This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-1352 Worksheet S Peri od: From 10/01/2022 Parts I-III AND SETTLEMENT SUMMARY 09/30/2023 Date/Time Prepared: 2/28/2024 8: 49 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 2/28/2024 8: 49 am ] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Contractor

number of times reopened = 0-9.

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

(3) Settled with Audit

(4) Reopened (5) Amended

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by 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	ELECTRONI C	
	1			SI GNATURE STATEMENT	
1	Pau	I 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 XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	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
Tho ak	povo amounts roprosont "duo to" or "duo from"	the applicable	program for th	o alamont of t	ho abovo compl	ov indicated	

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.

use only

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1352 Peri od: Worksheet S-2 From 10/01/2022 To 09/30/2023 Part I Date/Time Prepared: 2/28/2024 8:49 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1600 WEST WALNUT 1.00 PO Box: 1.00 City: JACKSONVILLE 2.00 State: IL Zip Code: 62650 County: MORGAN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 JACKSONVILLE MEMORIAL 141352 99914 04/26/2022 Ν 0 N 3.00 HOSPI TAL Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6 00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF JACKSONVILLE MEMORIAL 145951 99914 10/31/1997 Ρ Ν 9.00 HOSPITAL SNE 10.00 Hospital -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 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) 09/30/2023 10/01/2022 20.00 21.00 Type of Control (see instructions) 21.00 2 1 00 2. 00 3 00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for Ν N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 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 22.01 Ν N 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 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. 22.03 Did this hospital receive a geographic reclassification from urban to N 22 03 N N 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. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 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.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 23.00 Ν 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.

	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid paid 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.  If this provider is an IRF, enter the in-state 0 0 0 0 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	5.00	0	0	24. 00
		Urban/Ru 1.00		Date of		
26. 00	Enter your standard geographic classification (not wage) status at the beginning of th		2	2. (	<u> </u>	26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" for rural. 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 leffect in the cost reporting period.		0			35. 00
	errect in the cost reporting perrod.	Begi nni		Endi 2. (		
36. 00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for numbe	1.00 r	,	2. (	JU	36. 00
37. 00	of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status		0			37. 00
	is in effect in the cost reporting period. 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					37. 01
38. 00	<pre>instructions) 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.</pre>					38. 00
	onto oasooqaane aatoo.	Y/N		Υ/		
	Does this facility qualify for the inpatient hospital payment adjustment for low volum 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) Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or		)	2. ( N		39. 00
40.00	"N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" fo no in column 2, for discharges on or after October 1. (see instructions)		V	XVIII	XIX	40.00
			1. 00		3.00	
45. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment for disproportionate share in a	ccordance	N	N	N	45. 00
	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumsta pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I	nces	N	N	N	46. 00
47. 00	Pt. III.  Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N"	_	N	N	N	47. 00
	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for n Teaching Hospitals		N	N	N	48. 00
	Is this a hospital involved in training residents in approved GME programs? For cost r		N			56. 00
	periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in colum cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b) the instructions. For column 2, if the response to column 1 is "Y", or if this hospital involved in training residents in approved GME programs in the prior year or penultima and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reducti	(2), see I was te year,				
57. 00	"Y" for yes; otherwise, enter "N" for no in column 2. For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is this the first cost reporting period during which residents in approved GME program at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", diresidents start training in the first month of this cost reporting period? Enter "Y" "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 pe beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regar	s trained d for yes or ", riods	N			57. 00
	which month(s) of the cost report the residents were on duty, if the response to line for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Workshe If line 56 is yes, did this facility elect cost reimbursement for physicians' services defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	56 is "Y" et E-4.				58. 00

	Financial Systems		LLE MEMORIA				eu of Form CMS-	
HOSPI 7	TAL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	ATA	Provi der CC		Period: From 10/01/2022 To 09/30/2023		pared:
					Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					Si te 1.00	2.00	3.00	
	Section 5504 of the ACA Base Yea	r FTE Residents in N	lonprovi der	Settings				
64 00	period that begins on or after J Enter in column 1, if line 63 is	uly 1, 2009 and befo	<u>re June 30,</u> ty trained	2010. residents	0.0	0.00	0. 000000	64 00
01.00	in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	ber of unweighted no tations occurring in number of unweighte ur hospital. Enter in	n-primary c all nonpro d non-prima n column 3	are vider ry care the ratio	0.1	G. 60	0.00000	01.00
	(ee. a : a. v. aea z) (ee. a	Program Name		m Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
					FTEs Nonprovider Site	FTEs in Hospital	(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)				Unwei ghted	Unwei ghted	0.00000C	
					FTĔs	FTEs in	(col. 1 + col.	
					Nonprovi der Si te	Hospi tal	2))	
					1.00	2.00	3.00	
	Section 5504 of the ACA Current		n Nonprovid	er Setting				
66 00	beginning on or after July 1, 20 Enter in column 1 the number of		ry care res	i dent	0.0	0.00	0. 000000	66.00
00.00	FTEs attributable to rotations o				0. 0	0.00	0.000000	00.00
	Enter in column 2 the number of FTEs that trained in your hospit							
	(column 1 divided by (column 1 +							
		Program Name		m Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.	00	3. 00	4.00	5. 00	
67. 00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0. (		<del> </del>	67.00

	Is this hospital an extended neoplastic disease care hospital classified u 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87. 00	
			Approved for Permanent Adjustment (Y/N) 1.00	Number of Approved Permanent Adjustments 2.00	
88 00	Column 1: Is this hospital approved for a permanent adjustment to the TEFR	RA target	N 1.00		88. 00
	amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete co 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.				00.00
		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1. 00	2.00	3.00	
	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		C	89.00
			V	XI X	
			1. 00	2.00	
	Title V and XIX Services				
	Does this facility have title V and/or XIX inpatient hospital services? Er yes or "N" for no in the applicable column.		N	Υ	90.00
	Is this hospital reimbursed for title V and/or XIX through the cost report 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 certificati instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92. 00
	Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column.	d XIX? Enter	N	N	93. 00
	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no applicable column.	in the	N	N	94. 00
	If line 94 is "Y", enter the reduction percentage in the applicable column	١.	0.00	0.00	95.00
			N	N	96. 00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no applicable column.				

Health Financial Systems JACKSONVILLE ME	MORIAL HOSPITAL		In Lie	u of Form CMS	-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	F	Period: From 10/01/2022 To 09/30/2023	Date/Time Pr	repared:	
			V	2/28/2024 8: XI X	49 am	
			1.00	2.00		
98.00 Does title V or XIX follow Medicare (title XVIII) for the stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" 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 C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.			N	Y	98. 01	
98.02 Does title V or XIX follow Medicare (title XVIII) for the obed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes 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 cri reimbursed 101% of inpatient services cost? Enter "Y" for y 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 CAI outpatient services cost? Enter "Y" for yes or "N" for no	outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					
98.05 Does title V or XIX follow Medicare (title XVIII) and add I Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in	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.					
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			N	Y	98. 06	
Rural Providers						
105.00 Does this hospital qualify as a CAH?  106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	l-inclusive met	hod of payment	Y		105. 00 106. 00	
107.00 Column 1: If line 105 is Y, is this facility eligible for a training programs? Enter "Y" for yes or "N" for no in colum Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded	mn 1. (see ins o you train I&R	tructions) s in an	N		107. 00	
Enter "Y" for yes or "N" for no in column 2. (see instruction 108.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 42	N		108. 00	
[51.10 05001 611 51121 110 (6)1 2.1106 1 1 101 100 61 11 101 101	Physi cal	Occupati onal	Speech	Respi ratory	′	
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.	1.00 e Y	2.00 Y	3. 00 N	4. 00 Y	109. 00	
				1.00		
110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no. I	f yes,	N N	110. 00	
			1. 00	2.00		
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to of integration prong of the FCHIP demo in which this CAH is participated in the services; "B" for a for tele-health services.	cost reporting column 1 is Y, articipating in	period? Enter enter the column 2.	N		111. 00	
		1. 00	2. 00	3. 00	_	
112.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost is period? Enter "Y" for yes or "N" for no in column 1. If of "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital constitution in the demonstration.	reporting column 1 is ipating in the	N	2.00	0.00	112. 00	
participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information						
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.	B, or E only) "93" percent (includes	N			0115.00	
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	" for yes or	N			116. 00	
117.00 Is this facility legally-required to carry malpractice insu "Y" for yes or "N" for no.	urance? Enter	Y			117. 00	
118.00 Is the mal practice insurance a claims-made or occurrence point if the policy is claim-made. Enter 2 if the policy is occur			1		118. 00	

		1	0 09/30/2023	Date/IIme P 2/28/2024 8	
	'	Premi ums	Losses	Insurance	. , ,
		1. 00	2. 00	3. 00	
118.01 List amounts of malpractice premiums and paid lo	osses:	733, 196	5 0		0 118. 01
			1. 00	2.00	
118.02 Are mal practice premiums and paid losses reporte			N		118. 02
Administrative and General? If yes, submit supp and amounts contained therein.	porting schedule listing co	ost centers			
119. 00 DO NOT USE THIS LINE					119. 00
120.00 Is this a SCH or EACH that qualifies for the Out			N	N	120. 00
§3121 and applicable amendments? (see instruction "N" for no. Is this a rural hospital with < 100					
Hold Harmless provision in ACA §3121 and applica					
Enter in column 2, "Y" for yes or "N" for no.	(				
121.00 Did this facility incur and report costs for hig	gh cost implantable devices	s charged to	Υ		121. 00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related	taxes as defined in \$1903	(w)(3) of the	N		122. 00
Act?Enter "Y" for yes or "N" for no in column 1.					122.00
the Worksheet A line number where these taxes ar					
123.00 Did the facility and/or its subproviders (if app services, e.g., legal, accounting, tax preparati			Y	Y	123. 00
management/consulting services, from an unrelate					
for yes or "N" for no.	· ·				
If column 1 is "Y", were the majority of the exp					
professional services expenses, for services pur located in a CBSA outside of the main hospital C					
"N" for no.	SBSA: TH COLUMN 2, CITTED	i for yes or			
Certified Transplant Center Information					
125.00 Does this facility operate a Medicare-certified and "N" for no. If yes, enter certification date		'Y" for yes	N		125. 00
126.00 If this is a Medicare-certified kidney transplan		fication date			126. 00
in column 1 and termination date, if applicable,	in column 2.				
127.00 If this is a Medicare-certified heart transplant		fication date			127. 00
in column 1 and termination date, if applicable, 128.00 If this is a Medicare-certified liver transplant		fication date			128. 00
in column 1 and termination date, if applicable,		reaction date			120.00
129.00 If this is a Medicare-certified lung transplant		cation date			129. 00
in column 1 and termination date, if applicable, 130.00 If this is a Medicare-certified pancreas transpl		cti fi cati on			130. 00
date in column 1 and termination date, if applic		tification			130.00
131.00 If this is a Medicare-certified intestinal trans	splant program, enter the o	certi fi cati on			131. 00
date in column 1 and termination date, if applic		Figotion data			122.00
132.00  f this is a Medicare-certified islet transplant in column 1 and termination date, if applicable,		ircation date			132. 00
133. 00 Removed and reserved	66. 4 2.				133. 00
134.00 If this is a hospital-based organ procurement or		ne OPO number			134. 00
in column 1 and termination date, if applicable, All Providers	in column 2.				
140.00 Are there any related organization or home office	ce costs as defined in CMS	Pub. 15-1,	Υ	14H058	140. 00
chapter 10? Enter "Y" for yes or "N" for no in c	column 1. If yes, and home	office costs			
are claimed, enter in column 2 the home office of 1.00	<u>chain number. (see instruc</u> 2.00	tions)	3.00		
If this facility is part of a chain organization		ugh 143 the na		of the	
home office and enter the home office contractor	name and contractor numb				
141.00 Name: MEMORIAL HEALTH SYSTEMS Contracto	or's Name: MEMORIAL HEALTH	Contractor	's Number: 0013	1	141. 00
142.00 Street: 701 NORTH FIRST STREET PO Box:	SYSTEMS				142. 00
143. 00 Ci ty: SPRINGFI ELD State:	IL	Zi p Code:	6278	1	143. 00
144.00 Are provider based physicians' costs included in	Workshoot A2			1. 00 Y	144. 00
144. OUNT E provider based physicians costs included in	I WOI KSHEET A?			T	144.00
			1. 00	2.00	
145.00 If costs for renal services are claimed on Wkst.			Υ		145. 00
inpatient services only? Enter "Y" for yes or "N no, does the dialysis facility include Medicare					
period? Enter "Y" for yes or "N" for no in colu		reporting			
146.00 Has the cost allocation methodology changed from	the previously filed cos		N		146. 00
Enter "Y" for yes or "N" for no in column 1. (Se		40, §4020) If			
yes, enter the approval date (mm/dd/yyyy) in col	uiiii Z.		1	l	I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA		Provi der CC	N: 14-1352		eriod: com 10/01/2022 0 09/30/2023		repared:
							1.00	
147.00 Was there a change in the statisti	cal basis? Enter "Y" f	for yes	or "N" for	no.			N N	147. 00
148.00 Was there a change in the order of	allocation? Enter "Y"	" for ye	es or "N" fo	r no.			N	148. 00
149.00 Was there a change to the simplifi	ed cost finding method	d? Enter	"Y" for ye	s or "N" 1	for no		N	149. 00
			Part A	Part I		Title V	Title XIX	
			1. 00	2.00		3. 00	4.00	
Does this facility contain a provi								
or charges? Enter "Y" for yes or '	N for no for each con	mponent	N N	and Part N	B. (2	<u>ee 42 CFR 941.</u> N	3. 13) N	155. 00
156. 00 Subprovi der – TPF			N N	N N		N N	N	156. 00
157. 00 Subprovider - TRF			N	N N		N	N	157. 00
158. OO SUBPROVI DER			IN .	IV.		IV	I N	158. 00
159. 00 SNF			N	N		N	N	159. 00
160.00HOME HEALTH AGENCY			N	N		N	N	160. 00
161. 00 CMHC				N		N	N N	161. 00
		<u> </u>						
							1.00	
Mul ti campus								
165.00 Is this hospital part of a Multica	ampus hospital that has	s one or	r more campu	ses in di	fferer	nt CBSAs?	N	165. 00
Enter "Y" for yes or "N" for no.					7	0.004	FTF (0	
	Name		County 1.00	State	Zip (		FTE/Campus	
166.00  f  line 165 is yes, for each	0		1.00	2. 00	3. (	00 4.00	5.00	00 166. 00
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.	00 100. 00
cordiiii 5 (see mstructrons)						<u> </u>		
							1.00	
Health Information Technology (HI	() incentive in the Ame	eri can F	Recovery and	Reinvest	ment .	Act	•	
167.00 Is this provider a meaningful user							Υ	167. 00
168.00 If this provider is a CAH (line 10			user (line	167 is "`	Y"), €	enter the		168. 00
reasonable cost incurred for the H					_			4.0.04
168.01 If this provider is a CAH and is r						hardshi p		168. 01
exception under §413.70(a)(6)(ii)? 169.00 If this provider is a meaningful u						") enter the	0	00169.00
transition factor. (see instruction		ana 13	not a oni (	11110 100 1	3 11	), circo the	0.	00107.00
transition ractor. (See Thistractive	, , , , , , , , , , , , , , , , , , ,					Begi nni ng	Endi ng	
					Ī	1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	eginning date and endi	ing date	e for the re	porting				170. 00
						1. 00	2.00	
171.00  fline 167 is "Y", does this prov	vider have any days for	r indivi	duals enrol	Led in		1. 00 N	2.00	0 171. 00
section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, umn 1. If column 1 is y	Pt. I,	line 2, col	. 6? Enter		IV		0171.00

