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: 14-1352	Period: From 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/28/2024 8:49 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/28/2024 Time: 8:49 am
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 JACKSONVILLE MEMORIAL HOSPITAL (14-1352) 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	Paul Eddington		Y	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	Paul Eddington			2
3	Signatory Title	DIRECTOR, STRATEGIC FINANCE			3
4	Date	(Dated when report is electronica			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	602,364	-2,052,809	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
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	TOTAL	0	602,364	-2,052,809	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2024 8:49 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1600 WEST WALNUT	PO Box:			1.00
2.00	City: JACKSONVILLE	State: IL	Zip Code: 62650	County: MORGAN	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	JACKSONVILLE MEMORIAL HOSPITAL	141352	99914	1	04/26/2022	N	O	N	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									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	JACKSONVILLE MEMORIAL HOSPITAL SNF	145951	99914		10/31/1997	N	P	N	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									15.00
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)	2		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.	N	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)	N	N		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
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.	1	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2024 8:49 am

		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.	0	0	0	0	0	0	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.	0		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.			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)	N	N	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
	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.				58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1352	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part I Date/Time Prepared: 2/28/2024 8:49 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2024 8:49 am

		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	
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

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				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)	N	N	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

		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

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		V	XIX	
		1.00	2.00	
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?	Y		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)	Y		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)	N		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.	Y	Y	N	Y	109.00

			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.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2024 8:49 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	733,196	0	0	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.	N	N	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	Y	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
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	14H058	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: MEMORIAL HEALTH SYSTEMS	Contractor's Name: MEMORIAL HEALTH SYSTEMS	Contractor's Number: 00131	141.00
142.00	Street: 701 NORTH FIRST STREET	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62781	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.	Y		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2024 8:49 am

					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)		0.00	169.00
		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: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/28/2024 8:49 am

		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		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.	Y			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.	N	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)	Y	12/04/2023	Y	12/04/2023	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)	N		N		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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II Date/Time Prepared: 2/28/2024 8:49 am

		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				N	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.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	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.				N	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				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	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.				N	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.				N	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.				Y	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.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		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.			Y		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.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		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.	KEVIN		WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446		KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1352	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part II Date/Time Prepared: 2/28/2024 8:49 am

		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.	SIGNING DIRECTOR		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: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/28/2024 8:49 am

	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	21	7,665	176,448.00	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)		21	7,665	176,448.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	25,488.00	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)		25	9,125	201,936.00	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	44.00	15	5,475		0	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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		40				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: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/28/2024 8:49 am

	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)	3,158	171	7,286			1.00
2.00	HMO and other (see instructions)	1,291	1,164				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	0	0	0			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)	3,158	171	7,286			7.00
8.00	INTENSIVE CARE UNIT	347	40	1,046			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		78	700			13.00
14.00	Total (see instructions)	3,505	289	9,032	0.00	552.66	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	1,863	0	2,969	0.00	17.68	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						26.00
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	570.34	27.00
28.00	Observation Bed Days		455	2,202			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			101			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	90	187			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: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/28/2024 8:49 am

	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	905	175	2,277	1.00
2.00	HMO and other (see instructions)			295	244		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	905	175	2,277	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	0.00					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						26.00
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 UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1352	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/28/2024 8:49 am

		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)	0.220135	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,840,209	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?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	8,365,506	5.00
6.00	Medicaid charges	92,129,830	6.00
7.00	Medicaid cost (line 1 times line 6)	20,281,000	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	8,075,285	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	77,628	9.00
10.00	Stand-alone CHIP charges	207,809	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	45,746	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)	8,075,285	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)	1,669,455	658,505	2,327,960	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	367,505	658,505	1,026,010	21.00
22.00	Payments received from patients for amounts previously written off as charity care	81,375	10,010	91,385	22.00
23.00	Cost of charity care (see instructions)	286,130	648,495	934,625	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)	6,674,142	26.00
27.00	Medicare reimbursable bad debts (see instructions)	1,474,100	27.00
27.01	Medicare allowable bad debts (see instructions)	2,267,847	27.01
28.00	Non-Medicare bad debt amount (see instructions)	4,406,295	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,763,727	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,698,352	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,773,637	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1352	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/28/2024 8:49 am

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)		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)				20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)				21.00
22.00	Payments received from patients for amounts previously written off as charity care				22.00
23.00	Cost of charity care (see instructions)				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?		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		25.00
25.01	Charges for insured patients' liability (see instructions)		25.01
26.00	Bad debt amount (see instructions)		26.00
27.00	Medicare reimbursable bad debts (see instructions)		27.00
27.01	Medicare allowable bad debts (see instructions)		27.01
28.00	Non-Medicare bad debt amount (see instructions)		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/28/2024 8:49 am

		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		2,209,839	2,209,839	405,759	2,615,598	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,109,515	3,109,515	29,767	3,139,282	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-22,247	12,244,902	12,222,655	0	12,222,655	4.00
5.01	00540	NONPATIENT TELEPHONES	0	158,360	158,360	0	158,360	5.01
5.02	00550	DATA PROCESSING	1,040,734	3,279,655	4,320,389	0	4,320,389	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,446	207,211	208,657	0	208,657	5.03
5.04	00570	ADMITTING	747,452	41,168	788,620	0	788,620	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	652,847	1,100,919	1,753,766	0	1,753,766	5.05
5.06	00590	OTHER ADMIN & GENERAL	2,955,711	20,010,264	22,965,975	-222,382	22,743,593	5.06
7.00	00700	OPERATION OF PLANT	1,973,114	3,722,045	5,695,159	0	5,695,159	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	255,165	141,004	396,169	0	396,169	8.00
9.00	00900	HOUSEKEEPING	1,274,098	299,755	1,573,853	0	1,573,853	9.00
10.00	01000	DIETARY	1,385,824	1,416,074	2,801,898	-2,277,167	524,731	10.00
11.00	01100	CAFETERIA	0	0	0	2,277,167	2,277,167	11.00
13.00	01300	NURSING ADMINISTRATION	636,351	27,180	663,531	-6	663,525	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	251,097	24,348	275,445	-2,479	272,966	14.00
15.00	01500	PHARMACY	1,162,751	6,339,468	7,502,219	-5,987,375	1,514,844	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	824,989	49,032	874,021	0	874,021	16.00
17.00	01700	SOCIAL SERVICE	358,272	11,959	370,231	0	370,231	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	282,093	0	282,093	-58,760	223,333	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,387,255	2,782,850	8,170,105	-407,959	7,762,146	30.00
31.00	03100	INTENSIVE CARE UNIT	840,847	1,418,102	2,258,949	-6,188	2,252,761	31.00
43.00	04300	NURSERY	0	0	0	213,468	213,468	43.00
44.00	04400	SKILLED NURSING FACILITY	1,171,138	161,367	1,332,505	-13	1,332,492	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,744,055	5,078,832	7,822,887	-2,493,206	5,329,681	50.00
51.00	05100	RECOVERY ROOM	326,464	19,608	346,072	-487	345,585	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	233,855	233,855	52.00
53.00	05300	ANESTHESIOLOGY	0	187,915	187,915	39,834	227,749	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,600,189	1,223,378	2,823,567	-40,552	2,783,015	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	344,800	519,599	864,399	-36	864,363	55.00
56.00	05600	RADIOISOTOPE	135,370	180,964	316,334	-146	316,188	56.00
57.00	05700	CT SCAN	567,080	630,942	1,198,022	-8,899	1,189,123	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	319,601	124,966	444,567	-417	444,150	58.00
60.00	06000	LABORATORY	2,036,978	3,249,087	5,286,065	-30	5,286,035	60.00
65.00	06500	RESPIRATORY THERAPY	974,684	906,354	1,881,038	-146,560	1,734,478	65.00
66.00	06600	PHYSICAL THERAPY	2,678,476	283,180	2,961,656	-129	2,961,527	66.00
67.00	06700	OCCUPATIONAL THERAPY	957,000	149,133	1,106,133	-734	1,105,399	67.00
68.00	06800	SPEECH PATHOLOGY	352,906	6,175	359,081	0	359,081	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,392,380	1,392,380	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,465,098	1,465,098	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,137,484	6,137,484	73.00
74.00	07400	RENAL DIALYSIS	193,228	21,559	214,787	-3,959	210,828	74.00
76.00	03950	DIABETIC EDUCATION	267,812	4,330	272,142	0	272,142	76.00
76.97	07697	CARDIAC REHABILITATION	128,350	8,317	136,667	-1	136,666	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	54,935	68,207	123,142	0	123,142	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,448,915	1,275,100	2,724,015	-179,591	2,544,424	90.00
91.00	09100	EMERGENCY	3,322,422	4,557,144	7,879,566	-22,402	7,857,164	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		335,334	335,334	-335,334	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,632,202	77,585,141	117,217,343	0	117,217,343	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	181,438	13,348	194,786	0	194,786	192.00
194.00	07950	RENTED SPACE	0	0	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	0	0	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	0	131,435	131,435	0	131,435	194.02
194.03	07953	HEALTHY JACKSONVILLE	90,235	4,893	95,128	0	95,128	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	39,903,875	77,734,817	117,638,692	0	117,638,692	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/28/2024 8:49 am

		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	621,492	3,237,090		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	69,044	3,208,326		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,588,083	13,810,738		4.00
5.01	00540	NONPATIENT TELEPHONES	-108,389	49,971		5.01
5.02	00550	DATA PROCESSING	0	4,320,389		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	208,657		5.03
5.04	00570	ADMITTING	0	788,620		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	-19,459	1,734,307		5.05
5.06	00590	OTHER ADMIN & GENERAL	-9,594,468	13,149,125		5.06
7.00	00700	OPERATION OF PLANT	-180,071	5,515,088		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	396,169		8.00
9.00	00900	HOUSEKEEPING	0	1,573,853		9.00
10.00	01000	DIETARY	-101,813	422,918		10.00
11.00	01100	CAFETERIA	-568,035	1,709,132		11.00
13.00	01300	NURSING ADMINISTRATION	0	663,525		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	272,966		14.00
15.00	01500	PHARMACY	-300	1,514,544		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-14,030	859,991		16.00
17.00	01700	SOCIAL SERVICE	0	370,231		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-223,333	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-115,105	7,647,041		30.00
31.00	03100	INTENSIVE CARE UNIT	2,928	2,255,689		31.00
43.00	04300	NURSERY	0	213,468		43.00
44.00	04400	SKILLED NURSING FACILITY	-450	1,332,042		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-40	5,329,641		50.00
51.00	05100	RECOVERY ROOM	0	345,585		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	233,855		52.00
53.00	05300	ANESTHESIOLOGY	0	227,749		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,255	2,785,270		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	-374,370	489,993		55.00
56.00	05600	RADIOISOTOPE	0	316,188		56.00
57.00	05700	CT SCAN	0	1,189,123		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	444,150		58.00
60.00	06000	LABORATORY	-103,865	5,182,170		60.00
65.00	06500	RESPIRATORY THERAPY	-158,898	1,575,580		65.00
66.00	06600	PHYSICAL THERAPY	-59,706	2,901,821		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,105,399		67.00
68.00	06800	SPEECH PATHOLOGY	0	359,081		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,392,380		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,465,098		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-10,804	6,126,680		73.00
74.00	07400	RENAL DIALYSIS	0	210,828		74.00
76.00	03950	DIABETIC EDUCATION	0	272,142		76.00
76.97	07697	CARDIAC REHABILITATION	0	136,666		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	-27,137	96,005		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-926,280	1,618,144		90.00
91.00	09100	EMERGENCY	-2,696,480	5,160,684		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-12,999,231	104,218,112		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	194,786		192.00
194.00	07950	RENTED SPACE	0	0		194.00
194.01	07951	PASSAVANT FOUNDATION	0	0		194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	0	131,435		194.02
194.03	07953	HEALTHY JACKSONVILLE	0	95,128		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-12,999,231	104,639,461		200.00

