	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
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)		81,593	15.00
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)		13,494	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0161 | Component CCN: 14-8653 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | RHC VI | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	268,732	268,732	268,732	268,732	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001448	0.005219	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	389	1,403	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	12,085	5,154	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	12,474	6,557	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	339,980	339,980	339,980	339,980	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	450,114	450,114	450,114	450,114	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.036690	0.019286	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	16,515	8,681	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	28,989	15,238	0	0	10.00
11.00	Total number of injections/infusions (from your records)	58	209	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	499.81	72.91	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	12	51	0	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)	5,998	3,718	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
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)		44,227	15.00
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)		9,716	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0161 | Component CCN: 14-8644 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | RHC VII | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	182,277	182,277	182,277	182,277	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000700	0.003066	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	128	559	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	5,001	2,589	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	5,129	3,148	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	211,514	211,514	211,514	211,514	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	436,469	436,469	436,469	436,469	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.024249	0.014883	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	10,584	6,496	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	15,713	9,644	0	0	10.00
11.00	Total number of injections/infusions (from your records)	24	105	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	654.71	91.85	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	13	39	0	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)	8,511	3,582	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
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)		25,357	15.00
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)		12,093	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0161 | Component CCN: 14-8650 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | RHC VIII | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY 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	799,536	799,536	799,536	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001188	0.003788	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	950	3,029	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	24,378	9,198	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	25,328	12,227	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	937,802	937,802	937,802	937,802	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,208,712	1,208,712	1,208,712	1,208,712	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.027008	0.013038	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	32,645	15,759	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	57,973	27,986	0	0	10.00
11.00	Total number of injections/infusions (from your records)	117	373	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	495.50	75.03	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	27	74	0	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)	13,379	5,552	0	0	14.00

		COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00
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)	85,959	15.00
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)	18,931	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0161 | Component CCN: 14-8642 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | RHC IX | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY 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	387,122	387,122	387,122	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001535	0.002473	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	594	957	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	18,752	3,576	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	19,346	4,533	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	484,263	484,263	484,263	484,263	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	659,137	659,137	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	0.009361	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	26,332	6,170	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	45,678	10,703	0	0	10.00
11.00	Total number of injections/infusions (from your records)	90	145	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	507.53	73.81	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	35	45	0	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	3,321	0	0	14.00

		COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00
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)	56,381	15.00
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)	21,085	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0161 | Component CCN: 14-8639 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/21/2024 2:01 pm

Title XVIII | RHC X | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	716,606	716,606	716,606	716,606	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001645	0.005298	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,179	3,797	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	24,586	9,371	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	25,765	13,168	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	875,723	875,723	875,723	875,723	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,094,347	1,094,347	1,094,347	1,094,347	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.029421	0.015037	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	32,197	16,456	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	57,962	29,624	0	0	10.00
11.00	Total number of injections/infusions (from your records)	118	380	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	491.20	77.96	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	27	101	0	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)	13,262	7,874	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
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)		87,586	15.00
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)		21,136	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0161 Component CCN: 14-8624	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/21/2024 2:01 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		719,243	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			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			
3.50			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 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		719,243	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		284,352	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,003,595	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0161 Component CCN: 14-8654	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/21/2024 2:01 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		202,336	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			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			
3.50			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 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		202,336	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		25,123	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		227,459	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0161 Component CCN: 14-8640	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/21/2024 2:01 pm
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		13,182	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			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			
3.50			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 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		13,182	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		4,074	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		17,256	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0161 Component CCN: 14-8641	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/21/2024 2:01 pm
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		31,541	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			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			
3.50			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 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		31,541	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		5,363	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		36,904	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0161 Component CCN: 14-8643	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/21/2024 2:01 pm
		RHC V	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		46,511	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			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			
3.50			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 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		46,511	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		14,107	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		60,618	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0161 Component CCN: 14-8653	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/21/2024 2:01 pm
		RHC VI	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		35,953	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			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			
3.50			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 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		35,953	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		10,236	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		46,189	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0161 Component CCN: 14-8644	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/21/2024 2:01 pm
		RHC VII	Cost

		Part B		
		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 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			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			
3.50			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 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		38,443	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		12,824	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		51,267	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0161 Component CCN: 14-8650	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/21/2024 2:01 pm
		RHC VIII	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		98,211	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			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			
3.50			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 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		98,211	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		19,833	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		118,044	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0161 Component CCN: 14-8642	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/21/2024 2:01 pm
		RHC IX	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		48,226	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			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			
3.50			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 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		48,226	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		20,905	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		69,131	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0161 Component CCN: 14-8639	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/21/2024 2:01 pm
		RHC X	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	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 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			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			
3.50			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 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		105,646	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		22,199	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		127,845	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00