Heal th	Financial Systems JACKSONVILLE MEM	MORIAL HOSPITAL	_	In lie	eu of Form CMS-	2552-10
	"AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 14-1352	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part II Date/Time Pre	epared:
				Y/N	2/28/2024 8: 4 Date	ia aw
				1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			r all dates in <sup>.</sup>	the	
1. 00	Provider Organization and Operation  Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			N		1.00
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare F	Program? If	1.00 N	2.00	3. 00	2.00
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	mn 3, "V" for				
3.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.00
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	
4. 00 5. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacclumn 3. (see instructions) If no, see instructions.  Are the cost report total expenses and total revenues difference.	for Compiled, ailable in	Y	A		4. 00
	those on the filed financial statements? If yes, submit received					
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6. 00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	,	s the provider	N		6. 00
7. 00 8. 00						
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated of		the current	N		10.00
11. 00	cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. 00
	Treatming Treatment and the treatment of the treatment and				Y/N	
	Pad Dobts				1. 00	_
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			st reporting	Y N	12. 00 13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsuralinstructions.	ance amounts wa	aived? If yes,	see	N	14. 00
15. 00	Bed Complement Did total beds available change from the prior cost reporti	ng period? If	yes, see inst	ructions.	N	15. 00
		Par	-t A	Par	t B	
		1. 00	Date 2.00	Y/N 3. 00	Date 4.00	
	PS&R Data	1.00	2.00	3.00	7.00	
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	Y	12/04/2023	Y	12/04/2023	16. 00
17. 00	instructions) 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

Heal th	Financial Systems JACKSONVILLE MEN	MORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 14-1352	Peri od: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part II Date/Time Pre 2/28/2024 8:4	epared:
			i pti on	Y/N	Y/N	
20.00	LE Line 1/ on 17 in one of the DCOD		0	1. 00	3.00	20.00
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
	Troper t data for other book be the other day do the received	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	IOSPI TALS)		1.00	
	Capi tal Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made duri	ng the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost rep	porting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	ne cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportir	ng period? If	yes, submit	N	27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	ntered into dur	ing the cost	reporti ng	N	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	N	29. 00			
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	N	30.00			
31. 00	instructions. Has debt been recalled before scheduled maturity without is	N	31. 00			
	instructions. Purchased Services		-			
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ed through co	ntractual	N	32. 00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans					
34. 00	Were services furnished at the provider facility under an alf yes, see instructions.	arrangement wit	th provider-ba	ased physicians?	Y	34.00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		nts with the p	orovi der-based	N	35. 00
				Y/N	Date	
	U 066: C+-			1. 00	2. 00	
36. 00	Home Office Costs 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 pr	repared by the	home office?	Y		37. 00
38. 00	If yes, see instructions.			N		38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year end of the limit of the fiscal year end of the services to other the services to other the provider render services to other the services tha	d of the home o	ffi ce.			39. 00
	see instructions.	·	,			
40. 00	If line 36 is yes, did the provider render services to the instructions.	nome office?		N		40. 00
	1.00 2.				00	1
	Cost Report Preparer Contact Information					
41. 00	held by the cost report preparer in columns 1, 2, and 3,	KEVI N		WELLEN		41.00
42. 00	respectively. Enter the employer/company name of the cost report	CLI FTONLARSONA	LLEN LLP			42. 00
43. 00		314-925-4446		KEVI N. WELLEN@C	LACONNECT. COM	43. 00
	report preparer in columns 1 and 2, respectively.	I				II

Health Financial Systems	JACKSONVILLE ME	MORIAL HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE R	Provider CCN: 14-1352		Worksheet S-2			
			From 10/01/2022 To 09/30/2023		pared: 9 am	
		3.00				
Cost Report Preparer Contact	Information					
41.00 Enter the first name, last na	me and the title/position	SIGNING DIRECTOR			41. 00	
held by the cost report prepa	rer in columns 1, 2, and 3,					
respecti vel y.						
42.00 Enter the employer/company na	me of the cost report				42. 00	
preparer.						
43.00 Enter the telephone number ar	nd email address of the cost				43.00	
report preparer in columns 1	and 2, respectively.					

Health Financial Systems

JACKSONVILLE MEMORIAL HOSPITAL

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1352

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

Date/Time Prepared:

					0 09/30/2023	2/28/2024 8:49	
						I/P Days / 0/P	, am
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.		Avai I abl e			
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA			•			
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	21	7, 665	176, 448. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO 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		21	7, 665	176, 448. 00	0	7. 00
	beds) (see instructions)						
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	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER					_	18. 00
19. 00	SKILLED NURSING FACILITY	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	HOSPI CE	00.00					24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	00.00				0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00	40			0	
27. 00	Total (sum of lines 14-26)		40				27. 00
28. 00	Observation Bed Days					0	28. 00 29. 00
29. 00	Ambul ance Trips						
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	(	ין י		32. 00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days						33. 00
33. 00	LTCH site neutral days and discharges						33. 00
	Temporary Expansi on COVID-19 PHE Acute Care	30. 00	0			o	
54.00	Tomporary Expansion Covid 17 The Acute Care	30.00	0	1	1	١	54.00

Health Financial Systems JACKSONVILLE MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CC

Provider CCN: 14-1352

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3	
From 10/01/2022	Part	
To 09/30/2023	Date/Time Prepared:	2/28/2024 8: 49 am

						2/28/2024 8: 4	9 am
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	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	3, 158	171	7, 286	b		1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	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	(			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	2 150	0	7 20/	1		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	347	40	1, 040	,		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		552. 66	
15. 00	CAH visits	0	0	(	)		15. 00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	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	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			C	)		24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC				0.00		26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C			
27. 00	,		455	2 202	0.00	570. 34	1
28. 00	Observation Bed Days Ambulance Trips	0	455	2, 202	<u>′</u>		28. 00 29. 00
29. 00 30. 00	Employee discount days (see instruction)	١		101			30.00
30.00				101			31.00
32. 00		0	90	187			32.00
32. 00	Total ancillary labor & delivery room		70	107			32. 00
JZ. U1	outpatient days (see instructions)			(	Ί		JZ. UI
33. 00		o					33. 00
33. 01	3	o					33. 01
	Temporary Expansi on COVID-19 PHE Acute Care	o	О	C			34. 00
	,	, -1	-1		1	•	

| Peri od: | Worksheet S-3 | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared: Health Financial Systems JACKSONVIII
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-1352

				10	09/30/2023	2/28/2024 8:4	
		Full Time		Di sch	arges	27 207 202 1 0. 1	, d
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	905	175	2, 277	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			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						7. 00
	beds) (see instructions)						
8.00	I NTENSI VE 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	0.00		005	475	0.077	13.00
14. 00	Total (see instructions)	0. 00	C	905	175	2, 277	14. 00
15.00	CAH visits						15. 00 15. 10
15. 10 16. 00	REH hours and visits						
17. 00	SUBPROVIDER - IPF SUBPROVIDER - IRF						16. 00 17. 00
18. 00	SUBPROVI DER						17. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20. 00	NURSING FACILITY	0.00					20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CWHC - CWHC						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	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care						34. 00

	Financial Systems	JACKSONVILLE MEMORIAL		44 4050		u of Form CMS-2	
HOSPI I	AL UNCOMPENSATED AND INDIGENT CARE DATA	Pi	Provider CCN:		Period: From 10/01/2022 To 09/30/2023		pared:
						1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX D	ATA				1.00	
	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 paym					Y N	3. 00 4. 00
4.00							
5.00			8, 365, 506	5.00			
6. 00 7. 00	Medicaid charges Medicaid cost (line 1 times line 6)		92, 129, 830 20, 281, 000	6. 00 7. 00			
		8, 075, 285					
0.00	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							
10.00	Stand-alone CHIP charges					207, 809	
	Stand-alone CHIP cost (line 1 times line					45, 746	11. 00
	Difference between net revenue and costs					0	12. 00
	Other state or local government indigent						10.00
13.00	Net revenue from state or local indigent Charges for patients covered under state					0	
14.00	10)	e di Tocai Tilui gerit care	program (No	t incruded	II ITTIES 0 UI	U	14.00
15. 00	State or local indigent care program cos	st (line 1 times line 14)	)			0	15. 00
	Difference between net revenue and costs			rogram (see	instructions)	0	
	Grants, donations and total unreimbursed					s (see	1
	instructions for each line)						
	Private grants, donations, or endowment					0	
	Government grants, appropriations or tra				/	0 075 205	
19. 00	Total unreimbursed cost for Medicaid , C 8, 12 and 16)	HIP and State and Local	indigent car	re programs	(sum of lines	8, 075, 285	19. 00
	[6, 12 and 16)			Uni nsured	Insured	Total (col. 1	
				patients	pati ents	+ col . 2)	
				1.00	2. 00	3. 00	
	Uncompensated care cost (see instruction						
	Charity care charges and uninsured disco			1, 669, 45		2, 327, 960	
21. 00	Cost of patients approved for charity ca	are and uninsured discoun	nts (see	367, 50	5 658, 505	1, 026, 010	21. 00
22. 00	instructions) Payments received from patients for amou	unts previously written o	off as	81, 37	5 10, 010	91, 385	22. 00
00	charity care	p. 51. 5451 y W 1 C COII O		31, 37	13,310	71, 505	
22 00	Cost of charity care (see instructions)			286, 13	0 648, 495	934, 625	1 22 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?