RECLASSIFICATIONS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/28/2024 8:49 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	335,334		1.00
	0		0	335,334		
	B - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	100,192		1.00
	TOTALS		0	100,192		
	C - DRUGS SOLD TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,139,320		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
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	TOTALS		0	6,139,320		
	D - MEDICAL SUPPLIES & IMPLANTS SOLD					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,392,380		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,465,098		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
14.00		0.00	0	0		14.00
	0		0	2,857,478		
	E - CAFETERIA					
1.00	CAFETERIA	11.00	1,126,291	1,150,876		1.00
	TOTALS		1,126,291	1,150,876		
	F - CRNA AND AIDE WAGES					
1.00	ANESTHESIOLOGY	53.00	88,966	0		1.00
2.00	NONPHYSICIAN ANESTHETISTS	19.00	30,206	0		2.00
	TOTALS		119,172	0		
	G - NURSERY & L&D					
1.00	NURSERY	43.00	194,642	18,826		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	213,231	20,624		2.00
	TOTALS		407,873	39,450		
	H - MEDICAL DIRECTORS					
1.00	ADULTS & PEDIATRICS	30.00	0	43,498		1.00
2.00	RESPIRATORY THERAPY	65.00	0	8,813		2.00
3.00	RENAL DIALYSIS	74.00	0	6,150		3.00
	TOTALS		0	58,461		
500.00	Grand Total: Increases		1,653,336	10,681,111		500.00

RECLASSIFICATIONS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/28/2024 8:49 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	335,334	11		1.00
	0		0	335,334			
	B - PROPERTY INSURANCE						
1.00	OTHER ADMIN & GENERAL	5.06	0	100,192	12		1.00
	TOTALS		0	100,192			
	C - DRUGS SOLD TO PATIENTS						
1.00	OTHER ADMIN & GENERAL	5.06	0	63,729	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	6	0		2.00
3.00	CENTRAL SERVICE & SUPPLY	14.00	0	1	0		3.00
4.00	PHARMACY	15.00	0	5,987,375	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	3,593	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	209	0		6.00
7.00	SKILLED NURSING FACILITY	44.00	0	13	0		7.00
8.00	OPERATING ROOM	50.00	0	2,491	0		8.00
9.00	RECOVERY ROOM	51.00	0	487	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	40,378	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,861	0		11.00
12.00	RADIOLOGY - THERAPEUTIC	55.00	0	36	0		12.00
13.00	RADIOISOTOPE	56.00	0	146	0		13.00
14.00	CT SCAN	57.00	0	8,817	0		14.00
15.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	417	0		15.00
16.00	LABORATORY	60.00	0	30	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	10,543	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	1	0		18.00
19.00	RENAL DIALYSIS	74.00	0	912	0		19.00
20.00	CARDIAC REHABILITATION	76.97	0	1	0		20.00
21.00	CLINIC	90.00	0	5,674	0		21.00
22.00	EMERGENCY	91.00	0	11,600	0		22.00
	TOTALS		0	6,139,320			
	D - MEDICAL SUPPLIES & IMPLANTS SOLD						
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	2,478	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	5,979	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	541	0		3.00
4.00	OPERATING ROOM	50.00	0	2,490,715	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	8,754	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	37,691	0		6.00
7.00	CT SCAN	57.00	0	82	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	144,830	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	128	0		9.00
10.00	OCCUPATIONAL THERAPY	67.00	0	734	0		10.00
11.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,836	0		11.00
12.00	RENAL DIALYSIS	74.00	0	9,197	0		12.00
13.00	CLINIC	90.00	0	143,711	0		13.00
14.00	EMERGENCY	91.00	0	10,802	0		14.00
	0		0	2,857,478			
	E - CAFETERIA						
1.00	DIETARY	10.00	1,126,291	1,150,876	0		1.00
	TOTALS		1,126,291	1,150,876			
	F - CRNA AND AIDE WAGES						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	88,966	0	0		1.00
2.00	CLINIC	90.00	30,206	0	0		2.00
	TOTALS		119,172	0			
	G - NURSERY & L&D						
1.00	ADULTS & PEDIATRICS	30.00	407,873	39,450	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		407,873	39,450			
	H - MEDICAL DIRECTORS						
1.00	OTHER ADMIN & GENERAL	5.06	0	58,461	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	58,461			
500.00	Grand Total: Decreases		1,653,336	10,681,111			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/28/2024 8:49 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	730,500	0	0	0	0	1.00
2.00	Land Improvements	1,450,753	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,896,745	1,061,966	0	1,061,966	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	25,406,560	2,601,293	0	2,601,293	0	5.00
6.00	Movable Equipment	21,787,097	223,070	0	223,070	943,485	6.00
7.00	HIT designated Assets	753,492	0	0	0	201,255	7.00
8.00	Subtotal (sum of lines 1-7)	70,025,147	3,886,329	0	3,886,329	1,144,740	8.00
9.00	Reconciling Items	-19,756,168	-1,449,699	0	-1,449,699	0	9.00
10.00	Total (line 8 minus line 9)	89,781,315	5,336,028	0	5,336,028	1,144,740	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	730,500	0	1.00
2.00	Land Improvements	1,450,753	0	2.00
3.00	Buildings and Fixtures	20,958,711	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	28,007,853	0	5.00
6.00	Movable Equipment	21,066,682	0	6.00
7.00	HIT designated Assets	552,237	0	7.00
8.00	Subtotal (sum of lines 1-7)	72,766,736	0	8.00
9.00	Reconciling Items	-21,205,867	0	9.00
10.00	Total (line 8 minus line 9)	93,972,603	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 2/28/2024 8:49 am

	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	2,180,466	29,373	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,109,515	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,289,981	29,373	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	2,209,839	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,109,515	2.00
3.00	Total (sum of lines 1-2)	0	5,319,354	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 2/28/2024 8:49 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	51,147,817	0	51,147,817	0.702901	70,425	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	21,618,919	0	21,618,919	0.297099	29,767	2.00
3.00	Total (sum of lines 1-2)	72,766,736	0	72,766,736	1.000000	100,192	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	0	0	70,425	2,994,090	29,373	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	29,767	3,178,559	0	2.00
3.00	Total (sum of lines 1-2)	0	0	100,192	6,172,649	29,373	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	143,202	70,425	0	0	3,237,090	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	29,767	0	0	3,208,326	2.00
3.00	Total (sum of lines 1-2)	143,202	100,192	0	0	6,445,416	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/28/2024 8:49 am

	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)	B	-192,132	CAP REL COSTS-BLDG & FIXT	1.00	11	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)	B	-127,592	OTHER ADMIN & GENERAL	5.06	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)	A	-25,529	NONPATIENT TELEPHONES	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-44,118	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-9,349,863			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	OPERATION OF PLANT	7.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,959,396			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-558,323	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	-14,030	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	-9,712	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-19,459	CASHIERING/ACCOUNTS RECEIVABLE	5.05	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	-158,048	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		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-223,333	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	TRUST ACCOUNT FEES	A	354,255	OTHER ADMIN & GENERAL	5.06	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/28/2024 8:49 am

	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	
33.01	DOORBELL DINNERS	B	-101,813	DIETARY	10.00	0	33.01
33.02	MISC INCOME - A&G	B	-612	OTHER ADMIN & GENERAL	5.06	0	33.02
33.03	MISC INCOME - PT	B	-58,311	PHYSICAL THERAPY	66.00	0	33.03
33.04	MISC INCOME - RADIOLOGY	B	-45	RADIOLOGY-DIAGNOSTIC	54.00	0	33.04
33.05	MISC INCOME - PHARMACY	B	-300	PHARMACY	15.00	0	33.05
33.06	MISC INCOME - PLANT	B	-135,953	OPERATION OF PLANT	7.00	0	33.06
33.07	RETIREE HEALTH INSURANCE PLAN	B	144,486	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
34.00	ADVERTISING/MARKETING	A	3,918	OTHER ADMIN & GENERAL	5.06	0	34.00
34.01	ADVERTISING/MARKETING	A	270	LABORATORY	60.00	0	34.01
34.02	ADVERTISING/HR	A	2,025	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.02
35.00	LOBBYING EXPENSE	A	-28,272	OTHER ADMIN & GENERAL	5.06	0	35.00
36.00	PHYSICIAN RECRUITMENT	A	-234,520	OTHER ADMIN & GENERAL	5.06	0	36.00
37.00	PROVIDER TAX	A	-4,568,315	OTHER ADMIN & GENERAL	5.06	0	37.00
38.00	340B DRUGS & EXPENSES	A	-10,804	DRUGS CHARGED TO PATIENTS	73.00	0	38.00
39.00	INTERMEDIARY DEPRECIATION ADJUSTMENT	A	30,552	CAP REL COSTS-BLDG & FIXT	1.00	9	39.00
39.01	REVALUED ASSETS DEPRECIATION ADJUSTM	A	711,732	CAP REL COSTS-BLDG & FIXT	1.00	9	39.01
39.02	REVALUED ASSETS DEPRECIATION ADJUSTM	A	-330,109	CAP REL COSTS-MVBLE EQUIP	2.00	9	39.02
40.00	EMPLOYED PHYSICIAN BENEFITS	A	-14,823	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	TELEVISION	A	-1,094	RADIOLOGY - THERAPEUTIC	55.00	0	41.00
41.01	TELEVISION	A	-1,395	PHYSICAL THERAPY	66.00	0	41.01
41.02	TELEVISION	A	-1,437	HYPERBARIC OXYGEN THERAPY	76.98	0	41.02
41.03	MUTUAL FUND FEES	A	108,950	OTHER ADMIN & GENERAL	5.06	0	41.03
42.00	NON-ALLOWABLE TRANSPORTATION COSTS	A	-16,406	ADULTS & PEDIATRICS	30.00	0	42.00
42.01	NON-ALLOWABLE TRANSPORTATION COSTS	A	-452	INTENSIVE CARE UNIT	31.00	0	42.01
42.02	NON-ALLOWABLE TRANSPORTATION COSTS	A	-450	SKILLED NURSING FACILITY	44.00	0	42.02
42.03	NON-ALLOWABLE TRANSPORTATION COSTS	A	-40	OPERATING ROOM	50.00	0	42.03
42.04	NON-ALLOWABLE TRANSPORTATION COSTS	A	-50	RESPIRATORY THERAPY	65.00	0	42.04
42.05	NON-ALLOWABLE TRANSPORTATION COSTS	A	-20	CLINIC	90.00	0	42.05
42.06	NON-ALLOWABLE TRANSPORTATION COSTS	A	-87,455	EMERGENCY	91.00	0	42.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,999,231				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: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/28/2024 8:49 am

	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	HO CAPITAL - BLDG DIRECT	695	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO CAPITAL - MME DIRECT	115,406	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HO CAPITAL - BLDG POOLED	70,645	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO CAPITAL - MME POOLED	283,747	0	4.00
4.01	5.06	OTHER ADMIN & GENERAL	HO INTEREST OPERATING	167,550	0	4.01
4.02	5.06	OTHER ADMIN & GENERAL	HO MANAGEMENT OPERATING	7,402,532	7,454,714	4.02
4.03	5.01	NONPATIENT TELEPHONES	HO MANAGEMENT TELECOMMUNICAT	0	82,860	4.03
4.04	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	7,126,990	5,670,595	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			15,167,565	13,208,169	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		0.00	MEMORIAL HL SYS	100.00	6.00
7.00	C		0.00	PPA	100.00	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: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/28/2024 8:49 am