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

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

Medicare reimbursable bad debts (see instructions)

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

Medicare allowable bad debts (see instructions)

Non-Medicare bad debt amount (see instructions)

Bad debt amount (see instructions)

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

1.00

6, 674, 142

1, 474, 100

2, 267, 847

4, 406, 295

1, 763, 727

2, 698, 352

10, 773, 637 31. 00

24.00

25.01

26.00

27.00

27.01

28.00

29.00

30.00

0 25.00

25.00

25. 01

27. 00

27.01

28. 00

stay limit

		Uni nsurea	Insured	Total (col. 1	
		pati ents	pati ents	+ 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	stay limit		24. 00		
25. 00	If line 24 is yes, enter the charges for patient days beyond the indigent stay limit	care program'	s length of		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)	ŕ			30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31. 00

ealth Financial Systems J ECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (		CKSONVILLE MEMOF EXPENSES	Provider CC	N: 14-1352 F	Peri od:	u of Form CMS-2 Worksheet A	∠∪∪Z-I
LOLA	STITEMENT AND ADDUSTMENTS OF THE BALANCE OF	EXI ENGES	Trovider co			Date/Time Pre	narod:
					Го 09/30/2023	2/28/2024 8: 4	
	Cost Center Description	Sal ari es	Other		Reclassi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00		0.00	
. 00	00100 CAP REL COSTS-BLDG & FIXT		2, 209, 839	2, 209, 839	405, 759	2, 615, 598	1.0
. 00	00200 CAP REL COSTS-MVBLE EQUIP		3, 109, 515	3, 109, 515	29, 767	3, 139, 282	2.0
. 00	00300 OTHER CAP REL COSTS		0	(	0	0	
00	00400 EMPLOYEE BENEFITS DEPARTMENT	-22, 247	12, 244, 902	12, 222, 655		12, 222, 655	
01	00540 NONPATI ENT TELEPHONES	0	158, 360	158, 360		158, 360	
02 03	O0550 DATA PROCESSING   O0560 PURCHASING RECEIVING AND STORES	1, 040, 734	3, 279, 655	4, 320, 389		4, 320, 389	
03	00570 ADMITTING	1, 446 747, 452	207, 211 41, 168	208, 657 788, 620		208, 657 788, 620	
05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	652, 847	1, 100, 919	1, 753, 766		1, 753, 766	
06	00590 OTHER ADMIN & GENERAL	2, 955, 711	20, 010, 264	22, 965, 975		22, 743, 593	•
00	00700 OPERATION OF PLANT	1, 973, 114	3, 722, 045	5, 695, 159		5, 695, 159	1
00	00800 LAUNDRY & LINEN SERVICE	255, 165	141, 004	396, 169		396, 169	
00	00900 HOUSEKEEPI NG	1, 274, 098	299, 755	1, 573, 853		1, 573, 853	
0. 00	01000 DI ETARY	1, 385, 824	1, 416, 074	2, 801, 898	-2, 277, 167	524, 731	10.0
. 00	01100 CAFETERI A	0	0	(	2, 277, 167	2, 277, 167	11. (
3. 00	01300 NURSING ADMINISTRATION	636, 351	27, 180	663, 531	-6	663, 525	13. (
. 00	01400 CENTRAL SERVICE & SUPPLY	251, 097	24, 348	275, 445		272, 966	1
5. 00	01500 PHARMACY	1, 162, 751	6, 339, 468	7, 502, 219		1, 514, 844	
5. 00	01600 MEDICAL RECORDS & LIBRARY	824, 989	49, 032	874, 02		874, 021	
7. 00	01700 SOCIAL SERVICE	358, 272	11, 959	370, 231		370, 231	
9. 00	01900 NONPHYSICIAN ANESTHETISTS	282, 093	0	282, 093	-58, 760	223, 333	19.0
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	E 207 255	2 702 050	0 170 10	407.050	7 7/2 14/	20.
0.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	5, 387, 255 840, 847	2, 782, 850	8, 170, 105 2, 258, 949			
3. 00	04300 NURSERY	040, 047	1, 418, 102 0		-6, 188 213, 468	2, 252, 761 213, 468	
1. 00	04400 SKI LLED NURSI NG FACI LI TY	1, 171, 138	161, 367	1, 332, 509			
00	ANCI LLARY SERVI CE COST CENTERS	1, 171, 100	101,007	1,002,000	7 10	1,002,172	1 (
0. 00	05000 OPERATI NG ROOM	2, 744, 055	5, 078, 832	7, 822, 887	-2, 493, 206	5, 329, 681	50.0
1.00	05100 RECOVERY ROOM	326, 464	19, 608	346, 072		345, 585	
2. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	233, 855	233, 855	52.0
3. 00	05300 ANESTHESI OLOGY	0	187, 915	187, 915		227, 749	53.0
4. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 600, 189	1, 223, 378	2, 823, 567		2, 783, 015	
5. 00	05500 RADI OLOGY - THERAPEUTI C	344, 800	519, 599	864, 399		864, 363	
5. 00	05600 RADI OI SOTOPE	135, 370	180, 964	316, 334		316, 188	
7. 00	05700 CT SCAN	567, 080	630, 942	1, 198, 022		1, 189, 123	
3. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	319, 601	124, 966	444, 567 5, 286, 065		444, 150	
0. 00 5. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	2, 036, 978 974, 684	3, 249, 087 906, 354	1, 881, 038		5, 286, 035 1, 734, 478	
5. 00	06600 PHYSI CAL THERAPY	2, 678, 476	283, 180	2, 961, 656		2, 961, 527	
. 00	06700 OCCUPATI ONAL THERAPY	957, 000	149, 133	1, 106, 133		1, 105, 399	
	06800 SPEECH PATHOLOGY	352, 906	6, 175	359, 08		359, 081	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(		1, 392, 380	1
2. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	0	(		1, 465, 098	
. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	(	6, 137, 484	6, 137, 484	73.
1. 00	07400 RENAL DIALYSIS	193, 228	21, 559	214, 787	-3, 959	210, 828	74. (
5. 00	03950 DI ABETI C EDUCATION	267, 812	4, 330	272, 142	0	272, 142	76. (
5. 97	07697 CARDI AC REHABI LI TATI ON	128, 350	8, 317	136, 667	7 -1	136, 666	
5. 98	07698 HYPERBARI C OXYGEN THERAPY	54, 935	68, 207	123, 142	2 0	123, 142	76. 9
	OUTPATIENT SERVICE COST CENTERS						
0. 00	09000 CLI NI C	1, 448, 915	1, 275, 100	2, 724, 015		2, 544, 424	
. 00	09100 EMERGENCY	3, 322, 422	4, 557, 144	7, 879, 566	-22, 402	7, 857, 164	
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92. (
3 00	11300 I NTEREST EXPENSE		335, 334	335, 334	-335, 334	0	113. (
8.00		39, 632, 202	77, 585, 141	117, 217, 343			
J. UC	NONREI MBURSABLE COST CENTERS	37, 032, 202	77, 303, 141	117, 217, 34	<u>,                                    </u>	111, 211, 343	1, 10. (
o. no	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	nl	nl	(	ol ol	Ω	190. (
	19200 PHYSICIANS PRIVATE OFFICES	181, 438	13, 348	194, 786		194, 786	
	07950 RENTED SPACE	0	0	(			194. 0
74. UL	07951 PASSAVANT FOUNDATION	0	0	(	o o		194. (
94. OC 94. O1	107731 1 ASSAVANT 1 OUNDATION						
94. 01	07952 COMMUNITY BENEFIT & RELATIONS	ol	131, 435	131, 435	5 0	131, 435	194. C
94. 01 94. 02		90, 235	131, 435 4, 893	131, 435 95, 128		131, 435 95, 128	

Health Financial Systems  RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	JACKSONVILLE MEM	ORIAL HOSPITAL Provider CCN: 14-13		u of Form CMS-2552-10   Worksheet A
RESERVED TO THE STERRED OF THE STERRED OF	OI EM ENGES	Trovider con. Tr re	From 10/01/2022 To 09/30/2023	
Cost Center Description	Adjustments	Net Expenses		2/28/2024 8: 49 am
	(See A-8)	For Allocation		
GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00 00100 CAP REL COSTS-BLDG & FLXT	621, 492	3, 237, 090		1. 00
2.00 O0200 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 5.01   00540   NONPATIENT TELEPHONES	1, 588, 083	13, 810, 738		4.00
5. 01   00540 NONPATTENT TELEPHONES 5. 02   00550 DATA PROCESSING	-108, 389 0	49, 971 4, 320, 389		5. 01 5. 02
5. 03   00560 PURCHASING RECEIVING AND STORES	0	208, 657		5. 03
5. 04   00570   ADMI TTI NG	0	788, 620		5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-19, 459	1, 734, 307		5. 05
5.06 O0590 OTHER ADMIN & GENERAL	-9, 594, 468	13, 149, 125		5. 06
7. 00 O0700 OPERATION OF PLANT	-180, 071	5, 515, 088		7. 00
8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG	0	396, 169		8. 00 9. 00
10. 00   01000 DI ETARY	-101, 813	1, 573, 853 422, 918		10.00
11. 00   01100   CAFETERI A	-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 MEDI CAL RECORDS & LI BRARY	-14, 030	859, 991		16.00
17. 00   01700   SOCI AL SERVI CE 19. 00   01900   NONPHYSI CI AN ANESTHETI STS	-223, 333	370, 231 0		17. 00 19. 00
19. 00 O1900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	-223, 333	U <sub>I</sub>		19.00
30. 00 03000 ADULTS & PEDI ATRI CS	-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 O4400 SKILLED NURSING FACILITY	-450	1, 332, 042		44. 00
ANCILLARY SERVICE COST CENTERS	10	F 220 (41		F0.00
50. 00   05000   0PERATI NG ROOM 51. 00   05100   RECOVERY ROOM	-40 0	5, 329, 641 345, 585		50. 00 51. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	o o	233, 855		52. 00
53. 00   05300   ANESTHESI OLOGY	0	227, 749		53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	2, 255	2, 785, 270		54. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C	-374, 370	489, 993		55. 00
56. 00   05600   RADI OI SOTOPE	0	316, 188		56. 00
57. 00 05700 CT SCAN	0	1, 189, 123		57. 00 58. 00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI) 60. 00   06000   LABORATORY	-103, 865	444, 150 5, 182, 170		60.00
65. 00 06500 RESPIRATORY THERAPY	-158, 898	1, 575, 580		65. 00
66. 00   06600 PHYSI CAL THERAPY	-59, 706	2, 901, 821		66. 00
67. 00 06700 OCCUPATI ONAL 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 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	10.804	1, 465, 098		72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DIALYSIS	-10, 804 0	6, 126, 680 210, 828		73. 00 74. 00
76. 00 03950 DI ABETI C EDUCATI ON	o o	272, 142		76. 00
76. 97 07697 CARDI AC REHABILITATION	0	136, 666		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	-27, 137	96, 005		76. 98
OUTPATIENT SERVICE COST CENTERS				
90. 00   09000   CLI NI C	-926, 280	1, 618, 144		90.00
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART	-2, 696, 480	5, 160, 684		91. 00 92. 00
SPECIAL PURPOSE COST CENTERS				92.00
113. 00 11300 I NTEREST EXPENSE	0	0		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-12, 999, 231	104, 218, 112		118. 00
NONREI MBURSABLE COST CENTERS	_			
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	194, 786		192. 00
194. 00 07950 RENTED SPACE	0	0		194. 00
194.01 07951 PASSAVANT FOUNDATION 194.02 07952 COMMUNITY BENEFIT & RELATIONS		131, 435		194. 01 194. 02
194. 03 07953 HEALTHY JACKSONVILLE		95, 128		194. 02
200.00 TOTAL (SUM OF LINES 118 through 199)	-12, 999, 231	104, 639, 461		200. 00
· · · · · · · · · · · · · · · · · · ·		'		•

Provider CCN: 14-1352

Peri od: Worksheet A-6 From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/28/2024 8: 49 am

					2/28/2024 8: 4	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - INTEREST EXPENSE					
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	33 <u>5, 3</u> 34		1. 00
	O BRODERTY I NOURANGE		0	335, 334		
1 00	B - PROPERTY I NSURANCE	2 00	ما	100 100		1 00
1. 00	OTHER CAP REL COSTS	3.00	•	100, 192		1. 00
	TOTALS		0	100, 192		-
1.00	C - DRUGS SOLD TO PATIENTS DRUGS CHARGED TO PATIENTS	73.00	0	6, 139, 320		1.00
2.00	DRUGS CHARGED TO PATTENTS	0.00	o	0, 139, 320		2.00
3.00		0.00	0	Ö		3.00
4. 00		0.00	Ö	Ö		4. 00
5. 00		0.00	ő	0		5. 00
6. 00		0.00	o	0		6. 00
7. 00		0.00	Ö	Ö		7. 00
8. 00		0.00	O	0		8. 00
9.00		0.00	O	0		9.00
10.00		0.00	O	0		10.00
11.00		0.00	O	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	TOTALS — — — — —	0.00	0	0		22. 00
	D - MEDICAL SUPPLIES & IMPLAN	NTS SULD	U U	6, 139, 320		
1. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 392, 380		1.00
1.00	PATI ENT	71.00	٩	1, 372, 300		1.00
2.00	IMPL. DEV. CHARGED TO	72. 00	o	1, 465, 098		2. 00
	PATI ENTS			,,		
3.00		0.00	o	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 13. 00		0.00	0	0		12. 00 13. 00
14. 00	+	0.00	0	0		14. 00
14.00	0 — — — — —			2, 857, 478		14.00
	E - CAFETERIA		U	2,031,410		1
1.00	CAFETERI A	11.00	1, 126, 291	1, 150, 876		1.00
1. 50	TOTALS	<del> </del>	1, 126, 291	1, 150, 876		1.00
	F - CRNA AND ALDE WAGES	<u> </u>	., .20, 271	., .55, 5, 6		1
1.00	ANESTHESI OLOGY	53.00	88, 966	0		1.00
2.00	NONPHYSI CI AN ANESTHETI STS	19. 00	30, 206	0		2. 00
	TOTALS		119, 172	o		
	G - NURSERY & L&D					
1.00	NURSERY	43.00	194, 642	18, 826		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	21 <u>3, 2</u> 31	20, 624		2.00
	TOTALS		407, 873	39, 450		1
	H - MEDICAL DIRECTORS					
1.00	ADULTS & PEDIATRICS	30.00	0	43, 498		1.00
				0.010		2 00
2.00	RESPI RATORY THERAPY	65.00	0	8, 813		2. 00
2. 00 3. 00	RENAL DI ALYSI S	65. 00 74. 00	0_	6, 150		3. 00
3. 00			i			

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 14-1352

Peri od: From 10/01/2022 To 09/30/2023

Date/Time Prepared: 2/28/2024 8:49 am

						2/28/2024 8:	49 am
		Decreases			1		
	Cost Center	Li ne #	Sal ary		kst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00		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			100, 192			1
	C - DRUGS SOLD TO PATIENTS	<u>'</u>	<u>'</u>	· '			
1.00	OTHER ADMIN & GENERAL	5. 06	0	63, 729	0		1.00
2.00	NURSING ADMINISTRATION	13.00	o	6	o		2. 00
3. 00	CENTRAL SERVICE & SUPPLY	14. 00	o	1	o		3. 00
4. 00	PHARMACY	15. 00	ő	5, 987, 375	o		4. 00
5. 00	ADULTS & PEDIATRICS	30.00	Ö	3, 593	o		5. 00
6. 00	INTENSIVE CARE UNIT	31.00	o	209	0		6. 00
7. 00	SKILLED NURSING FACILITY	44.00	0	13	0		7. 00
		i .	-1		0		1
8.00	OPERATING ROOM	50.00	0	2, 491			8. 00
9.00	RECOVERY ROOM	51.00	0	487	0		9. 00
10.00	ANESTHESI OLOGY	53.00	0	40, 378	0		10.00
11. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 861	0		11. 00
12. 00	RADI OLOGY - THERAPEUTI C	55. 00	0	36	0		12. 00
13. 00	RADI OI SOTOPE	56.00	0	146	0		13. 00
14. 00	CT SCAN	57.00	0	8, 817	0		14. 00
15. 00	MAGNETIC RESONANCE IMAGING	58. 00	0	417	0		15. 00
	(MRI)						
16.00	LABORATORY	60.00	0	30	0		16. 00
17. 00	RESPI RATORY THERAPY	65.00	0	10, 543	0		17. 00
18.00	PHYSI CAL 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	o	1	o		20.00
21.00	CLINIC	90.00	o	5, 674	O		21. 00
22. 00	EMERGENCY	91.00	ol	11, 600	o		22. 00
	TOTALS	+		6, 139, 320			
	D - MEDICAL SUPPLIES & IMPLAN	NTS SOLD	<u> </u>				
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	2, 478	0		1.00
2. 00	INTENSIVE CARE UNIT	31.00	o	5, 979	0		2. 00
3. 00	ADULTS & PEDIATRICS	30.00	o	541	o		3. 00
4. 00	OPERATING ROOM	50.00	ő	2, 490, 715	ő		4. 00
5. 00	ANESTHESI OLOGY	53.00	Ö	8, 754	0		5. 00
6. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	37, 691	0		6. 00
7. 00	CT SCAN	57.00	0	82	0		7. 00
8. 00	RESPIRATORY THERAPY		-		0		8. 00
		65.00	0	144, 830	0		4
9.00	PHYSICAL THERAPY	66.00	0	128	-		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 DI ALYSI S	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	DI ETARY	10. 00	<u>1, 126, 2</u> 91	1, 150, 876	0		1. 00
	TOTALS		1, 126, 291	1, 150, 876			
	F - CRNA AND ALDE WAGES						
1.00	NONPHYSICIAN ANESTHETISTS	19. 00	88, 966	0	0		1. 00
2.00	CLINIC	90.00	30, 206	0	o		2. 00
	TOTALS	+	119, 172				
	G - NURSERY & L&D	<u>'</u>		<u>'</u>			
1.00	ADULTS & PEDIATRICS	30.00	407, 873	39, 450	0		1.00
2.00		0.00	0	0.,	o		2. 00
00	TOTALS — — — —	<del>                                     </del>	407, 873	39, 450	— —		1 2.00
	H - MEDICAL DIRECTORS	<u> </u>	137, 073	37, 430			1
1.00	OTHER ADMIN & GENERAL	5. 06	0	58, 461	0		1.00
2.00	OTHER ADMIN & GENERAL	0.00	0	50, 401	0		2. 00
				0			3. 00
3.00	TOTALS — — — —	0.00	— — 씢		"		3.00
E00.00			1 452 224	58, 461			E00 00
SUU. UU	Grand Total: Decreases	I I	1, 653, 336	10, 681, 111			500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 14-1352 Peri od: Worksheet A-7 From 10/01/2022 Part I Date/Time Prepared: 09/30/2023 2/28/2024 8:49 am Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 730, 500 1.00 0 1.00 0 2.00 Land Improvements 1, 450, 753 0 2.00 0 3.00 19, 896, 745 3.00 Buildings and Fixtures 1,061,966 1, 061, 966 0 0 4.00 Building Improvements 0 4.00 5.00 Fixed Equipment 25, 406, 560 2,601,293 0 2, 601, 293 5.00 0 6.00 Movable Equipment 21, 787, 097 223, 070 223, 070 943, 485 6.00 0 7.00 HIT designated Assets 753, 492 201, 255 7.00 0 8.00 Subtotal (sum of lines 1-7) 70, 025, 147 3, 886, 329 3, 886, 329 1, 144, 740 8.00 9.00 Reconciling Items -19, 756, 168 -1, 449, 699 0 -1, 449, 699 9.00 89, 781, 315 Total (line 8 minus line 9) 5, 336, 028 5, 336, 028 10.00 1, 144, 740 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 730, 500 1.00 2.00 Land Improvements 1, 450, 753 0 2. 00 3.00 Buildings and Fixtures 20, 958, 711 0 3.00 0 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 28, 007, 853 0 5.00 Movable Equipment 0 6.00 21, 066, 682 6.00 7. 00 7.00 HIT designated Assets 552, 237 0

72, 766, 736

-21, 205, 867

93, 972, 603

0

Heal th	Financial Systems JA	ACKSONVILLE MEM	ORIAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 14-1352	Peri od:	Worksheet A-7	
					From 10/01/2022		
					To 09/30/2023		pared:
			CI	IMMADY OF CAD	TAI	2/28/2024 8: 4	9 am
			51	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9. 00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 180, 466	29, 373	8	0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3, 109, 515	0		0	0	2.00
3.00	Total (sum of lines 1-2)	5, 289, 981	29, 373	3	0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description		Total (1) (sum	ו			
		Capi tal -Relate					
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	(SHEET A, COLUM	N 2, LINES 1 a	ind 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	5			2.00
3.00	Total (sum of lines 1-2)	0	5, 319, 354				3. 00

Heal th	n Financial Systems J	ACKSONVILLE MEM	IORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	F	eriod: rom 10/01/2022 o 09/30/2023		
		COME	PUTATION OF RAT	TI OS	ALLOCATION OF		
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1, 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		2.00	3.00	4.00	3.00	
1.00	CAP REL COSTS-BLDG & FLXT	51, 147, 817	0	51, 147, 817	0, 702901	70, 425	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	21, 618, 919		21, 618, 919			2. 00
3.00	Total (sum of lines 1-2)	72, 766, 736		72, 766, 736	1. 000000	100, 192	3.00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL							
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS	_	1			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	70, 425		29, 373	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	29, 767		0	2.00
3.00	Total (sum of lines 1-2)	U	<u> </u>	100, 192 JMMARY OF CAPLT		29, 373	3. 00
			30	JIVIIVIARY OF CAPIT	AL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			,	,	Capi tal -Rel ate	` ' '	
			ĺ	<b>_</b>	d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13.00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	143, 202				3, 237, 090	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	29, 767	0	0	3, 208, 326	2.00

0 143, 202

70, 425 29, 767 100, 192

0 0 0

3, 208, 326 2. 00 6, 445, 416 3. 00

0 0 0

2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)

	Health Financial Systems		JACKSONVILLE MEMORIAL HOSPITAL In L					
ADJUST	MENTS TO EXPENSES				Period: From 10/01/2022 To 09/30/2023		pared:	
				Expense Classification on To/From Which the Amount is		2/28/2024 8: 4	9 am	
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.		
1.00	Investment income - CAP REL	1. 00 B	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 11	1.00	
1.00	COSTS-BLDG & FLXT (chapter 2)	В	-192, 132	CAF REE COSTS-BEDG & TIXT	1.00	11	1.00	
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00	
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other (chapter 2)	В	-127, 592	OTHER ADMIN & GENERAL	5. 06	0	3. 00	
4.00	Trade, quantity, and time		0		0.00	0	4. 00	
5. 00	di scounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00	
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00	
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter	А	-25, 529	NONPATIENT TELEPHONES	5. 01	0	7. 00	
8.00	Tel evi si on and radio servi ce	А	-44, 118	OPERATION OF PLANT	7. 00	0	8. 00	
9. 00 10. 00	(chapter 21) Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -9, 349, 863		0.00	0		
11. 00	adjustment Sale of scrap, waste, etc.	В	0	OPERATION OF PLANT	7. 00	0	11. 00	
12. 00	(chapter 23) 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		-558, 323	CAFETERI A	11. 00		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	В	-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	Vendi ng machi nes	В	-9, 712	CAFETERI A	11. 00	0	20.00	
21. 00	Income from imposition of interest, finance or penalty	В		CASHI ERI NG/ACCOUNTS RECEI VABLE	5. 05	0	21. 00	
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to	,	0		0.00	0	22. 00	
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	-158, 048	RESPIRATORY THERAPY	65. 00		23. 00	
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00	
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 00	
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00	
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00	
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist	А	-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	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00	
00	limitation (chapter 14)			ADULTO A DESCRIPCIÓ			00	
30. 99	Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00		30. 99	
31. 00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	O	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	А	354, 255	OTHER ADMIN & GENERAL	5. 06	0	33. 00	