	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	695	9		1.00
2.00	115,406	9		2.00
3.00	70,645	9		3.00
4.00	283,747	9		4.00
4.01	167,550	0		4.01
4.02	-52,182	0		4.02
4.03	-82,860	0		4.03
4.04	1,456,395	0		4.04
5.00	1,959,396			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	HOME OFFICE		6.00
7.00	PHYSICIAN ORG		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: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/28/2024 8:49 am

	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	5.06	OTHER ADMIN & GENERAL	5,217,648	5,217,648	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	98,699	98,699	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	-3,380	-3,380	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	-2,300	-2,300	0	0	0	4.00
5.00	55.00	RADIOLOGY - THERAPEUTIC	373,276	373,276	0	0	0	5.00
6.00	60.00	LABORATORY	104,135	104,135	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	800	800	0	0	0	7.00
8.00	76.98	HYPERBARIC OXYGEN THERAPY	25,700	25,700	0	0	0	8.00
9.00	90.00	CLINIC	926,260	926,260	0	0	0	9.00
10.00	91.00	EMERGENCY	2,625,886	2,609,025	16,861	0	0	10.00
200.00			9,366,724	9,349,863	16,861		0	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	5.06	OTHER ADMIN & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	76.98	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			0	0	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	5.06	OTHER ADMIN & GENERAL	0	0	0	5,217,648		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	98,699		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	-3,380		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	-2,300		4.00
5.00	55.00	RADIOLOGY - THERAPEUTIC	0	0	0	373,276		5.00
6.00	60.00	LABORATORY	0	0	0	104,135		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	800		7.00
8.00	76.98	HYPERBARIC OXYGEN THERAPY	0	0	0	25,700		8.00
9.00	90.00	CLINIC	0	0	0	926,260		9.00
10.00	91.00	EMERGENCY	0	0	0	2,609,025		10.00
200.00			0	0	0	9,349,863		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/28/2024 8:49 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					240	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					6.48	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,233.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	96.24	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	48.12	48.12	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					214,952	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					214,952	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					214,952	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					214,952	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					11,549	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					11,549	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,555	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					13,104	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					13,104	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/28/2024 8:49 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	40.75	0.00	0.00	0.00	40.75	47.00
48.00	Overtime rate (see instructions)	144.36	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	5,882.67	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100.00	0.00	0.00	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2,080.00	0.00	0.00	0.00	2,080.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	96.24	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	200,179	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	5,883	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	3,922	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	1,961	0	0	0	1,961	56.00
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT						
57.00	Salary equivalency amount (from line 23)					214,952	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					13,104	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					1,961	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					230,017	63.00
64.00	Total cost of outside supplier services (from your records)					191,069	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
	LINE 33 CALCULATION						
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					11,549	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,555	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					13,104	100.02
	LINE 34 CALCULATION						
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,555	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					1,555	101.02
	LINE 35 CALCULATION						
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1352	Period: From 10/01/2022 To 09/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/28/2024 8:49 am

		Respiratory Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		297	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		6.48	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	5,695.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	75.57	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.79	37.79	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	430,409	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	430,409	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	430,409	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	430,409	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	11,224	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	11,224	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,925	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	13,149	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	13,149	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/28/2024 8:49 am

		Respiratory Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	189.75	0.00	0.00	0.00	189.75	47.00
48.00	Overtime rate (see instructions)	113.36	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	21,510.06	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100.00	0.00	0.00	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2,080.00	0.00	0.00	0.00	2,080.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	75.57	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	157,186	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	21,510	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	14,339	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	7,171	0	0	0	7,171	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	430,409	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	13,149	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	7,171	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	450,729	63.00
64.00	Total cost of outside supplier services (from your records)	608,777	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	158,048	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	11,224	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,925	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	13,149	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,925	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,925	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/28/2024 8:49 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		26	1.00
2.00	Line 1 multiplied by 15 hours per week		390	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		123	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		6.48	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	980.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	91.21	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	45.61	45.61	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	89,386	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	89,386	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	89,386	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	89,386	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	5,610	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	5,610	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	797	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	6,407	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	6,407	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/28/2024 8:49 am

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	13.75	0.00	0.00	0.00	13.75	47.00
48.00	Overtime rate (see instructions)	136.82	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	1,881.28	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100.00	0.00	0.00	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2,080.00	0.00	0.00	0.00	2,080.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	91.21	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	189,717	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	1,881	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	1,254	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	627	0	0	0	627	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	89,386	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	6,407	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	627	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	96,420	63.00
64.00	Total cost of outside supplier services (from your records)	88,296	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	5,610	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	797	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	6,407	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	797	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	797	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/28/2024 8:49 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,237,090	3,237,090				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,208,326		3,208,326			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,810,738	8,926	0	13,819,664		4.00
5.01	00540	NONPATIENT TELEPHONES	49,971	1,940	0	0	51,911	5.01
5.02	00550	DATA PROCESSING	4,320,389	87,151	296,407	364,348	3,369	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	208,657	47,943	0	506	552	5.03
5.04	00570	ADMITTING	788,620	12,463	1,352	261,674	1,270	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,734,307	15,010	0	228,554	884	5.05
5.06	00590	OTHER ADMIN & GENERAL	13,149,125	108,125	431,682	1,034,759	3,921	5.06
7.00	00700	OPERATION OF PLANT	5,515,088	1,145,163	146,438	690,764	2,706	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	396,169	40,238	4,433	89,330	387	8.00
9.00	00900	HOUSEKEEPING	1,573,853	29,947	15,698	446,046	497	9.00
10.00	01000	DIETARY	422,918	51,336	19,409	90,859	994	10.00
11.00	01100	CAFETERIA	1,709,132	44,286	0	394,301	0	11.00
13.00	01300	NURSING ADMINISTRATION	663,525	62,912	7,180	222,779	2,485	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	272,966	10,682	51,351	87,906	0	14.00
15.00	01500	PHARMACY	1,514,544	26,762	8,477	407,065	718	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	859,991	44,614	13,657	288,819	773	16.00
17.00	01700	SOCIAL SERVICE	370,231	11,425	0	125,427	884	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,647,041	218,221	143,694	1,708,690	4,197	30.00
31.00	03100	INTENSIVE CARE UNIT	2,255,689	34,474	54,355	294,370	1,436	31.00
43.00	04300	NURSERY	213,468	8,599	3,642	68,142	110	43.00
44.00	04400	SKILLED NURSING FACILITY	1,332,042	68,525	7,553	410,001	497	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,329,641	250,492	415,468	960,661	6,242	50.00
51.00	05100	RECOVERY ROOM	345,585	10,826	2,282	114,291	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	233,855	15,329	3,990	74,650	166	52.00
53.00	05300	ANESTHESIOLOGY	227,749	6,770	186,451	31,146	1,270	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,785,270	81,403	476,242	560,207	2,761	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	489,993	31,265	521,045	120,710	607	55.00
56.00	05600	RADIOISOTOPE	316,188	3,465	0	47,391	0	56.00
57.00	05700	CT SCAN	1,189,123	3,824	0	198,528	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	444,150	13,557	0	111,888	0	58.00
60.00	06000	LABORATORY	5,182,170	71,966	81,020	713,122	2,540	60.00
65.00	06500	RESPIRATORY THERAPY	1,575,580	33,157	114,021	341,225	1,104	65.00
66.00	06600	PHYSICAL THERAPY	2,901,821	102,017	15,357	937,702	3,313	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,105,399	36,981	1,764	335,034	442	67.00
68.00	06800	SPEECH PATHOLOGY	359,081	998	2,192	123,548	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,392,380	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,465,098	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,126,680	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	210,828	7,377	2,128	67,647	0	74.00
76.00	03950	DIABETIC EDUCATION	272,142	3,864	406	93,758	0	76.00
76.97	07697	CARDIAC REHABILITATION	136,666	22,387	13,072	44,934	221	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	96,005	9,708	45,995	19,232	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,618,144	84,030	36,185	451,401	1,933	90.00
91.00	09100	EMERGENCY	5,160,684	191,979	81,945	1,163,140	4,031	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	104,218,112	3,060,137	3,204,891	13,724,555	50,310	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	7,601	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	194,786	35,831	3,435	63,519	1,491	192.00
194.00	07950	RENTED SPACE	0	125,282	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	0	1,325	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	131,435	3,681	0	0	110	194.02
194.03	07953	HEALTHY JACKSONVILLE	95,128	3,233	0	31,590	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	104,639,461	3,237,090	3,208,326	13,819,664	51,911	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/28/2024 8:49 am

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	5,071,664					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	57,680	315,338				5.03
5.04	00570	ADMITTING	288,180	9,962	1,363,521			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	288,180	1,159	0	2,268,094		5.05
5.06	00590	OTHER ADMIN & GENERAL	345,860	10,766	0	0	15,084,238	5.06
7.00	00700	OPERATION OF PLANT	0	35,781	0	0	7,535,940	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,391	0	0	540,948	8.00
9.00	00900	HOUSEKEEPING	0	38,389	0	0	2,104,430	9.00
10.00	01000	DIETARY	172,821	79,988	0	0	838,325	10.00
11.00	01100	CAFETERIA	0	0	0	0	2,147,719	11.00
13.00	01300	NURSING ADMINISTRATION	288,180	2,575	0	0	1,249,636	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	1,037	0	0	423,942	14.00
15.00	01500	PHARMACY	115,359	7,947	0	0	2,080,872	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	230,501	818	0	0	1,439,173	16.00
17.00	01700	SOCIAL SERVICE	57,680	2,335	0	0	567,982	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	518,681	9,174	80,125	133,295	10,463,118	30.00
31.00	03100	INTENSIVE CARE UNIT	345,860	1,459	18,549	30,858	3,037,050	31.00
43.00	04300	NURSERY	0	545	2,149	3,575	300,230	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,260	17,722	29,482	1,867,082	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	172,821	21,249	134,433	223,642	7,514,649	50.00
51.00	05100	RECOVERY ROOM	0	259	8,244	13,715	495,202	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	597	2,837	4,720	336,144	52.00
53.00	05300	ANESTHESIOLOGY	0	1,898	15,493	25,773	496,550	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	576,357	2,691	77,225	128,471	4,690,627	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	574	46,166	76,802	1,287,162	55.00
56.00	05600	RADIOISOTOPE	0	1,870	13,064	21,733	403,711	56.00
57.00	05700	CT SCAN	0	43	202,342	336,367	1,930,227	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	15	39,479	65,677	674,766	58.00
60.00	06000	LABORATORY	288,180	5,938	163,965	272,770	6,781,671	60.00
65.00	06500	RESPIRATORY THERAPY	172,821	2,248	68,671	114,241	2,423,068	65.00
66.00	06600	PHYSICAL THERAPY	461,001	2,065	67,939	113,022	4,604,237	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,111	26,160	43,519	1,558,410	67.00
68.00	06800	SPEECH PATHOLOGY	0	57	2,772	4,611	493,259	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	27,574	45,872	1,465,826	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	28,092	46,733	1,539,923	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	111,899	186,154	6,424,733	73.00
74.00	07400	RENAL DIALYSIS	0	2,466	3,951	6,573	300,970	74.00
76.00	03950	DIABETIC EDUCATION	0	1,291	222	370	372,053	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,168	2,137	3,555	224,140	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	72	1,966	3,271	176,249	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,710	36,833	61,275	2,292,511	90.00
91.00	09100	EMERGENCY	461,001	9,788	163,512	272,018	7,508,098	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,841,163	279,696	1,363,521	2,268,094	103,674,871	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	7,601	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	572	0	0	299,634	192.00
194.00	07950	RENTED SPACE	0	0	0	0	125,282	194.00
194.01	07951	PASSAVANT FOUNDATION	230,501	0	0	0	231,826	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	0	34,639	0	0	169,865	194.02
194.03	07953	HEALTHY JACKSONVILLE	0	431	0	0	130,382	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,071,664	315,338	1,363,521	2,268,094	104,639,461	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/28/2024 8:49 am

		Cost Center Description	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	15,084,238					5.06
7.00	00700	OPERATION OF PLANT	1,269,316	8,805,256				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	91,115	195,711	827,774			8.00
9.00	00900	HOUSEKEEPING	354,460	145,657	4,720	2,609,267		9.00
10.00	01000	DIETARY	141,203	249,687	3,521	73,635	1,306,371	10.00
11.00	01100	CAFETERIA	361,751	215,399	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	210,482	305,993	0	73,635	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	71,407	51,957	0	5,296	0	14.00
15.00	01500	PHARMACY	350,492	130,163	0	55,227	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	242,407	216,991	0	15,584	0	16.00
17.00	01700	SOCIAL SERVICE	95,668	55,568	0	5,296	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	1,762,359	1,061,384	175,687	655,458	978,166	30.00
31.00	03100	INTENSIVE CARE UNIT	511,546	167,675	17,787	73,635	55,840	31.00
43.00	04300	NURSERY	50,569	41,822	1,423	15,786	0	43.00
44.00	04400	SKILLED NURSING FACILITY	314,482	333,291	96,170	118,271	189,382	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,265,730	1,218,342	161,897	259,842	82,983	50.00
51.00	05100	RECOVERY ROOM	83,409	52,656	12,466	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,618	74,557	1,558	17,299	0	52.00
53.00	05300	ANESTHESIOLOGY	83,636	32,929	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	790,066	395,927	96,345	112,975	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	216,803	152,064	3,551	52,453	0	55.00
56.00	05600	RADIOISOTOPE	67,999	16,853	0	0	0	56.00
57.00	05700	CT SCAN	325,118	18,600	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	113,654	65,936	0	0	0	58.00
60.00	06000	LABORATORY	1,142,271	350,028	505	81,453	0	60.00
65.00	06500	RESPIRATORY THERAPY	408,129	161,268	3,813	52,453	0	65.00
66.00	06600	PHYSICAL THERAPY	775,515	496,190	65,435	94,768	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	262,491	179,868	0	34,346	0	67.00
68.00	06800	SPEECH PATHOLOGY	83,082	4,854	0	39,339	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	246,896	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	259,377	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,082,150	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	50,694	35,880	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	62,667	18,794	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	37,753	108,884	229	27,739	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	29,687	47,219	1,021	19,821	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	386,139	408,702	132	126,088	0	90.00
91.00	09100	EMERGENCY	1,264,626	933,744	175,997	594,934	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,921,767	7,944,593	822,257	2,605,333	1,306,371	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,280	36,968	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	50,469	174,276	5,517	3,934	0	192.00
194.00	07950	RENTED SPACE	21,102	609,345	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	39,048	6,446	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	28,611	17,901	0	0	0	194.02
194.03	07953	HEALTHY JACKSONVILLE	21,961	15,727	0	0	0	194.03
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)	15,084,238	8,805,256	827,774	2,609,267	1,306,371	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/28/2024 8:49 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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	2,724,869					11.00
13.00	01300	NURSING ADMINISTRATION	46,615	1,886,361				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	38,879	0	591,481			14.00
15.00	01500	PHARMACY	78,029	0	0	2,694,783		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	107,826	0	0	0	2,021,981	16.00
17.00	01700	SOCIAL SERVICE	30,440	46,086	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	478,722	623,586	0	0	118,832	30.00
31.00	03100	INTENSIVE CARE UNIT	93,068	92,795	0	0	27,509	31.00
43.00	04300	NURSERY	12,990	19,923	0	0	3,187	43.00
44.00	04400	SKILLED NURSING FACILITY	116,968	169,804	0	0	26,283	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	273,639	368,440	0	0	199,375	50.00
51.00	05100	RECOVERY ROOM	19,198	28,462	0	0	12,227	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,974	21,419	0	0	4,207	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	22,977	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	148,915	0	0	0	114,531	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	28,682	0	0	0	68,468	55.00
56.00	05600	RADIOISOTOPE	7,926	0	0	0	19,375	56.00
57.00	05700	CT SCAN	47,489	0	0	0	299,861	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	26,241	0	0	0	58,551	58.00
60.00	06000	LABORATORY	237,453	0	0	0	243,172	60.00
65.00	06500	RESPIRATORY THERAPY	102,632	122,869	0	0	101,845	65.00
66.00	06600	PHYSICAL THERAPY	226,201	0	0	0	100,758	66.00
67.00	06700	OCCUPATIONAL THERAPY	71,710	0	0	0	38,797	67.00
68.00	06800	SPEECH PATHOLOGY	23,398	0	0	0	4,110	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	288,214	0	40,895	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	303,267	0	41,662	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,693,788	165,955	73.00
74.00	07400	RENAL DIALYSIS	10,046	0	0	0	5,860	74.00
76.00	03950	DIABETIC EDUCATION	38,387	0	0	0	330	76.00
76.97	07697	CARDIAC REHABILITATION	10,428	0	0	0	3,170	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	5,998	0	0	0	2,916	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	109,022	0	0	0	54,626	90.00
91.00	09100	EMERGENCY	291,311	392,977	0	0	242,502	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,696,187	1,886,361	591,481	2,693,788	2,021,981	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	15,220	0	0	995	0	192.00
194.00	07950	RENTED SPACE	0	0	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	0	0	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	0	0	0	0	0	194.02
194.03	07953	HEALTHY JACKSONVILLE	13,462	0	0	0	0	194.03
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)	2,724,869	1,886,361	591,481	2,694,783	2,021,981	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/28/2024 8:49 am

		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	801,040					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	486,325	0	16,803,637	254,259	17,057,896	30.00
31.00	03100	INTENSIVE CARE UNIT	69,818	0	4,146,723	-217,260	3,929,463	31.00
43.00	04300	NURSERY	46,723	0	492,653	-3,494	489,159	43.00
44.00	04400	SKILLED NURSING FACILITY	198,174	0	3,429,907	0	3,429,907	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	11,344,897	0	11,344,897	50.00
51.00	05100	RECOVERY ROOM	0	0	703,620	0	703,620	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	525,776	0	525,776	52.00
53.00	05300	ANESTHESIOLOGY	0	0	636,092	0	636,092	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	6,349,386	0	6,349,386	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	1,809,183	0	1,809,183	55.00
56.00	05600	RADIOISOTOPE	0	0	515,864	0	515,864	56.00
57.00	05700	CT SCAN	0	0	2,621,295	0	2,621,295	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	939,148	0	939,148	58.00
60.00	06000	LABORATORY	0	0	8,836,553	0	8,836,553	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	3,376,077	0	3,376,077	65.00
66.00	06600	PHYSICAL THERAPY	0	0	6,363,104	0	6,363,104	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,145,622	0	2,145,622	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	648,042	0	648,042	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,041,831	0	2,041,831	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,144,229	0	2,144,229	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	10,366,626	0	10,366,626	73.00
74.00	07400	RENAL DIALYSIS	0	0	403,450	0	403,450	74.00
76.00	03950	DIABETIC EDUCATION	0	0	492,231	0	492,231	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	412,343	0	412,343	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	282,911	0	282,911	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	3,377,220	0	3,377,220	90.00
91.00	09100	EMERGENCY	0	0	11,404,189	-33,505	11,370,684	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	801,040	0	102,612,609	0	102,612,609	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	45,849	0	45,849	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	550,045	0	550,045	192.00
194.00	07950	RENTED SPACE	0	0	755,729	0	755,729	194.00
194.01	07951	PASSAVANT FOUNDATION	0	0	277,320	0	277,320	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	0	0	216,377	0	216,377	194.02
194.03	07953	HEALTHY JACKSONVILLE	0	0	181,532	0	181,532	194.03
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)	801,040	0	104,639,461	0	104,639,461	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/28/2024 8:49 am

		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	8,926	0	8,926	8,926	4.00
5.01	00540	NONPATIENT TELEPHONES	0	1,940	0	1,940	0	5.01
5.02	00550	DATA PROCESSING	0	87,151	296,407	383,558	235	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	47,943	0	47,943	0	5.03
5.04	00570	ADMITTING	0	12,463	1,352	13,815	169	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	15,010	0	15,010	148	5.05
5.06	00590	OTHER ADMIN & GENERAL	0	108,125	431,682	539,807	668	5.06
7.00	00700	OPERATION OF PLANT	0	1,145,163	146,438	1,291,601	446	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	40,238	4,433	44,671	58	8.00
9.00	00900	HOUSEKEEPING	0	29,947	15,698	45,645	288	9.00
10.00	01000	DIETARY	0	51,336	19,409	70,745	59	10.00
11.00	01100	CAFETERIA	0	44,286	0	44,286	255	11.00
13.00	01300	NURSING ADMINISTRATION	0	62,912	7,180	70,092	144	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	10,682	51,351	62,033	57	14.00
15.00	01500	PHARMACY	88,885	26,762	8,477	124,124	263	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	44,614	13,657	58,271	186	16.00
17.00	01700	SOCIAL SERVICE	0	11,425	0	11,425	81	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	64,907	218,221	143,694	426,822	1,107	30.00
31.00	03100	INTENSIVE CARE UNIT	14,092	34,474	54,355	102,921	190	31.00
43.00	04300	NURSERY	0	8,599	3,642	12,241	44	43.00
44.00	04400	SKILLED NURSING FACILITY	4,350	68,525	7,553	80,428	265	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,758	250,492	415,468	671,718	620	50.00
51.00	05100	RECOVERY ROOM	0	10,826	2,282	13,108	74	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	15,329	3,990	19,319	48	52.00
53.00	05300	ANESTHESIOLOGY	28	6,770	186,451	193,249	20	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	81,403	476,242	557,645	362	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	31,265	521,045	552,310	78	55.00
56.00	05600	RADIOISOTOPE	0	3,465	0	3,465	31	56.00
57.00	05700	CT SCAN	0	3,824	0	3,824	128	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,068	13,557	0	22,625	72	58.00
60.00	06000	LABORATORY	0	71,966	81,020	152,986	460	60.00
65.00	06500	RESPIRATORY THERAPY	1,683	33,157	114,021	148,861	220	65.00
66.00	06600	PHYSICAL THERAPY	0	102,017	15,357	117,374	605	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	36,981	1,764	38,745	216	67.00
68.00	06800	SPEECH PATHOLOGY	0	998	2,192	3,190	80	68.00
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
74.00	07400	RENAL DIALYSIS	0	7,377	2,128	9,505	44	74.00
76.00	03950	DIABETIC EDUCATION	0	3,864	406	4,270	61	76.00
76.97	07697	CARDIAC REHABILITATION	372	22,387	13,072	35,831	29	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	9,708	45,995	55,703	12	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	84,030	36,185	120,215	291	90.00
91.00	09100	EMERGENCY	2,277	191,979	81,945	276,201	751	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	191,420	3,060,137	3,204,891	6,456,448	8,865	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	7,601	0	7,601	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	35,831	3,435	39,266	41	192.00
194.00	07950	RENTED SPACE	0	125,282	0	125,282	0	194.00
194.01	07951	PASSAVANT FOUNDATION	0	1,325	0	1,325	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	0	3,681	0	3,681	0	194.02
194.03	07953	HEALTHY JACKSONVILLE	0	3,233	0	3,233	20	194.03
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)	191,420	3,237,090	3,208,326	6,636,836	8,926	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/28/2024 8:49 am