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 14-1352 Peri od: Worksheet A-8 From 10/01/2022 | To 09/30/2023 | Date/Time Prepared:

				''	0 09/30/2023	2/28/2024 8: 4	
				Expense Classification on	Worksheet A	272072021 0. 1	Zili
				To/From Which the Amount is			
				Toy I I om min on the famount is	to bo haj dotod		
	Cost Center Description	Rasis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2.00	3.00	4, 00	5. 00	
33. 01	DOORBELL DI NNERS	В	-101, 813		10.00	0.00	33. 01
33. 02	MISC INCOME - A&G	B		OTHER ADMIN & GENERAL	5. 06	0	33. 02
33. 02	MISC INCOME - A&G	В		PHYSICAL THERAPY	66.00	0	33. 02
	MISC INCOME - PI	В	·	i e		0	33. 04
33. 04		1		RADI OLOGY-DI AGNOSTI C	54.00	0	
33. 05	MISC INCOME - PHARMACY	В		PHARMACY	15. 00	0	33. 05
33. 06	MISC INCOME - PLANT	В	·	OPERATION OF PLANT	7. 00	0	33. 06
33. 07	RETIREE HEALTH INSURANCE PLAN	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 07
34. 00	ADVERTI SI NG/MARKETI NG	A	·	OTHER ADMIN & GENERAL	5. 06	0	34. 00
34. 01	ADVERTI SI NG/MARKETI NG	A		LABORATORY	60. 00	0	34. 01
34. 02	ADVERTI SI NG/HR	A	·	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	PROVI DER 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	A	30, 552	CAP REL COSTS-BLDG & FIXT	1. 00	9	39. 00
	ADJUSTMENT						
39. 01	REVALUED ASSETS DEPRECIATION	A	711, 732	CAP REL COSTS-BLDG & FIXT	1. 00	9	39. 01
	ADJUSTM		,				
39. 02	REVALUED ASSETS DEPRECIATION	l A	-330, 109	CAP REL COSTS-MVBLE EQUIP	2. 00	9	39. 02
	ADJUSTM		,				
40.00	EMPLOYED PHYSICIAN BENEFITS	A	-14.823	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	40. 00
41. 00	TELEVISION	A		RADI OLOGY - THERAPEUTI C	55. 00	0	41. 00
41. 01	TELEVISION	A	·	PHYSI CAL THERAPY	66. 00	0	41. 01
41. 02	TELEVI SI ON	A		HYPERBARIC OXYGEN THERAPY	76. 98	0	41. 02
41. 03	MUTUAL FUND FEES	A	·	OTHER ADMIN & GENERAL	5. 06	0	41. 03
42. 00	NON-ALLOWABLE TRANSPORTATION	A		ADULTS & PEDIATRICS	30.00	0	42. 00
42.00	COSTS	A	- 10, 400	ADDETS & FEDIATRICS	30.00	U	42.00
42. 01	NON-ALLOWABLE TRANSPORTATION	A	452	INTENSIVE CARE UNIT	31. 00	0	42. 01
42.01	COSTS	A	-432	INTENSIVE CARE UNIT	31.00	U	42.01
42. 02	NON-ALLOWABLE TRANSPORTATION	A	450	SKILLED NURSING FACILITY	44.00	0	42. 02
42. 02	COSTS	A	-430	SKILLED NORSING FACILITY	44.00	U	42.02
42. 03	NON-ALLOWABLE TRANSPORTATION	A	40	ODEDATI NC DOOM	EO 00	0	42. 03
42.03	COSTS	A	-40	OPERATING ROOM	50. 00	U	42.03
40.04	1		Ε0	DECDI DATODY THEDADY	/F 00		40.04
42. 04	NON-ALLOWABLE TRANSPORTATION	A	-50	RESPIRATORY THERAPY	65. 00	0	42. 04
42.05	COSTS	_	20	CLINIC	00.00		42.05
42. 05	NON-ALLOWABLE TRANSPORTATION	A	-20	CLINIC	90. 00	0	42. 05
10.61	COSTS		07 155	EMEDOENOV	04.00		40.07
42. 06	NON-ALLOWABLE TRANSPORTATION	A	-87, 455	EMERGENCY	91. 00	0	42. 06
F0 60	COSTS		40.000.001				F0 00
50.00	TOTAL (sum of lines 1 thru 49)		-12, 999, 231				50. 00
	(Transfer to Worksheet A,						
(4) 5	column 6, line 200.)			0110 0 1 15 1			

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.

<sup>(2)</sup> 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.

Provider CCN: 14-1352

Worksheet A-8-1

From 10/01/2022 OFFICE COSTS 09/30/2023 Date/Time Prepared:

					2/28/2024 8: 4	19 am
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	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).			15, 167, 565	13, 208, 169	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and/	or Home Office	
			Keratea organi zatron(3) ana	or riollic orricc	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3.00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00	В	0. 00 MEMORI AL HL SYS 100. 00	6. 00
7.00	С	0. 00 PPA 100. 00	7. 00
8. 00		0.00	8. 00
9. 00		0.00	9. 00
10. 00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

5.00 1, 959, 396 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 par

3.00

4.00

4.01

4 02

4.03

4.04

5 00

nas not	been posted to worksheet A,	cordinits i and/or 2, the amount arrowable should be indicated in cordinit 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

i ci ilibai	STINDAR SOMETIC WHICH CHILD AVITTE						
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		110	100.00				

(1) Use the following symbols to indicate interrelationship to related organizations:

9

0

0

0

3.00

4.00

4.01

4 02

4.03

4.04

70, 645

283, 747

167, 550

-52, 182

-82,860

1, 456, 395

- 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 organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 14-1352

						To 09/30/2023	Date/Time Pre	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				'	'		Hours	
	1. 00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00	5. 06	OTHER ADMIN & GENERAL	5, 217, 648			0	0	1. 00
2.00	30. 00	ADULTS & PEDIATRICS	98, 699	98, 699	9 0	0	0	2. 00
3.00		INTENSIVE CARE UNIT	-3, 380	-3, 380	) c	0	0	3.00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	-2, 300	-2, 300	) c	0	0	4.00
5.00	55. 00	RADIOLOGY - THERAPEUTIC	373, 276	373, 276	5 C	0	0	5. 00
6.00		LABORATORY	104, 135	104, 135	5 0	0	0	6. 00
7.00	65. 00	RESPI RATORY THERAPY	800	800	) c	0	0	7. 00
8.00	76. 98	HYPERBARIC OXYGEN THERAPY	25, 700	25, 700	) c	0	0	8. 00
9.00		CLI NI C	926, 260	926, 260	) c	0	0	9. 00
10.00		EMERGENCY	2, 625, 886	2, 609, 025	16, 861	0	0	
200.00			9, 366, 724				0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit		Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
1 00	1.00	2.00	8.00	9. 00	12.00	13. 00	14.00	1 00
1.00		OTHER ADMIN & GENERAL	0	1	1	1	1	
2.00		ADULTS & PEDIATRICS	0		1	0	1	
3.00		INTENSIVE CARE UNIT	0	(			0	
4.00		RADI OLOGY-DI AGNOSTI C	0		) (	0	0	
5. 00		RADIOLOGY - THERAPEUTIC	0		) (	0	0	
6. 00		LABORATORY	0		) (	0	0	
7.00		RESPI RATORY THERAPY	0	9			0	
8.00		HYPERBARIC OXYGEN THERAPY	0	9			0	
9.00		CLI NI C	0	9			0	
10.00		EMERGENCY	0	9			0	1
200.00		Cook Cook or (Dhord of or	D	A-1:+1 DCE	RCE	)	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE		Adjustment		
		l denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00	1	
1. 00	5. 06	OTHER ADMIN & GENERAL	0					1. 00
2.00	1	ADULTS & PEDIATRICS	0			98, 699	•	2. 00
3.00	31.00	INTENSIVE CARE UNIT	0			-3, 380		3. 00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	0		ol c	-2, 300		4. 00
5.00	55. 00	RADIOLOGY - THERAPEUTIC	0	(	o c	373, 276		5. 00
6.00	60.00	LABORATORY	0	(	) c	104, 135		6. 00
7.00	65. 00	RESPI RATORY THERAPY	0	(	) c	800		7. 00
8. 00		HYPERBARIC OXYGEN THERAPY	0	(	) c	25, 700		8. 00
9.00	90.00	CLI NI C	0	(	) c	926, 260		9. 00
10.00	91.00	EMERGENCY	0	(	) c	2, 609, 025	5	10.00
200.00			0	(	o c	9, 349, 863	:	200.00

	Financial Systems  JA  JABLE COST DETERMINATION FOR THERAPY SERVICES	ACKSONVILLE MEMOR FURNISHED BY	Provider CO	CN: 14-1352	Period:	u of Form CMS-2 Worksheet A-8	
OUTSI	DE SUPPLIERS				From 10/01/2022 To 09/30/2023		
					Physical Therapy		- dili
						1. 00	
	PART I - GENERAL INFORMATION					50	
1. 00 2. 00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see instruct	ions)			52 780	1. 00 2. 00
3. 00 4. 00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)  Number of unduplicated days in which therapy assistant was on provider site but neither supervisor						3. 00 4. 00
	nor therapist was on provider site (see insti	or super visor	0	4.00			
5. 00 6. 00							
0.00	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)						
7. 00	Standard travel expense rate					6. 48	7. 00
8. 00	Optional travel expense rate per mile	Cunorui coro	Thomani ata	Acci etente	Ai doo	0.00	8. 00
		Supervi sors 1.00	Therapists 2.00	Assi stants 3.00	Ai des 4. 00	Trai nees 5. 00	
9. 00	Total hours worked	0.00	2, 233. 50				1
10. 00 11. 00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0. 00 48. 12	96. 24 48. 12	0. ( 0. (		0. 00	10. 00 11. 00
	one-half of column 2, line 10; column 3,	.0.12	.02	0			00
12. 00	one-half of column 3, line 10) Number of travel hours (provider site)	0	0		0		12. 00
	Number of travel hours (offsite)	o o	o		0		12. 01
13. 00 13. 01	,	0	0		0		13. 00 13. 01
13.01	Number of mires dirveil (offsite)	U U			O .		13.01
	Part II - SALARY EQUIVALENCY COMPUTATION					1. 00	
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	1
16. 00 17. 00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a		atory therapy	or lines 14-	·16 for all	0 214, 952	16. 00 17. 00
40.00	others)	•	3 13				
18. 00 19. 00	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, li					0	18. 00 19. 00
	Total allowance amount (sum of lines 17-19 for	or respiratory t				214, 952	20. 00
	If the sum of columns 1 and 2 for respiratory	/ therapy or coli					
	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	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra	lines 21-23. ainees (line 17	divided by su			0.00	21. 00
22. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine	lines 21-23. ainees (line 17 line 9 for all	divided by su others)			0.00	22. 00
22. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions)	lines 21-23. ainees (line 17 line 9 for all ees (line 2 time	divided by su others) s line 21)	m of columns	1 and 2, line 9	0.00	22. 00
22. 00 23. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	lines 21-23. ainees (line 17 line 9 for all ees (line 2 time	divided by su others) s line 21)	m of columns	1 and 2, line 9	0. 00 0 214, 952	22. 00 23. 00
22. 00 23. 00 24. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11)	lines 21-23. ainees (line 17 line 9 for all ees (line 2 time	divided by su others) s line 21)	m of columns	1 and 2, line 9	0. 00 0 214, 952 11, 549	22. 00 23. 00 24. 00
22. 00 23. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	lines 21-23. ainees (line 17 dine 9 for all dees (line 2 time) WANCE AND TRAVEL	divided by su others) s line 21) EXPENSE COMPI	m of columns UTATION - PRO	1 and 2, line 9	0. 00 0 214, 952	22. 00 23. 00 24. 00 25. 00
22. 00 23. 00 24. 00 25. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3	lines 21-23. ainees (line 17 line 9 for all lees (line 2 times) WANCE AND TRAVEL sum of lines 24	divided by supporters) s line 21)  EXPENSE COMPL and 25 for a	m of columns  UTATION - PRO	1 and 2, line 9	0. 00 0 214, 952 11, 549 0	22. 00 23. 00 24. 00 25. 00 26. 00
22. 00 23. 00 24. 00 25. 00 26. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	lines 21-23. ainees (line 17 line 9 for all ees (line 2 times VANCE AND TRAVEL  sum of lines 24 for respiratory	divided by substitute of the s	UTATION - PRO	1 and 2, line 9  OVIDER SITE  3 and 4 for all	0. 00 0 214, 952 11, 549 0 11, 549	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions)  PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance  Therapists (line 3 times column 2, line 11)  Assistants (line 4 times column 3, line 11)  Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)  Total standard travel allowance and standard 27)	lines 21-23. ainees (line 17 line 9 for all ees (line 2 time WANCE AND TRAVEL  sum of lines 24 for respiratory travel expense	divided by substitute of the s	UTATION - PRO	1 and 2, line 9  OVIDER SITE  3 and 4 for all	0.00 0 214, 952 11, 549 0 11, 549 1, 555	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions)  PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance  Therapists (line 3 times column 2, line 11)  Assistants (line 4 times column 3, line 11)  Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)  Total standard travel allowance and standard	lines 21-23. ainees (line 17 line 9 for all lees (line 2 time) WANCE AND TRAVEL  sum of lines 24 for respiratory travel expense	divided by substance of the substance of	UTATION - PRO	1 and 2, line 9  OVIDER SITE  3 and 4 for all	0.00 0 214, 952 11, 549 0 11, 549 1, 555	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,	lines 21-23. ainees (line 17 line 9 for all ees (line 2 times  VANCE AND TRAVEL  sum of lines 24 for respiratory  travel expense of columns 1 and line 12)	and 25 for a therapy or so at the provide 2, line 12)	UTATION - PRO II others) um of lines ; er site (sum	1 and 2, line 9  OVIDER SITE  3 and 4 for all	0.00 0 214, 952 11, 549 0 11, 549 1, 555 13, 104	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of	lines 21-23. ainees (line 17 line 9 for all ees (line 2 times  VANCE AND TRAVEL  sum of lines 24 for respiratory  travel expense  Expense of columns 1 and line 12)  sum of lines 29	and 25 for a therapy or so at the provide 2, line 12) and 30 for a	UTATION - PRO II others) um of lines 3 er site (sum	1 and 2, line 9  OVIDER SITE  3 and 4 for all  of lines 26 and	0.00 0 214, 952 11, 549 0 11, 549 1, 555 13, 104	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traina Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	lines 21-23. ainees (line 17 dines 21 dines 21 dines 21 dines 21 dines 21 dines 21 dines 24 dines 24 dines 24 dines 24 dines 25 dines 26 dines 27 dines 27 dines 28 dines 29 d	and 25 for a therapy or so at the provide 2, line 12) and 30 for a 13 for respira	UTATION - PRO II others) um of lines 3 er site (sum	1 and 2, line 9  OVIDER SITE  3 and 4 for all  of lines 26 and	0.00 0 214, 952 11, 549 0 11, 549 1, 555 13, 104	22. 00 23. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traina Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns)	lines 21-23. ainees (line 17 line 9 for all lees (line 2 time)  WANCE AND TRAVEL  sum of lines 24 for respiratory  travel expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line lexpense (line 2	and 25 for a therapy or so at the provide 2, line 12) and 30 for a 13 for respira	UTATION - PRO II others) um of lines 3 er site (sum II others) atory therapy	1 and 2, line 9  OVIDER SITE  3 and 4 for all  of lines 26 and	0.00 0 214, 952 11, 549 0 11, 549 1, 555 13, 104	22. 00 23. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00

00	Standard travel expense rate					6. 48	1
00	Optional travel expense rate per mile					0.00	8.
		Supervi sors	Therapi sts	Assistants	Ai des	Trai nees	
	I=	1.00	2. 00	3. 00	4. 00	5. 00	_
00	Total hours worked	0. 00			0.00		1
. 00	AHSEA (see instructions)	0.00			0. 00	0.00	
. 00	Standard travel allowance (columns 1 and 2,	48. 12	48. 12	0. 00			11.
	one-half of column 2, line 10; column 3,						
00	one-half of column 3, line 10)	0	0				12
00	Number of travel hours (provider site)	0	0	· · · · · · · · · · · · · · · · · · ·			12.
	Number of travel hours (offsite)	0	0	- 1			12
	Number of miles driven (provider site)	0	0				13.
01	Number of miles driven (offsite)	U	0	0			13.
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
00	Supervisors (column 1, line 9 times column 1,	line 10)				0	14
00	Therapists (column 2, line 9 times column 2,					214, 952	15
00	Assistants (column 3, line 9 times column 3,	line10)				0	16
00	Subtotal allowance amount (sum of lines 14 ar	nd 15 for respi	ratory therapy	or lines 14-16	o for all	214, 952	17
	others)	·	, , ,				
00	Aides (column 4, line 9 times column 4, line	10)				0	18
00	Trainees (column 5, line 9 times column 5, li	ne 10)				0	19
00	Total allowance amount (sum of lines 17-19 for	or respiratory	therapy or lin	es 17 and 18 fo	or all others)	214, 952	20
	If the sum of columns 1 and 2 for respiratory	therapy or co	lumns 1-3 for	physical therap	y, speech path	nol ogy or	
	occupational therapy, line 9, is greater than		no entries on	lines 21 and 22	2 and enter on	line 23	
	the amount from line 20. Otherwise complete					T	١
00	Weighted average rate excluding aides and tra			m of columns 1	and 2, line 9	0.00	21
	for respiratory therapy or columns 1 thru 3,						
00	Weighted allowance excluding aides and traine	ees (line 2 tim	ies line 21)			0	1
00	Total salary equivalency (see instructions)		L EVERNOE COMP	UTATION BROWN	DED 01.TE	214, 952	23
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	IANCE AND TRAVE	L EXPENSE COMP	UTATION - PROVI	DER SITE		4
00	Standard Travel Allowance					11 540	١.,
00	Therapists (line 3 times column 2, line 11)					11, 549	
00	Assistants (line 4 times column 3, line 11)	6.1.	4 105 6			0	
00	Subtotal (line 24 for respiratory therapy or				1.4.6	11, 549	
00	Standard travel expense (line 7 times line 3	for respirator	y therapy or s	um of lines 3 a	and 4 For all	1, 555	27
00	others) Total standard travel allowance and standard	traval avnonce	at the provid	or sito (sum of	Flinos 26 and	13, 104	28
00	27)	traver expense	at the provid	er site (sum or	Titles 20 and	13, 104	20
	Optional Travel Allowance and Optional Travel	Expense					1
00	Therapists (column 2, line 10 times the sum of		d 2. line 12 )			0	29
00	Assistants (column 3, line 10 times column 3,					0	
00	Subtotal (line 29 for respiratory therapy or		9 and 30 for a	II others)		0	
00	Optional travel expense (line 8 times columns			,	or sum of	0	1
	columns 1-3, line 13 for all others)	•		3 13			
00	Standard travel allowance and standard travel	expense (line	28)			13, 104	33
00	Optional travel allowance and standard travel	expense (sum	of lines 27 an	d 31)		0	34
00	Optional travel allowance and optional travel	expense (sum	of lines 31 an	d 32)		0	35
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	NCE AND TRAVEL	EXPENSE COMPU	TATION - SERVIC	CES OUTSIDE PRO	OVI DER SITE	
	Standard Travel Expense						
00	Therapists (line 5 times column 2, line 11)					0	36
00	Assistants (line 6 times column 3, line 11)					0	37
00	Subtotal (sum of lines 36 and 37)					0	38
00	Standard travel expense (line 7 times the sur	n of lines 5 an	d 6)			0	39
	Optional Travel Allowance and Optional Travel						
00	Therapists (sum of columns 1 and 2, line 12.0	01 times column	2, line 10)			0	40
00	Assistants (column 3, line 12.01 times column	n 3, line 10)				0	41
00	Subtotal (sum of lines 40 and 41)					0	42
00	Optional travel expense (line 8 times the sur					0	43
	Total Travel Allowance and Travel Expense - C	offsite Service:	s; Complete on	e of the follow	wing three line	es 44, 45,	
	or 46, as appropriate.						1
	Standard travel allowance and standard travel						44
$\cap \cap$	Optional travel allowance and standard travel	expense (sum	of lines 39 an	d 42 - see inst	tructions)	0	45

	Financial Systems JA ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	CKSONVILLE MEMO FURNISHED BY	Provi der CC		Period: From 10/01/2022 To 09/30/2023	w of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre	-3 pared:
					Physical Therapy	2/28/2024 8: 4 Cost	9 am
						1. 00	
16. 00	Optional travel allowance and optional travel	expense (sum	of lines 42 and	d 43 - see in	structions)		46. 00
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
	DADT W. OVEDTIME COMPUTATION	1. 00	2. 00	3. 00	4. 00	5. 00	
17. 00	PART V - OVERTIME COMPUTATION Overtime hours worked during reporting	40. 75	0.00	0. 0	0.00	40. 75	   47. 00
7.00	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. 73	0.00	0. 0	0.00	40. 73	47.00
8. 00 9. 00	Overtime rate (see instructions) Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	144. 36 5, 882. 67	0. 00 0. 00	0. C 0. C			48. 00 49. 00
	CALCULATION OF LIMIT	400.00			ام ما	100.00	
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100. 00	0. 00	0.0	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	0.0	0.00	2, 080. 00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52. 00	Adjusted hourly salary equivalency amount (see instructions)	96. 24	0.00	0.0	0.00		52.00
3. 00	Overtime cost limitation (line 51 times line 52)	200, 179	О		0 0		53.00
4. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	5, 883	0		0 0		54.00
5. 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
6. 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	1, 961	0		0 0	1, 961	56. 00
	respiratory therapy and columns 1 through 3 for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND FYCESS COST	AD HISTMENT			1. 00	
7. 00	Salary equivalency amount (from line 23)	IND EXCESS COST	ADSOSTMENT			214, 952	57.00
8. 00	Travel allowance and expense - provider site					13, 104	
9. 00	Travel allowance and expense - Offsite service	es (from lines	44, 45, or 46)	)		0	59.00
	Overtime allowance (from column 5, line 56)					1, 961	
	Equipment cost (see instructions) Supplies (see instructions)					0	
3. 00	Total allowance (sum of lines 57-62)					230, 017	
4. 00	Total cost of outside supplier services (from	your records)				191, 069	
	Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION		enter zero)			0	1
00 00	Line 26 = line 24 for respiratory therapy or	sum of lines 2	4 and 25 for al	I others		11, 549	100 00
	Line 27 = line 7 times line 3 for respiratory				others	1, 555	
00.01						13, 104	100. 02
	Line 33 = line 28 = sum of lines 26 and 27						1
00. 02	LINE 34 CALCULATION	therapy or su	n of lines 3 ar	nd 4 for all	others		
00. 02 01. 00					others	1, 555	