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		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
5.01	00540	NONPATIENT TELEPHONES	1,940					5.01
5.02	00550	DATA PROCESSING	126	383,919				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	21	4,366	52,330			5.03
5.04	00570	ADMITTING	47	21,815	1,653	37,499		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	33	21,815	192	0	37,198	5.05
5.06	00590	OTHER ADMIN & GENERAL	147	26,181	1,787	0	0	5.06
7.00	00700	OPERATION OF PLANT	101	0	5,938	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14	0	1,724	0	0	8.00
9.00	00900	HOUSEKEEPING	19	0	6,371	0	0	9.00
10.00	01000	DIETARY	37	13,082	13,278	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	93	21,815	427	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	172	0	0	14.00
15.00	01500	PHARMACY	27	8,733	1,319	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29	17,449	136	0	0	16.00
17.00	01700	SOCIAL SERVICE	33	4,366	387	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	157	39,264	1,522	2,191	2,191	30.00
31.00	03100	INTENSIVE CARE UNIT	54	26,181	242	507	507	31.00
43.00	04300	NURSERY	4	0	90	59	59	43.00
44.00	04400	SKILLED NURSING FACILITY	19	0	209	485	485	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	232	13,082	3,526	3,677	3,677	50.00
51.00	05100	RECOVERY ROOM	0	0	43	225	225	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6	0	99	78	78	52.00
53.00	05300	ANESTHESIOLOGY	47	0	315	424	424	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	103	43,630	447	2,112	2,112	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	23	0	95	1,263	1,263	55.00
56.00	05600	RADIOISOTOPE	0	0	310	357	357	56.00
57.00	05700	CT SCAN	0	0	7	5,742	5,441	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	2	1,080	1,080	58.00
60.00	06000	LABORATORY	95	21,815	985	4,485	4,485	60.00
65.00	06500	RESPIRATORY THERAPY	41	13,082	373	1,878	1,878	65.00
66.00	06600	PHYSICAL THERAPY	124	34,897	343	1,858	1,858	66.00
67.00	06700	OCCUPATIONAL THERAPY	17	0	1,512	715	715	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	9	76	76	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	754	754	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	768	768	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,060	3,060	73.00
74.00	07400	RENAL DIALYSIS	0	0	409	108	108	74.00
76.00	03950	DIABETIC EDUCATION	0	0	214	6	6	76.00
76.97	07697	CARDIAC REHABILITATION	8	0	194	58	58	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	12	54	54	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	72	0	450	1,007	1,007	90.00
91.00	09100	EMERGENCY	151	34,897	1,624	4,472	4,472	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,880	366,470	46,416	37,499	37,198	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	56	0	95	0	0	192.00
194.00	07950	RENTED SPACE	0	0	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	0	17,449	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	4	0	5,748	0	0	194.02
194.03	07953	HEALTHY JACKSONVILLE	0	0	71	0	0	194.03
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)	1,940	383,919	52,330	37,499	37,198	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/28/2024 8:49 am

		Cost Center Description	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	568,590					5.06
7.00	00700	OPERATION OF PLANT	47,846	1,345,932				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,434	29,916	79,817			8.00
9.00	00900	HOUSEKEEPING	13,361	22,265	455	88,404		9.00
10.00	01000	DIETARY	5,323	38,166	339	2,495	143,524	10.00
11.00	01100	CAFETERIA	13,636	32,925	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,934	46,773	0	2,495	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	2,692	7,942	0	179	0	14.00
15.00	01500	PHARMACY	13,211	19,896	0	1,871	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,137	33,168	0	528	0	16.00
17.00	01700	SOCIAL SERVICE	3,606	8,494	0	179	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	66,435	162,238	16,940	22,206	107,466	30.00
31.00	03100	INTENSIVE CARE UNIT	19,282	25,630	1,715	2,495	6,135	31.00
43.00	04300	NURSERY	1,906	6,393	137	535	0	43.00
44.00	04400	SKILLED NURSING FACILITY	11,854	50,945	9,273	4,007	20,806	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	47,711	186,229	15,611	8,804	9,117	50.00
51.00	05100	RECOVERY ROOM	3,144	8,049	1,202	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,134	11,396	150	586	0	52.00
53.00	05300	ANESTHESIOLOGY	3,153	5,033	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,781	60,520	9,290	3,828	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	8,172	23,244	342	1,777	0	55.00
56.00	05600	RADIOISOTOPE	2,563	2,576	0	0	0	56.00
57.00	05700	CT SCAN	12,255	2,843	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,284	10,079	0	0	0	58.00
60.00	06000	LABORATORY	43,057	53,504	49	2,760	0	60.00
65.00	06500	RESPIRATORY THERAPY	15,384	24,651	368	1,777	0	65.00
66.00	06600	PHYSICAL THERAPY	29,232	75,845	6,310	3,211	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,894	27,494	0	1,164	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,132	742	0	1,333	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,307	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,777	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,791	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,911	5,485	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	2,362	2,873	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,423	16,643	22	940	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,119	7,218	98	672	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	14,555	62,472	13	4,272	0	90.00
91.00	09100	EMERGENCY	47,669	142,728	16,971	20,157	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	562,467	1,214,375	79,285	88,271	143,524	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	48	5,651	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,902	26,639	532	133	0	192.00
194.00	07950	RENTED SPACE	795	93,142	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	1,472	985	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	1,078	2,736	0	0	0	194.02
194.03	07953	HEALTHY JACKSONVILLE	828	2,404	0	0	0	194.03
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)	568,590	1,345,932	79,817	88,404	143,524	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/28/2024 8:49 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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	91,102					11.00
13.00	01300	NURSING ADMINISTRATION	1,558	151,331				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1,300	0	74,375			14.00
15.00	01500	PHARMACY	2,609	0	0	172,053		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,605	0	0	0	122,509	16.00
17.00	01700	SOCIAL SERVICE	1,018	3,697	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	16,003	50,028	0	0	7,204	30.00
31.00	03100	INTENSIVE CARE UNIT	3,112	7,444	0	0	1,668	31.00
43.00	04300	NURSERY	434	1,598	0	0	193	43.00
44.00	04400	SKILLED NURSING FACILITY	3,911	13,622	0	0	1,593	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,149	29,558	0	0	12,088	50.00
51.00	05100	RECOVERY ROOM	642	2,283	0	0	741	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	467	1,718	0	0	255	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,393	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,979	0	0	0	6,944	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	959	0	0	0	4,151	55.00
56.00	05600	RADIOISOTOPE	265	0	0	0	1,175	56.00
57.00	05700	CT SCAN	1,588	0	0	0	18,102	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	877	0	0	0	3,550	58.00
60.00	06000	LABORATORY	7,939	0	0	0	14,743	60.00
65.00	06500	RESPIRATORY THERAPY	3,431	9,857	0	0	6,175	65.00
66.00	06600	PHYSICAL THERAPY	7,563	0	0	0	6,109	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,398	0	0	0	2,352	67.00
68.00	06800	SPEECH PATHOLOGY	782	0	0	0	249	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	36,241	0	2,479	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	38,134	0	2,526	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	171,989	10,061	73.00
74.00	07400	RENAL DIALYSIS	336	0	0	0	355	74.00
76.00	03950	DIABETIC EDUCATION	1,283	0	0	0	20	76.00
76.97	07697	CARDIAC REHABILITATION	349	0	0	0	192	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	201	0	0	0	177	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,645	0	0	0	3,312	90.00
91.00	09100	EMERGENCY	9,740	31,526	0	0	14,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	90,143	151,331	74,375	171,989	122,509	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	509	0	0	64	0	192.00
194.00	07950	RENTED SPACE	0	0	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	0	0	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	0	0	0	0	0	194.02
194.03	07953	HEALTHY JACKSONVILLE	450	0	0	0	0	194.03
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)	91,102	151,331	74,375	172,053	122,509	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/28/2024 8:49 am

		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	33,286					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,208		941,982	0	941,982	30.00
31.00	03100	INTENSIVE CARE UNIT	2,901		200,984	0	200,984	31.00
43.00	04300	NURSERY	1,942		25,635	0	25,635	43.00
44.00	04400	SKILLED NURSING FACILITY	8,235		206,137	0	206,137	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		1,014,799	0	1,014,799	50.00
51.00	05100	RECOVERY ROOM	0		29,736	0	29,736	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		36,334	0	36,334	52.00
53.00	05300	ANESTHESIOLOGY	0		204,058	0	204,058	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		721,753	0	721,753	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0		593,677	0	593,677	55.00
56.00	05600	RADIOISOTOPE	0		11,099	0	11,099	56.00
57.00	05700	CT SCAN	0		49,930	0	49,930	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		43,649	0	43,649	58.00
60.00	06000	LABORATORY	0		307,363	0	307,363	60.00
65.00	06500	RESPIRATORY THERAPY	0		227,976	0	227,976	65.00
66.00	06600	PHYSICAL THERAPY	0		285,329	0	285,329	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		85,222	0	85,222	67.00
68.00	06800	SPEECH PATHOLOGY	0		9,669	0	9,669	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		49,535	0	49,535	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		51,973	0	51,973	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		228,961	0	228,961	73.00
74.00	07400	RENAL DIALYSIS	0		18,261	0	18,261	74.00
76.00	03950	DIABETIC EDUCATION	0		11,095	0	11,095	76.00
76.97	07697	CARDIAC REHABILITATION	0		55,747	0	55,747	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		65,320	0	65,320	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		211,311	0	211,311	90.00
91.00	09100	EMERGENCY	0		606,061	0	606,061	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,286	0	6,293,596	0	6,293,596	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		13,300	0	13,300	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		69,237	0	69,237	192.00
194.00	07950	RENTED SPACE	0		219,219	0	219,219	194.00
194.01	07951	PASSAVANT FOUNDATION	0		21,231	0	21,231	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	0		13,247	0	13,247	194.02
194.03	07953	HEALTHY JACKSONVILLE	0		7,006	0	7,006	194.03
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)	33,286	0	6,636,836	0	6,636,836	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/28/2024 8:49 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (DEPT TIME)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	405,457					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,508,668				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,118	0	39,474,775			4.00
5.01	00540	NONPATIENT TELEPHONES	243	0	0	940		5.01
5.02	00550	DATA PROCESSING	10,916	324,155	1,040,734	61	23,301	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	6,005	0	1,446	10	265	5.03
5.04	00570	ADMITTING	1,561	1,479	747,452	23	1,324	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,880	0	652,847	16	1,324	5.05
5.06	00590	OTHER ADMIN & GENERAL	13,543	472,093	2,955,711	71	1,589	5.06
7.00	00700	OPERATION OF PLANT	143,436	160,146	1,973,114	49	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,040	4,848	255,165	7	0	8.00
9.00	00900	HOUSEKEEPING	3,751	17,167	1,274,098	9	0	9.00
10.00	01000	DIETARY	6,430	21,226	259,533	18	794	10.00
11.00	01100	CAFETERIA	5,547	0	1,126,291	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,880	7,852	636,351	45	1,324	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1,338	56,158	251,097	0	0	14.00
15.00	01500	PHARMACY	3,352	9,271	1,162,751	13	530	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,588	14,936	824,989	14	1,059	16.00
17.00	01700	SOCIAL SERVICE	1,431	0	358,272	16	265	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,333	157,146	4,880,682	76	2,383	30.00
31.00	03100	INTENSIVE CARE UNIT	4,318	59,443	840,847	26	1,589	31.00
43.00	04300	NURSERY	1,077	3,983	194,642	2	0	43.00
44.00	04400	SKILLED NURSING FACILITY	8,583	8,260	1,171,138	9	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,375	454,361	2,744,055	113	794	50.00
51.00	05100	RECOVERY ROOM	1,356	2,496	326,464	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,920	4,364	213,231	3	0	52.00
53.00	05300	ANESTHESIOLOGY	848	203,905	88,966	23	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,196	520,825	1,600,189	50	2,648	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,916	569,820	344,800	11	0	55.00
56.00	05600	RADIOISOTOPE	434	0	135,370	0	0	56.00
57.00	05700	CT SCAN	479	0	567,080	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,698	0	319,601	0	0	58.00
60.00	06000	LABORATORY	9,014	88,605	2,036,978	46	1,324	60.00
65.00	06500	RESPIRATORY THERAPY	4,153	124,695	974,684	20	794	65.00
66.00	06600	PHYSICAL THERAPY	12,778	16,795	2,678,476	60	2,118	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,632	1,929	957,000	8	0	67.00
68.00	06800	SPEECH PATHOLOGY	125	2,397	352,906	0	0	68.00
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
74.00	07400	RENAL DIALYSIS	924	2,327	193,228	0	0	74.00
76.00	03950	DIABETIC EDUCATION	484	444	267,812	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,804	14,296	128,350	4	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,216	50,301	54,935	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,525	39,572	1,289,394	35	0	90.00
91.00	09100	EMERGENCY	24,046	89,616	3,322,422	73	2,118	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	383,293	3,504,911	39,203,101	911	22,242	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	952	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,488	3,757	181,438	27	0	192.00
194.00	07950	RENTED SPACE	15,692	0	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	166	0	1	0	1,059	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	461	0	0	2	0	194.02
194.03	07953	HEALTHY JACKSONVILLE	405	0	90,235	0	0	194.03
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)	3,237,090	3,208,326	13,819,664	51,911	5,071,664	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.983806	0.914400	0.350088	55.224468	217.658641	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			8,926	1,940	383,919	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/28/2024 8:49 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (DEPT TIME)	
			1.00	2.00	4.00	5.01	5.02	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000226	2.063830	16.476503	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: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/28/2024 8:49 am