LINE 34 = SUM OF TITIES 27 and 31

LINE 35 CALCULATION

102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others

102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line

0 102. 00 0 102. 01

0 102. 02

13 for all others 102.02 Line 35 = sum of lines 31 and 32

	IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provider CO	CN: 14-1352	Peri od: From 10/01/2022 To 09/30/2023	Worksheet A-8 Parts I-VI Date/Time Pre 2/28/2024 8:4	pared:				
					Therapy	0031					
	DADT I CENEDAL INFORMATION					1. 00					
1. 00	PART I - GENERAL INFORMATION  Total number of weeks worked (excluding aide:	s) (see instruct	i ons)			52	1.00				
2. 00	Line 1 multiplied by 15 hours per week					780					
3. 00 4. 00	Number of unduplicated days in which supervi: Number of unduplicated days in which therapy					297 0	3. 00 4. 00				
1. 00	nor therapist was on provider site (see inst		ni provider si	te but her th	er supervisor	0	4.0				
5. 00	Number of unduplicated offsite visits - supe					0					
5. 00	Number of unduplicated offsite visits - thera assistant and on which supervisor and/or the					0	6.0				
	instructions)	.,	3		,, (						
7. 00 3. 00	Standard travel expense rate Optional travel expense rate per mile					6. 48 0. 00					
7. 00	operand traver expense rate per mire	Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	0.0				
2.00	Total house weeked	1.00	2.00	3.00	4. 00 00 0. 00	5. 00	0.0				
9. 00 10. 00	Total hours worked AHSEA (see instructions)	0. 00 0. 00	5, 695. 50 75. 57		00 0.00 00 0.00	0. 00 0. 00	9.00				
11. 00	Standard travel allowance (columns 1 and 2,	37. 79	37. 79		00		11. 00				
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)										
12. 00	Number of travel hours (provider site)	О	0		0		12. 00				
12. 01	Number of travel hours (offsite)						12. 0				
13. 00 13. 01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		0		13. 00 13. 0				
	Part II - SALARY EQUIVALENCY COMPUTATION					1. 00					
	Supervisors (column 1, line 9 times column 1,						14.0				
15. 00 16. 00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					430, 409 0	ı				
7. 00	Subtotal allowance amount (sum of lines 14 au		atory therapy	or lines 14	-16 for all	430, 409					
	others)	10)					10.0				
18. 00 19. 00	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l					0					
	Total allowance amount (sum of lines 17-19 for	or respiratory t				430, 409					
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than										
	the amount from line 20. Otherwise complete	lines 21-23.		occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on the amount from line 20. Otherwise complete lines 21-23.							
21. 00	Weighted average rate excluding aides and tra										
		•	,	m of columns	1 and 2, line 9	0.00	21. 0				
22. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train	line 9 for all	others)	m of columns	1 and 2, line 9	0	22. 0				
22. 00 23. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions)	line 9 for all ees (line 2 time	others) es line 21)		·		22. 0				
23. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	line 9 for all ees (line 2 time	others) es line 21)		·	0 430, 409	22. 00 23. 00				
23. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions)  PART III - STANDARD AND OPTIONAL TRAVEL ALLOW  Standard Travel Allowance  Therapists (line 3 times column 2, line 11)	line 9 for all ees (line 2 time	others) es line 21)		·	0 430, 409 11, 224	22. 00 23. 00 24. 00				
23. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions)  PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance  Therapists (line 3 times column 2, line 11)	line 9 for all ees (line 2 time WANCE AND TRAVEL	others) es line 21) .EXPENSE COMP	UTATION - PR	·	0 430, 409	22. 00 23. 00 24. 00 25. 00				
23. 00 24. 00 25. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions)  PART III - STANDARD AND OPTIONAL TRAVEL ALLOW  Standard Travel Allowance  Therapists (line 3 times column 2, line 11)  Assistants (line 4 times column 3, line 11)  Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3	line 9 for all ees (line 2 time VANCE AND TRAVEL sum of lines 24	others) es line 21) EXPENSE COMP	UTATION - PR	OVIDER SITE	0 430, 409 11, 224 0	22. 00 23. 00 24. 00 25. 00 26. 00				
23. 00 24. 00 25. 00 26. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions)  PART III - STANDARD AND OPTIONAL TRAVEL ALLOW  Standard Travel Allowance  Therapists (line 3 times column 2, line 11)  Assistants (line 4 times column 3, line 11)  Subtotal (line 24 for respiratory therapy or	line 9 for all ees (line 2 time WANCE AND TRAVEL  sum of lines 24 for respiratory	others) es line 21)  EXPENSE COMP  and 25 for a therapy or s	UTATION - PR II others) um of lines	OVIDER SITE  3 and 4 for all	0 430, 409 11, 224 0 11, 224	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00				
23. 00 24. 00 25. 00 26. 00 27. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27)	line 9 for all ees (line 2 time WANCE AND TRAVEL  sum of lines 24 for respiratory travel expense	others) es line 21)  EXPENSE COMP  and 25 for a therapy or s	UTATION - PR II others) um of lines	OVIDER SITE  3 and 4 for all	11, 224 0 11, 224 1, 925	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00				
23. 00 24. 00 25. 00 26. 00 27. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel	line 9 for all ees (line 2 time VANCE AND TRAVEL  sum of lines 24 for respiratory  travel expense  Expense	others) es line 21)  EXPENSE COMP  and 25 for a therapy or s at the provid	UTATION - PR II others) um of lines	OVIDER SITE  3 and 4 for all	0 430, 409 11, 224 0 11, 224 1, 925 13, 149	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00				
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions)  PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance  Therapists (line 3 times column 2, line 11)  Assistants (line 4 times column 3, line 11)  Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)  Total standard travel allowance and standard 27)  Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3	line 9 for all ees (line 2 time VANCE AND TRAVEL  sum of lines 24 for respiratory  travel expense  Expense of columns 1 and line 12)	others) es line 21)  EXPENSE COMP  and 25 for a therapy or s at the provid	UTATION - PR II others) um of lines er site (sum	OVIDER SITE  3 and 4 for all	0 430, 409 11, 224 0 11, 224 1, 925 13, 149 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00				
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or	line 9 for all ees (line 2 time VANCE AND TRAVEL  sum of lines 24 for respiratory travel expense  Expense of columns 1 and line 12) sum of lines 29	others) es line 21)  EXPENSE COMP  and 25 for a therapy or s at the provid  2 line 12 ) and 30 for a	UTATION - PR  II others) um of lines er site (sum	OVIDER SITE  3 and 4 for all  of lines 26 and	0 430, 409 11, 224 0 11, 224 1, 925 13, 149 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00				
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions)  PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance  Therapists (line 3 times column 2, line 11)  Assistants (line 4 times column 3, line 11)  Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)  Total standard travel allowance and standard 27)  Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3	line 9 for all ees (line 2 time VANCE AND TRAVEL  sum of lines 24 for respiratory travel expense  Expense of columns 1 and line 12) sum of lines 29	others) es line 21)  EXPENSE COMP  and 25 for a therapy or s at the provid  2 line 12 ) and 30 for a	UTATION - PR  II others) um of lines er site (sum	OVIDER SITE  3 and 4 for all  of lines 26 and	0 430, 409 11, 224 0 11, 224 1, 925 13, 149 0 0	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00				
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel	line 9 for allees (line 2 time  WANCE AND TRAVEL  sum of lines 24 for respiratory  travel expense  Expense of columns 1 and, line 12) sum of lines 29 s 1 and 2, line  I expense (line	others) es line 21)  EXPENSE COMP  and 25 for a therapy or s at the provid  2, line 12) and 30 for a 13 for respir 28)	UTATION - PR  II others) um of lines er site (sum  II others) atory therap	OVIDER SITE  3 and 4 for all  of lines 26 and	0 430, 409 11, 224 0 11, 224 1, 925 13, 149 0 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00				
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 33. 00 34. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions)  PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance  Therapists (line 3 times column 2, line 11)  Assistants (line 4 times column 3, line 11)  Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)  Total standard travel allowance and standard 27)  Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns 1-3, line 13 for all others)  Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel	line 9 for allees (line 2 time  WANCE AND TRAVEL  sum of lines 24 for respiratory  travel expense  Expense of columns 1 and, line 12)  sum of lines 29 s 1 and 2, line  I expense (sum of lines (sum o	others) es line 21)  EXPENSE COMP  I and 25 for a therapy or s at the provid  I 2, line 12 ) and 30 for a 13 for respir 28) of lines 27 an	UTATION - PR  II others) um of lines er site (sum  II others) atory therap	OVIDER SITE  3 and 4 for all  of lines 26 and	0 430, 409 11, 224 0 11, 224 1, 925 13, 149 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00				
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions)  PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance  Therapists (line 3 times column 2, line 11)  Assistants (line 4 times column 3, line 11)  Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)  Total standard travel allowance and standard 27)  Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others)  Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	line 9 for allees (line 2 time  VANCE AND TRAVEL  sum of lines 24 for respiratory  travel expense  Expense of columns 1 and, line 12) sum of lines 29 s 1 and 2, line  l expense (sum of lines (sum of lexpense (sum of lexpen	others) es line 21)  EXPENSE COMP  I and 25 for a / therapy or s at the provid  I 2, line 12 ) O and 30 for a 13 for respir  28) Of lines 27 an of lines 31 an	UTATION - PR  II others) um of lines er site (sum  II others) atory therap  d 31) d 32)	OVIDER SITE  3 and 4 for all of lines 26 and y or sum of	0 430, 409 11, 224 0 11, 224 1, 925 13, 149 0 0 0 13, 149 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00				
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3 columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense	line 9 for allees (line 2 time  VANCE AND TRAVEL  sum of lines 24 for respiratory  travel expense  Expense of columns 1 and, line 12) sum of lines 29 s 1 and 2, line  l expense (sum of lines (sum of lexpense (sum of lexpen	others) es line 21)  EXPENSE COMP  I and 25 for a / therapy or s at the provid  I 2, line 12 ) O and 30 for a 13 for respir  28) Of lines 27 an of lines 31 an	UTATION - PR  II others) um of lines er site (sum  II others) atory therap  d 31) d 32)	OVIDER SITE  3 and 4 for all of lines 26 and y or sum of	0 430, 409 11, 224 0 11, 224 1, 925 13, 149 0 0 13, 149 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00				
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 33. 00 34. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions)  PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance  Therapists (line 3 times column 2, line 11)  Assistants (line 4 times column 3, line 11)  Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)  Total standard travel allowance and standard 27)  Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others)  Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	line 9 for allees (line 2 time  VANCE AND TRAVEL  sum of lines 24 for respiratory  travel expense  Expense of columns 1 and, line 12) sum of lines 29 s 1 and 2, line  l expense (sum of lines (sum of lexpense (sum of lexpen	others) es line 21)  EXPENSE COMP  I and 25 for a / therapy or s at the provid  I 2, line 12 ) O and 30 for a 13 for respir  28) Of lines 27 an of lines 31 an	UTATION - PR  II others) um of lines er site (sum  II others) atory therap  d 31) d 32)	OVIDER SITE  3 and 4 for all of lines 26 and y or sum of	0 430, 409 11, 224 0 11, 224 1, 925 13, 149 0 0 13, 149 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00				
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 3, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	line 9 for all ees (line 2 time WANCE AND TRAVEL  sum of lines 24 for respiratory  travel expense  Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (sum of lexpense	others) es line 21)  EXPENSE COMP  I and 25 for a therapy or s at the provid  I 2, line 12 ) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	UTATION - PR  II others) um of lines er site (sum  II others) atory therap  d 31) d 32)	OVIDER SITE  3 and 4 for all of lines 26 and y or sum of	0 430, 409 11, 224 0 11, 224 1, 925 13, 149 0 0 0 13, 149 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00				
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00 38. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	line 9 for all ees (line 2 time WANCE AND TRAVEL  sum of lines 24 for respiratory travel expense  Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line l expense (sum of l expense	others) es line 21)  EXPENSE COMP  I and 25 for a therapy or s at the provid  I 2, line 12 ) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	UTATION - PR  II others) um of lines er site (sum  II others) atory therap  d 31) d 32)	OVIDER SITE  3 and 4 for all of lines 26 and y or sum of	0 430, 409 11, 224 0 11, 224 1, 925 13, 149 0 0 13, 149 0 0 0 0 0 0 0	22. 0 23. 0 24. 0 25. 0 26. 0 27. 0 28. 0 30. 0 31. 0 32. 0 34. 0 35. 0				
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 3, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	line 9 for all ees (line 2 time VANCE AND TRAVEL  sum of lines 24 for respiratory travel expense  Expense of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (sum of lines 4) expense (sum of lines 5 and 6) Expense	others) es line 21)  EXPENSE COMP  and 25 for a therapy or s at the provid  2, line 12) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	UTATION - PR  II others) um of lines er site (sum  II others) atory therap  d 31) d 32)	OVIDER SITE  3 and 4 for all of lines 26 and y or sum of	0 430, 409 11, 224 0 11, 224 1, 925 13, 149 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00				
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional travel allowance and optional travel allowance and optional travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.04 Assistants (column 3, line 12.01 times columns)	line 9 for allees (line 2 time  WANCE AND TRAVEL  sum of lines 24 for respiratory  travel expense  of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (sum of lexpense sum of lexp	others) es line 21)  EXPENSE COMP  and 25 for a therapy or s at the provid  2, line 12) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	UTATION - PR  II others) um of lines er site (sum  II others) atory therap  d 31) d 32)	OVIDER SITE  3 and 4 for all of lines 26 and y or sum of	0 430, 409 11, 224 0 11, 224 1, 925 13, 149 0 0 0 13, 149 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 0 23. 0 24. 0 25. 0 26. 0 27. 0 28. 0 30. 0 31. 0 32. 0 31. 0 35. 0 36. 0 37. 0 38. 0 39. 0				
3. 00 4. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 6. 00 9. 00 0.	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 3, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel allowance and optional travel allowance and optional travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum optional Travel Allowance and Optional Travel Expense Therapists (sum of columns 1 and 2, line 12.04 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	line 9 for allees (line 2 time  WANCE AND TRAVEL  sum of lines 24 for respiratory  travel expense  Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (sum of lexpense of lexpense of lines 5 and Expense  Of times column of lines 5 and Expense  Of times column of lines 10)	others) es line 21)  EXPENSE COMP  I and 25 for a therapy or s at the provid  I 2, line 12) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	UTATION - PR  II others) um of lines er site (sum  II others) atory therap  d 31) d 32)	OVIDER SITE  3 and 4 for all of lines 26 and y or sum of	0 430, 409 11, 224 1, 925 13, 149 0 0 0 13, 149 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 0 23. 0 25. 0 26. 0 27. 0 28. 0 30. 0 31. 0 32. 0 34. 0 35. 0 37. 0 38. 0 37. 0 38. 0 39. 0 40. 0 41. 0 42. 0				
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 6. 00 7. 00 8. 00 0. 00 1. 00 0. 00 1. 00 0. 00 1. 00 0. 00 1. 00 0. 00 1. 00 0. 00 0. 00 1. 00 0.	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional travel allowance and optional travel allowance and optional travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.04 Assistants (column 3, line 12.01 times columns)	line 9 for allees (line 2 time  WANCE AND TRAVEL  sum of lines 24 for respiratory  travel expense  Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (sum of lines 4 sum of lines 29 s 1 and 2, line l expense (sum of lines 5 and Expense On times column 1 and lines 1 sum of lines 5 and 1 sum of lines 5 and 1 sum of lines 5 and 1 sum of lines 1 sum of lin	others) es line 21)  EXPENSE COMP  I and 25 for a therapy or s at the provid  I 2, line 12) and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU  I 6) 2, line 10)	UTATION - PR  II others) um of lines er site (sum  II others) atory therap  d 31) d 32) TATION - SER	OVIDER SITE  3 and 4 for all  of lines 26 and  y or sum of	0 430, 409 11, 224 0 11, 224 1, 925 13, 149 0 0 0 13, 149 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 0 23. 0 24. 0 25. 0 26. 0 27. 0 28. 0 30. 0 31. 0 32. 0 31. 0 35. 0 37. 0 37. 0 38. 0 39. 0 40. 0 41. 0				