		Cost Center Description	PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,057,613					5.03
5.04	00570	ADMITTING	33,410	466,135,793				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,888	0	466,135,793			5.05
5.06	00590	OTHER ADMIN & GENERAL	36,108	0	0	-15,084,238	89,555,223	5.06
7.00	00700	OPERATION OF PLANT	120,007	0	0	0	7,535,940	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,850	0	0	0	540,948	8.00
9.00	00900	HOUSEKEEPING	128,753	0	0	0	2,104,430	9.00
10.00	01000	DIETARY	268,274	0	0	0	838,325	10.00
11.00	01100	CAFETERIA	0	0	0	0	2,147,719	11.00
13.00	01300	NURSING ADMINISTRATION	8,636	0	0	0	1,249,636	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	3,479	0	0	0	423,942	14.00
15.00	01500	PHARMACY	26,655	0	0	0	2,080,872	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,743	0	0	0	1,439,173	16.00
17.00	01700	SOCIAL SERVICE	7,831	0	0	0	567,982	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,769	27,393,236	27,393,236	0	10,463,118	30.00
31.00	03100	INTENSIVE CARE UNIT	4,893	6,341,516	6,341,516	0	3,037,050	31.00
43.00	04300	NURSERY	1,827	734,726	734,726	0	300,230	43.00
44.00	04400	SKILLED NURSING FACILITY	4,225	6,058,800	6,058,800	0	1,867,082	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	71,268	45,960,154	45,960,154	0	7,514,649	50.00
51.00	05100	RECOVERY ROOM	868	2,818,587	2,818,587	0	495,202	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,002	969,905	969,905	0	336,144	52.00
53.00	05300	ANESTHESIOLOGY	6,367	5,296,629	5,296,629	0	496,550	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,026	26,401,847	26,401,847	0	4,690,627	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,924	15,783,398	15,783,398	0	1,287,162	55.00
56.00	05600	RADIOISOTOPE	6,273	4,466,372	4,466,372	0	403,711	56.00
57.00	05700	CT SCAN	145	69,150,817	69,150,817	0	1,930,227	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	49	13,497,160	13,497,160	0	674,766	58.00
60.00	06000	LABORATORY	19,916	56,056,351	56,056,351	0	6,781,671	60.00
65.00	06500	RESPIRATORY THERAPY	7,538	23,477,299	23,477,299	0	2,423,068	65.00
66.00	06600	PHYSICAL THERAPY	6,927	23,226,866	23,226,866	0	4,604,237	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,556	8,943,587	8,943,587	0	1,558,410	67.00
68.00	06800	SPEECH PATHOLOGY	192	947,532	947,532	0	493,259	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,427,135	9,427,135	0	1,465,826	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,604,007	9,604,007	0	1,539,923	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	38,256,069	38,256,069	0	6,424,733	73.00
74.00	07400	RENAL DIALYSIS	8,271	1,350,897	1,350,897	0	300,970	74.00
76.00	03950	DIABETIC EDUCATION	4,330	76,017	76,017	0	372,053	76.00
76.97	07697	CARDIAC REHABILITATION	3,917	730,637	730,637	0	224,140	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	241	672,144	672,144	0	176,249	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,090	12,592,421	12,592,421	0	2,292,511	90.00
91.00	09100	EMERGENCY	32,827	55,901,684	55,901,684	0	7,508,098	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	938,075	466,135,793	466,135,793	-15,084,238	88,590,633	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	7,601	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,917	0	0	0	299,634	192.00
194.00	07950	RENTED SPACE	0	0	0	0	125,282	194.00
194.01	07951	PASSAVANT FOUNDATION	0	0	0	0	231,826	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	116,177	0	0	0	169,865	194.02
194.03	07953	HEALTHY JACKSONVILLE	1,444	0	0	0	130,382	194.03
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)	315,338	1,363,521	2,268,094		15,084,238	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.298160	0.002925	0.004866		0.168435	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	52,330	37,499	37,198		568,590	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.049479	0.000080	0.000080		0.006349	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/28/2024 8:49 am

		Cost Center Description	PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
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: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/28/2024 8:49 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
7.00	00700	OPERATION OF PLANT	226,755					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,040	574,852				8.00
9.00	00900	HOUSEKEEPING	3,751	3,278	51,735			9.00
10.00	01000	DIETARY	6,430	2,445	1,460	63,821		10.00
11.00	01100	CAFETERIA	5,547	0	0	0	271,233	11.00
13.00	01300	NURSING ADMINISTRATION	7,880	0	1,460	0	4,640	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1,338	0	105	0	3,870	14.00
15.00	01500	PHARMACY	3,352	0	1,095	0	7,767	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,588	0	309	0	10,733	16.00
17.00	01700	SOCIAL SERVICE	1,431	0	105	0	3,030	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,333	122,007	12,996	47,787	47,652	30.00
31.00	03100	INTENSIVE CARE UNIT	4,318	12,352	1,460	2,728	9,264	31.00
43.00	04300	NURSERY	1,077	988	313	0	1,293	43.00
44.00	04400	SKILLED NURSING FACILITY	8,583	66,786	2,345	9,252	11,643	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,375	112,430	5,152	4,054	27,238	50.00
51.00	05100	RECOVERY ROOM	1,356	8,657	0	0	1,911	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,920	1,082	343	0	1,391	52.00
53.00	05300	ANESTHESIOLOGY	848	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,196	66,907	2,240	0	14,823	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,916	2,466	1,040	0	2,855	55.00
56.00	05600	RADIOISOTOPE	434	0	0	0	789	56.00
57.00	05700	CT SCAN	479	0	0	0	4,727	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,698	0	0	0	2,612	58.00
60.00	06000	LABORATORY	9,014	351	1,615	0	23,636	60.00
65.00	06500	RESPIRATORY THERAPY	4,153	2,648	1,040	0	10,216	65.00
66.00	06600	PHYSICAL THERAPY	12,778	45,442	1,879	0	22,516	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,632	0	681	0	7,138	67.00
68.00	06800	SPEECH PATHOLOGY	125	0	780	0	2,329	68.00
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
74.00	07400	RENAL DIALYSIS	924	0	0	0	1,000	74.00
76.00	03950	DIABETIC EDUCATION	484	0	0	0	3,821	76.00
76.97	07697	CARDIAC REHABILITATION	2,804	159	550	0	1,038	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,216	709	393	0	597	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,525	92	2,500	0	10,852	90.00
91.00	09100	EMERGENCY	24,046	122,222	11,796	0	28,997	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	204,591	571,021	51,657	63,821	268,378	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	952	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,488	3,831	78	0	1,515	192.00
194.00	07950	RENTED SPACE	15,692	0	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	166	0	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	461	0	0	0	0	194.02
194.03	07953	HEALTHY JACKSONVILLE	405	0	0	0	1,340	194.03
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)	8,805,256	827,774	2,609,267	1,306,371	2,724,869	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.831585	1.439978	50.435237	20.469297	10.046230	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,345,932	79,817	88,404	143,524	91,102	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.935622	0.138848	1.708785	2.248852	0.335881	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/28/2024 8:49 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
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: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/28/2024 8:49 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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	408,457					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	2,857,478				14.00
15.00	01500	PHARMACY	0	0	6,141,587			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	466,135,793		16.00
17.00	01700	SOCIAL SERVICE	9,979	0	0	0	12,001	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	135,026	0	0	27,393,236	7,286	30.00
31.00	03100	INTENSIVE CARE UNIT	20,093	0	0	6,341,516	1,046	31.00
43.00	04300	NURSERY	4,314	0	0	734,726	700	43.00
44.00	04400	SKILLED NURSING FACILITY	36,768	0	0	6,058,800	2,969	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	79,779	0	0	45,960,154	0	50.00
51.00	05100	RECOVERY ROOM	6,163	0	0	2,818,587	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,638	0	0	969,905	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,296,629	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,401,847	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	15,783,398	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	4,466,372	0	56.00
57.00	05700	CT SCAN	0	0	0	69,150,817	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	13,497,160	0	58.00
60.00	06000	LABORATORY	0	0	0	56,056,351	0	60.00
65.00	06500	RESPIRATORY THERAPY	26,605	0	0	23,477,299	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	23,226,866	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8,943,587	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	947,532	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,392,380	0	9,427,135	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,465,098	0	9,604,007	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	6,139,320	38,256,069	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,350,897	0	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	76,017	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	730,637	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	672,144	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	12,592,421	0	90.00
91.00	09100	EMERGENCY	85,092	0	0	55,901,684	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	408,457	2,857,478	6,139,320	466,135,793	12,001	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	2,267	0	0	192.00
194.00	07950	RENTED SPACE	0	0	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	0	0	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	0	0	0	0	0	194.02
194.03	07953	HEALTHY JACKSONVILLE	0	0	0	0	0	194.03
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)	1,886,361	591,481	2,694,783	2,021,981	801,040	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.618261	0.206994	0.438776	0.004338	66.747771	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	151,331	74,375	172,053	122,509	33,286	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.370494	0.026028	0.028014	0.000263	2.773602	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/28/2024 8:49 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
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: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/28/2024 8:49 am

		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
5.01	00540	NONPATIENT TELEPHONES		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00560	PURCHASING RECEIVING AND STORES		5.03
5.04	00570	ADMITTING		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00590	OTHER ADMIN & GENERAL		5.06
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
15.00	01500	PHARMACY		15.00
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
44.00	04400	SKILLED NURSING FACILITY	0	44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
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
55.00	05500	RADIOLOGY - THERAPEUTIC	0	55.00
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
60.00	06000	LABORATORY	0	60.00
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
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
74.00	07400	RENAL DIALYSIS	0	74.00
76.00	03950	DIABETIC EDUCATION	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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
194.00	07950	RENTED SPACE	0	194.00
194.01	07951	PASSAVANT FOUNDATION	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	0	194.02
194.03	07953	HEALTHY JACKSONVILLE	0	194.03
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)	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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/28/2024 8:49 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			19.00		
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

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-2 | Date/Time Prepared: 2/28/2024 8:49 am

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		ADULTS & PEDIATRICS	1	30.00	254,259	7.00
8.00		ICU	1	31.00	-217,260	8.00
9.00		NURSERY	1	43.00	-3,494	9.00
10.00		EMERGENCY	1	91.00	-33,505	10.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | 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	17,057,896		17,057,896	0	17,057,896	30.00
31.00	03100	INTENSIVE CARE UNIT	3,929,463		3,929,463	0	3,929,463	31.00
43.00	04300	NURSERY	489,159		489,159	0	489,159	43.00
44.00	04400	SKILLED NURSING FACILITY	3,429,907		3,429,907	0	3,429,907	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,344,897		11,344,897	0	11,344,897	50.00
51.00	05100	RECOVERY ROOM	703,620		703,620	0	703,620	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	525,776		525,776	0	525,776	52.00
53.00	05300	ANESTHESIOLOGY	636,092		636,092	0	636,092	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,349,386		6,349,386	0	6,349,386	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,809,183		1,809,183	0	1,809,183	55.00
56.00	05600	RADIOISOTOPE	515,864		515,864	0	515,864	56.00
57.00	05700	CT SCAN	2,621,295		2,621,295	0	2,621,295	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	939,148		939,148	0	939,148	58.00
60.00	06000	LABORATORY	8,836,553		8,836,553	0	8,836,553	60.00
65.00	06500	RESPIRATORY THERAPY	3,376,077	0	3,376,077	0	3,376,077	65.00
66.00	06600	PHYSICAL THERAPY	6,363,104	0	6,363,104	0	6,363,104	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,145,622	0	2,145,622	0	2,145,622	67.00
68.00	06800	SPEECH PATHOLOGY	648,042	0	648,042	0	648,042	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,041,831		2,041,831	0	2,041,831	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,144,229		2,144,229	0	2,144,229	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,366,626		10,366,626	0	10,366,626	73.00
74.00	07400	RENAL DIALYSIS	403,450		403,450	0	403,450	74.00
76.00	03950	DIABETIC EDUCATION	492,231		492,231	0	492,231	76.00
76.97	07697	CARDIAC REHABILITATION	412,343		412,343	0	412,343	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	282,911		282,911	0	282,911	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,377,220		3,377,220	0	3,377,220	90.00
91.00	09100	EMERGENCY	11,370,684		11,370,684	0	11,370,684	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,958,844		3,958,844		3,958,844	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	106,571,453	0	106,571,453	0	106,571,453	200.00
201.00		Less Observation Beds	3,958,844		3,958,844		3,958,844	201.00
202.00		Total (see instructions)	102,612,609	0	102,612,609	0	102,612,609	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | 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	21,952,825		21,952,825			30.00
31.00	03100	INTENSIVE CARE UNIT	6,341,516		6,341,516			31.00
43.00	04300	NURSERY	734,726		734,726			43.00
44.00	04400	SKILLED NURSING FACILITY	6,058,800		6,058,800			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,410,513	37,549,641	45,960,154	0.246842	0.000000	50.00
51.00	05100	RECOVERY ROOM	797,734	2,020,853	2,818,587	0.249636	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	613,259	356,646	969,905	0.542090	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,076,231	4,220,398	5,296,629	0.120094	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,994,541	24,407,306	26,401,847	0.240490	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	15,783,398	15,783,398	0.114626	0.000000	55.00
56.00	05600	RADIOISOTOPE	121,976	4,344,396	4,466,372	0.115500	0.000000	56.00
57.00	05700	CT SCAN	7,247,628	61,903,189	69,150,817	0.037907	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	765,816	12,731,344	13,497,160	0.069581	0.000000	58.00
60.00	06000	LABORATORY	14,288,616	41,767,735	56,056,351	0.157637	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,628,426	15,848,873	23,477,299	0.143802	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,239,680	20,987,186	23,226,866	0.273954	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,208,027	6,735,560	8,943,587	0.239906	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	225,221	722,311	947,532	0.683926	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,889,672	6,537,463	9,427,135	0.216591	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,268,884	7,335,123	9,604,007	0.223264	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,628,754	29,627,315	38,256,069	0.270980	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,099,774	251,123	1,350,897	0.298653	0.000000	74.00
76.00	03950	DIABETIC EDUCATION	752	75,265	76,017	6.475275	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	209	730,428	730,637	0.564361	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	672,144	672,144	0.420908	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	592,787	11,999,634	12,592,421	0.268195	0.000000	90.00
91.00	09100	EMERGENCY	6,836,379	49,065,305	55,901,684	0.203405	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,044,569	4,395,842	5,440,411	0.727674	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	106,067,315	360,068,478	466,135,793			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	106,067,315	360,068,478	466,135,793			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | 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
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.246842		50.00
51.00	05100	RECOVERY ROOM	0.249636		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.542090		52.00
53.00	05300	ANESTHESIOLOGY	0.120094		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240490		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.114626		55.00
56.00	05600	RADIOISOTOPE	0.115500		56.00
57.00	05700	CT SCAN	0.037907		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.069581		58.00
60.00	06000	LABORATORY	0.157637		60.00
65.00	06500	RESPIRATORY THERAPY	0.143802		65.00
66.00	06600	PHYSICAL THERAPY	0.273954		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.239906		67.00
68.00	06800	SPEECH PATHOLOGY	0.683926		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.216591		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.223264		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270980		73.00
74.00	07400	RENAL DIALYSIS	0.298653		74.00
76.00	03950	DIABETIC EDUCATION	6.475275		76.00
76.97	07697	CARDIAC REHABILITATION	0.564361		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.420908		76.98
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.268195		90.00
91.00	09100	EMERGENCY	0.203405		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.727674		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | Hospital | Cost

		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	1,014,799	45,960,154	0.022080	1,658,057	36,610	50.00
51.00	05100	RECOVERY ROOM	29,736	2,818,587	0.010550	257,788	2,720	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	36,334	969,905	0.037461	0	0	52.00
53.00	05300	ANESTHESIOLOGY	204,058	5,296,629	0.038526	189,274	7,292	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	721,753	26,401,847	0.027337	620,197	16,954	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	593,677	15,783,398	0.037614	0	0	55.00
56.00	05600	RADIOISOTOPE	11,099	4,466,372	0.002485	46,822	116	56.00
57.00	05700	CT SCAN	49,930	69,150,817	0.000722	1,047,432	756	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	43,649	13,497,160	0.003234	246,476	797	58.00
60.00	06000	LABORATORY	307,363	56,056,351	0.005483	3,581,824	19,639	60.00
65.00	06500	RESPIRATORY THERAPY	227,976	23,477,299	0.009710	3,000,049	29,130	65.00
66.00	06600	PHYSICAL THERAPY	285,329	23,226,866	0.012284	522,762	6,422	66.00
67.00	06700	OCCUPATIONAL THERAPY	85,222	8,943,587	0.009529	586,627	5,590	67.00
68.00	06800	SPEECH PATHOLOGY	9,669	947,532	0.010204	116,567	1,189	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	49,535	9,427,135	0.005255	837,037	4,399	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,973	9,604,007	0.005412	777,298	4,207	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	228,961	38,256,069	0.005985	2,608,245	15,610	73.00
74.00	07400	RENAL DIALYSIS	18,261	1,350,897	0.013518	547,391	7,400	74.00
76.00	03950	DIABETIC EDUCATION	11,095	76,017	0.145954	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	55,747	730,637	0.076299	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	65,320	672,144	0.097182	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	211,311	12,592,421	0.016781	85,624	1,437	90.00
91.00	09100	EMERGENCY	606,061	55,901,684	0.010842	43,922	476	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	218,619	5,440,411	0.040184	12,480	501	92.00
200.00		Total (lines 50 through 199)	5,137,477	431,047,926		16,785,872	161,245	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | Hospital | Cost

		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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
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: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | Hospital | Cost

		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	45,960,154	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,818,587	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	969,905	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,296,629	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,401,847	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	15,783,398	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	4,466,372	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	69,150,817	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	13,497,160	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	56,056,351	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	23,477,299	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	23,226,866	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8,943,587	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	947,532	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9,427,135	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,604,007	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,256,069	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,350,897	0.000000	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	76,017	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	730,637	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	672,144	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	12,592,421	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	55,901,684	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,440,411	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	431,047,926		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | Hospital | Cost

		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	1,658,057	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	257,788	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	189,274	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	620,197	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	46,822	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	1,047,432	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	246,476	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	3,581,824	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,000,049	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	522,762	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	586,627	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	116,567	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	837,037	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	777,298	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,608,245	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	547,391	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	85,624	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	43,922	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	12,480	0	0	0	92.00
200.00		Total (lines 50 through 199)		16,785,872	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | Hospital | Cost

		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	0.246842	0	10,215,474	0	0	50.00
51.00	05100	RECOVERY ROOM	0.249636	0	368,172	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.542090	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.120094	0	978,380	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240490	0	6,291,769	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.114626	0	5,423,383	0	0	55.00
56.00	05600	RADIOISOTOPE	0.115500	0	1,718,934	0	0	56.00
57.00	05700	CT SCAN	0.037907	0	19,273,930	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.069581	0	3,264,681	0	0	58.00
60.00	06000	LABORATORY	0.157637	0	9,860,853	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.143802	0	4,753,121	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.273954	0	5,663,979	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.239906	0	1,023,861	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.683926	0	77,159	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.216591	0	1,776,543	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.223264	0	2,489,496	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270980	0	8,246,247	3,945	0	73.00
74.00	07400	RENAL DIALYSIS	0.298653	0	3,350	0	0	74.00
76.00	03950	DIABETIC EDUCATION	6.475275	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.564361	0	270,075	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.420908	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.268195	0	3,410,265	8,755	0	90.00
91.00	09100	EMERGENCY	0.203405	0	12,231,032	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.727674	0	1,407,215	0	0	92.00
200.00		Subtotal (see instructions)		0	98,747,919	12,700	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	98,747,919	12,700	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | Hospital | Cost

		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	2,521,608	0		50.00
51.00	05100	RECOVERY ROOM	91,909	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	117,498	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,513,108	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	621,661	0		55.00
56.00	05600	RADIOISOTOPE	198,537	0		56.00
57.00	05700	CT SCAN	730,617	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	227,160	0		58.00
60.00	06000	LABORATORY	1,554,435	0		60.00
65.00	06500	RESPIRATORY THERAPY	683,508	0		65.00
66.00	06600	PHYSICAL THERAPY	1,551,670	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	245,630	0		67.00
68.00	06800	SPEECH PATHOLOGY	52,771	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	384,783	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	555,815	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,234,568	1,069		73.00
74.00	07400	RENAL DIALYSIS	1,000	0		74.00
76.00	03950	DIABETIC EDUCATION	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	152,420	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	914,616	2,348		90.00
91.00	09100	EMERGENCY	2,487,853	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,023,994	0		92.00
200.00		Subtotal (see instructions)	17,865,161	3,417		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	17,865,161	3,417		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1352 | Component CCN: 14-5951 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | Skilled Nursing Facility | PPS

		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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
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: 14-1352 | Component CCN: 14-5951 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | Skilled Nursing Facility | PPS

		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	45,960,154	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,818,587	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	969,905	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,296,629	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,401,847	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	15,783,398	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	4,466,372	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	69,150,817	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	13,497,160	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	56,056,351	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	23,477,299	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	23,226,866	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8,943,587	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	947,532	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9,427,135	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,604,007	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,256,069	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,350,897	0.000000	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	76,017	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	730,637	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	672,144	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	12,592,421	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	55,901,684	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,440,411	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	431,047,926		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1352 | Component CCN: 14-5951 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | Skilled Nursing Facility | PPS

		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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	249	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	35,931	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	73,975	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	4,725	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	317,697	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	190,581	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	776,093	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	695,314	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	27,084	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	74,714	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	313,460	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	390	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	21,712	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	173	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,532,098	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | Hospital | Cost

	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)	9,488	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,488	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)	7,286	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)	0	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)	3,158	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)	0	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	17,057,896	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)	17,057,896	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)	17,057,896	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)	1,797.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,677,579	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)	5,677,579	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | Hospital | Cost

	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	3,929,463	1,046	3,756.66	347	1,303,561	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)	3,333,567	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)	10,314,707	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)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	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)	2,202	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,797.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,958,844	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | Hospital | Cost

	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	941,982	17,057,896	0.055223	3,958,844	218,619	90.00
91.00	Nursing Program cost	0	17,057,896	0.000000	3,958,844	0	91.00
92.00	Allied health cost	0	17,057,896	0.000000	3,958,844	0	92.00
93.00	All other Medical Education	0	17,057,896	0.000000	3,958,844	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1352 Component CCN: 14-5951	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/28/2024 8:49 am
	Title XVIII	Skilled Nursing Facility	PPS

	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)	2,969	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,969	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)	2,969	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)	0	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)	1,863	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)	0	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	3,429,907	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)	3,429,907	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)	3,429,907	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1

Component CCN: 14-5951 | Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | Skilled Nursing Facility | 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)		48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)		48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
55.01	Permanent adjustment amount per discharge		55.01
55.02	Adjustment amount per discharge (contractor use only)		55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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)		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)		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	3,429,907	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	1,155.24	71.00
72.00	Program routine service cost (line 9 x line 71)	2,152,212	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,152,212	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,152,212	83.00
84.00	Program inpatient ancillary services (see instructions)	594,335	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,746,547	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1352 Component CCN: 14-5951	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/28/2024 8:49 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

	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	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | Hospital | Cost

		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		9,178,245		30.00
31.00	03100	INTENSIVE CARE UNIT		2,221,511		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.246842	1,658,057	409,278	50.00
51.00	05100	RECOVERY ROOM	0.249636	257,788	64,353	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.542090	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.120094	189,274	22,731	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240490	620,197	149,151	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.114626	0	0	55.00
56.00	05600	RADIOISOTOPE	0.115500	46,822	5,408	56.00
57.00	05700	CT SCAN	0.037907	1,047,432	39,705	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.069581	246,476	17,150	58.00
60.00	06000	LABORATORY	0.157637	3,581,824	564,628	60.00
65.00	06500	RESPIRATORY THERAPY	0.143802	3,000,049	431,413	65.00
66.00	06600	PHYSICAL THERAPY	0.273954	522,762	143,213	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.239906	586,627	140,735	67.00
68.00	06800	SPEECH PATHOLOGY	0.683926	116,567	79,723	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.216591	837,037	181,295	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.223264	777,298	173,543	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270980	2,608,245	706,782	73.00
74.00	07400	RENAL DIALYSIS	0.298653	547,391	163,480	74.00
76.00	03950	DIABETIC EDUCATION	6.475275	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.564361	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.420908	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.268195	85,624	22,964	90.00
91.00	09100	EMERGENCY	0.203405	43,922	8,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.727674	12,480	9,081	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		16,785,872	3,333,567	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)		16,785,872		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1352 | Component CCN: 14-5951 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | Skilled Nursing Facility | 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	0.246842	0	0	50.00
51.00	05100	RECOVERY ROOM	0.249636	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.542090	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.120094	249	30	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240490	35,931	8,641	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.114626	0	0	55.00
56.00	05600	RADIOISOTOPE	0.115500	0	0	56.00
57.00	05700	CT SCAN	0.037907	73,975	2,804	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.069581	4,725	329	58.00
60.00	06000	LABORATORY	0.157637	317,697	50,081	60.00
65.00	06500	RESPIRATORY THERAPY	0.143802	190,581	27,406	65.00
66.00	06600	PHYSICAL THERAPY	0.273954	776,093	212,614	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.239906	695,314	166,810	67.00
68.00	06800	SPEECH PATHOLOGY	0.683926	27,084	18,523	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.216591	74,714	16,182	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.223264	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270980	313,460	84,941	73.00
74.00	07400	RENAL DIALYSIS	0.298653	390	116	74.00
76.00	03950	DIABETIC EDUCATION	6.475275	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.564361	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.420908	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.268195	21,712	5,823	90.00
91.00	09100	EMERGENCY	0.203405	173	35	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.727674	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,532,098	594,335	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)		2,532,098		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1352	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/28/2024 8:49 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	17,868,578	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	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)	17,868,578	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	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)	18,047,264	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	88,781	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	17,708,658	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)	249,825	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)	249,825	30.00
31.00	Primary payer payments	553	31.00
32.00	Subtotal (line 30 minus line 31)	249,272	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)	2,137,085	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	1,389,105	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,071,247	36.00
37.00	Subtotal (see instructions)	1,638,377	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)	1,638,377	40.00
40.01	Sequestration adjustment (see instructions)	32,768	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	3,658,418	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)	-2,052,809	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	0	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: 14-1352	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/28/2024 8:49 am
	Title XVIII	Hospital	Cost

		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: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I Date/Time Prepared: 2/28/2024 8:49 am

Title XVIII | Hospital | Cost

		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		8,541,478		5,040,725	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	05/10/2023	1,142,501	09/25/2023	740,748	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	09/25/2023	954,245	05/10/2023	2,123,055	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)		188,256		-1,382,307	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)		8,729,734		3,658,418	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		602,364		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		2,052,809	6.02
7.00	Total Medicare program liability (see instructions)		9,332,098		1,605,609	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: 14-1352	Period: From 10/01/2022 To 09/30/2023	Worksheet E-1 Part I Date/Time Prepared: 2/28/2024 8:49 am
Component CCN: 14-5951		
Title XVIII	Skilled Nursing Facility	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		913,679		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)		913,679		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)		913,679		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: 14-1352	Period: From 10/01/2022 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/28/2024 8:49 am
	Title XVIII	Hospital	Cost

			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	Provider CCN: 14-1352	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/28/2024 8:49 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	10,314,707	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	10,314,707	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	10,417,854	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	10,417,854	19.00
20.00	Deductibles (exclude professional component)	976,300	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	9,441,554	22.00
23.00	Coinsurance	4,000	23.00
24.00	Subtotal (line 22 minus line 23)	9,437,554	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	130,762	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	84,995	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	129,206	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	9,522,549	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	9,522,549	30.00
30.01	Sequestration adjustment (see instructions)	190,451	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	8,729,734	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	602,364	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1352 Component CCN: 14-5951	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part VI Date/Time Prepared: 2/28/2024 8:49 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,030,279	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,030,279	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	97,953	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	932,326	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.98	Recovery of accelerated depreciation.	0	14.98
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	932,326	15.00
15.01	Sequestration adjustment (see instructions)	18,647	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	0	15.75
16.00	Interim payments	913,679	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/28/2024 8:49 am

		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	1,965,000	0	0	0	1.00
2.00	Temporary investments	8,118,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	23,935,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,799,000	0	0	0	7.00
8.00	Prepaid expenses	1,179,000	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	97,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	37,093,000	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	730,500	0	0	0	12.00
13.00	Land improvements	1,450,753	0	0	0	13.00
14.00	Accumulated depreciation	-811,910	0	0	0	14.00
15.00	Buildings	20,958,711	0	0	0	15.00
16.00	Accumulated depreciation	-4,630,425	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	28,007,853	0	0	0	19.00
20.00	Accumulated depreciation	-12,039,600	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	21,066,683	0	0	0	23.00
24.00	Accumulated depreciation	-15,118,718	0	0	0	24.00
25.00	Minor equipment depreciable	995,852	0	0	0	25.00
26.00	Accumulated depreciation	-591,075	0	0	0	26.00
27.00	HIT designated Assets	552,237	0	0	0	27.00
28.00	Accumulated depreciation	-1,404,879	0	0	0	28.00
29.00	Minor equipment-nondepreciable	21,205,867	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	60,371,849	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	136,631,000	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	30,854,151	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	167,485,151	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	264,950,000	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	7,339,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,737,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,552,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	596,000	0	0	0	43.00
44.00	Other current liabilities	10,285,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	24,509,000	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	12,104,000	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	238,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,342,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	36,851,000	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	228,099,000				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	228,099,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	264,950,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/28/2024 8:49 am

		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		188,267,910		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		37,933,719				2.00
3.00	Total (sum of line 1 and line 2)		226,201,629		0		3.00
4.00	PPA & CRNA CORPS	1,795,492		0		0	4.00
5.00	RESISTRICTED ASSETS	101,879		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)		1,897,371		0		10.00
11.00	Subtotal (line 3 plus line 10)		228,099,000		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		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)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		228,099,000		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		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)	0		0	3.00
4.00	PPA & CRNA CORPS		0		4.00
5.00	RESISTRICTED ASSETS		0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			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)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1352 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/28/2024 8:49 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	22,750,595		22,750,595	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	6,058,800		6,058,800	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)	28,809,395		28,809,395	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	6,373,691		6,373,691	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)	6,373,691		6,373,691	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	35,183,086		35,183,086	17.00
18.00	Ancillary services	62,660,619	300,077,093	362,737,712	18.00
19.00	Outpatient services	8,492,336	66,270,726	74,763,062	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
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	PHYSICIAN REVENUE	204	493,880	494,084	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	106,336,245	366,841,699	473,177,944	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		117,638,692		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)		117,638,692		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1352	Period: From 10/01/2022 To 09/30/2023	Worksheet G-3 Date/Time Prepared: 2/28/2024 8:49 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	473,177,944	1.00
2.00	Less contractual allowances and discounts on patients' accounts	334,741,938	2.00
3.00	Net patient revenues (line 1 minus line 2)	138,436,006	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	117,638,692	4.00
5.00	Net income from service to patients (line 3 minus line 4)	20,797,314	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,810,740	6.00
7.00	Income from investments	2,723,618	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	660,586	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	14,030	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	9,262	21.00
22.00	Rental of hospital space	506,978	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	1,345,163	24.00
24.01	340B INCOME	17,013	24.01
24.02	INTEREST PENALTY INCOME	19,459	24.02
24.03	CHANGE IN FMV OF INTEREST RATE SWAP	350,695	24.03
24.04	GRANTS	42,473	24.04
24.05	UNREALIZED GAIN ON INVESTMENTS	9,099,310	24.05
24.06	EQUITY INCOME OF AFFILATE	486,314	24.06
24.50	COVID-19 PHE Funding	1,229,302	24.50
25.00	Total other income (sum of lines 6-24)	18,314,943	25.00
26.00	Total (line 5 plus line 25)	39,112,257	26.00
27.00	REALIZED LOSS ON INVESTMENTS	991,020	27.00
27.01	DEFERRED TAX BENEFIT	17,060	27.01
27.02	RETIREE BENEFIT ADJUSTMENT	144,486	27.02
27.03	LOSS ON DISPOSAL OF FIXED ASSETS	25,972	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	1,178,538	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	37,933,719	29.00