REASON	Financial Systems JA ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	CKSONVILLE MEMO	Provider CC		Peri od: From 10/01/2022 To 09/30/2023	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 2/28/2024 8:4	-3 pared:
					Respi ratory Therapy	Cost	
						1. 00	
45. 00	Optional travel allowance and standard travel	expense (sum o	of lines 39 an	d 42 - see in	structions)		45. 00
46. 00	Optional travel allowance and optional travel						46. 00
		Therapists 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4. 00	<u>Total</u> 5. 00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
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. 0	0.00	189. 75	47. 00
48. 00	Overtime rate (see instructions)	113. 36	0. 00				48. 00
49. 00	Total overtime (including base and overtime	21, 510. 06	0. 00	0.0	0.00		49. 00
	allowance) (multiply line 47 times line 48) 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	O. C	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	0.0	0.00	2, 080. 00	51. 00
	DETERMINATION OF OVERTIME ALLOWANCE						
	Adjusted hourly salary equivalency amount (see instructions)	75. 57	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 A	ND EXCESS COST	ADJUSTMENT			1.00	
57.00	Salary equivalency amount (from line 23)					430, 409	57. 00
58. 00	Travel allowance and expense - provider site			`		13, 149	
59. 00 60. 00	Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56)	es (110III 111Ies	44, 45, 01 46	)		0 7 171	59. 00 60. 00
61. 00	Equipment cost (see instructions)						61.00
	Supplies (see instructions)					0	
	Total allowance (sum of lines 57-62)	vous seconde)				450, 729	
	Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63		enter zero)			608, 777 158, 048	
	LINE 33 CALCULATION					130, 040	05.00
	Line 26 = line 24 for respiratory therapy or					11, 224	
100 01	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27	therapy or su	m of lines 3 a	nd 4 for all	others	1, 925 13, 149	100. 01 100. 02
	LINE 34 CALCULATION		m of lines 2 a	nd 4 for all	othors	1 025	101. 00
100. 02			ii or rriies s a	nu 4 ioi aii	others	1, 923	
100. 02 101. 00 101. 01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or			II others			101. 01
100. 02 101. 00 101. 01 101. 02	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 2	9 and 30 for a				101. 01 101. 02
100. 02 101. 00 101. 01 101. 02 102. 00	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	sum of lines 2 <sup>th</sup>	9 and 30 for a 9 and 30 for a	II others	mns 1-3, line	1, 925	

REASON	Financial Systems JA ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	CKSONVILLE MEMOI	Provi der CCN	: 14-1352	Peri od: From 10/01/2022 To 09/30/2023 Occupati onal		-3 pared:
					Therapy		
	PART I - GENERAL INFORMATION					1. 00	
1.00	Total number of weeks worked (excluding aides	) (see instruct	i ons)			26	
2. 00 3. 00 4. 00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis Number of unduplicated days in which therapy	390 123 0	3. 00				
5. 00 6. 00	nor therapist was on provider site (see instr Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera assistant and on which supervisor and/or ther instructions)		0				
7.00	Standard travel expense rate					6. 48	
8. 00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.00 Trai nees	8. 00
		1.00	2.00	3.00	4. 00	5. 00	
9. 00 10. 00 11. 00	Total hours worked AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0. 00 0. 00 45. 61	980. 00 91. 21 45. 61	0. ( 0. ( 0. (	0.00	l e	
12. 00 12. 01 13. 00 13. 01	Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (offsite)	0 0	0 0		0 0 0		12. 00 12. 01 13. 00 13. 01
13.01	Number of miles driven (offsite)	U <sub>1</sub>	U <sub>I</sub>		<u> </u>		13.01
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
	Supervisors (column 1, line 9 times column 1,					l e	14. 00
15. 00 16. 00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					89, 386 0	1
17. 00	Subtotal allowance amount (sum of lines 14 an		atory therapy o	or lines 14	-16 for all	89, 386	
18. 00	others) Aides (column 4, line 9 times column 4, line	10)				0	18. 00
19. 00	Trainees (column 5, line 9 times column 5, li	ne 10)				0	19. 00
20. 00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete	therapy or coll line 2, make n	umns 1-3 for ph	nysical thei	apy, speech path		20.00
21. 00	Weighted average rate excluding aides and tra	inees (line 17		of columns	1 and 2, line 9	0.00	21. 00
22. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine					0	22. 00
23. 00	Total salary equivalency (see instructions)					89, 386	23. 00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW. Standard Travel Allowance	ANCE AND TRAVEL	EXPENSE COMPUT	TATION - PRO	OVIDER SITE		
24. 00	Therapists (line 3 times column 2, line 11)					5, 610	
25. 00 26. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 24	and 25 for all	others)		0 5, 610	1
27. 00	Standard travel expense (line 7 times line 3				and 4 for all	797	
28. 00	others) Total standard travel allowance and standard 27)	·	at the provider	site (sum	of lines 26 and	6, 407	28. 00
29. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum o		2, line 12 )			0	29. 00
30.00	Assistants (column 3, line 10 times column 3,	line 12)	•			0	30.00
31. 00 32. 00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns				or sum of	0	
	columns 1-3, line 13 for all others)		•	, chorup			
33. 00 34. 00	Standard travel allowance and standard travel Optional travel allowance and standard travel			31)		6, 407 0	1
35. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	expense (sum o	f lines 31 and	32)	/ICES OUTSIDE PRO	0	1
36. 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	1
38. 00 39. 00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	of lines 5 and	6)			0	
40.00	Optional Travel Allowance and Optional Travel		2 line 10)				40.00
40. 00 41. 00	Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column		z, iiile 10)			0	
42. 00 43. 00	Subtotal (sum of lines 40 and 41)	of columns 1 2	lino 12 01)			0	
43.00	Optional travel expense (line 8 times the sum Total Travel Allowance and Travel Expense - 0			of the foll	owing three line		43.00
44 00	or 46, as appropriate. Standard travel allowance and standard travel	expense (sum o	flines 38 and	39 - See ii	nstructions)	0	44.00
. 1. 00	Totalisara travor arrowance and Standard traver	expense (suii 0	. 111103 30 and	5, 366 H	.5 .1 40 .1 0113)		1 17.00

REASON	Financial Systems JA ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	CKSONVILLE MEMO	Provi der CO	CN: 14-1352	Peri od: From 10/01/2022 To 09/30/2023	2/28/2024 8:49 am	
					Occupati onal Therapy	Cost	
						1. 00	
45. 00	Optional travel allowance and standard travel	expense (sum o	of lines 39 an	d 42 - see in	structions)	0	45. 00
46. 00	Optional travel allowance and optional travel		of lines 42 an				46. 00
		Therapists 1.00	Assi stants 2. 00	Ai des 3.00	Trai nees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
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	0.0	0.00	13. 75	47. 00
48. 00	Overtime rate (see instructions)	136. 82	0. 00				48. 00
49. 00	Total overtime (including base and overtime	1, 881. 28	0. 00	0.0	0.00		49. 00
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT						
50. 00	Percentage of overtime hours by category	100. 00	0.00	0.0	0.00	100.00	50 00
00.00	(divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100.00	0.00	0.0	3. 33	166. 66	00.00
51.00	Allocation of provider's standard work year	2, 080. 00	0.00	0.0	0.00	2, 080. 00	51.00
	for one full-time employee times the						
	percentages on line 50) (see instructions)						
E2 00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	91. 21	0.00	0.0	0.00		52. 00
52.00	(see instructions)	91. 21	0.00	0.0	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
	Dort VI COMPUTATION OF THEDADY LIMITATION A	ND EVCESS COST	AD IIICTMENT			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							58.00
59.00							59.00
60.00						627	60.00
	Equipment cost (see instructions)					0	
	Supplies (see instructions)					0	
	Total allowance (sum of lines 57-62)					96, 420	
						88, 296	
65. 00	5.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero)  LINE 33 CALCULATION						65. 00
100 00	100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						100. 00
100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							100. 01
	00. 02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION						100. 02
	101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						101. 00
101.00	101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 101.02 Line 34 = sum of lines 27 and 31						101. 01 101. 02
101.01	Line 34 = sum of lines 27 and 31					171	
101. 01 101. 02	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION						
101. 01 101. 02 102. 00	Line 34 = sum of lines 27 and 31				mns 1-3, line	0	102. 00 102. 01

Health Financial Systems JACKSONVILLE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1352 Peri od: Worksheet B From 10/01/2022 Part I Date/Time Prepared: 09/30/2023 2/28/2024 8:49 am CAPITAL RELATED COSTS NONPATI ENT Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** for Cost **BENEFITS TELEPHONES** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 5. 01 GENERAL SERVICE COST CENTERS 1 00 3, 237, 090 3, 237, 090 1 00 00100 CAP REL COSTS-BLDG & FLXT 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 13, 819, 664 4.00 00540 NONPATI ENT TELEPHONES 1, 940 51, 911 5 01 49, 971 O 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, 943 506 552 5.03 5.04 00570 ADMITTING 788, 620 12, 463 261, 674 1, 270 5.04 1.352 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 228, 554 1, 734, 307 15, 010 5 05 5 05 884 5.06 00590 OTHER ADMIN & GENERAL 13, 149, 125 108, 125 431, 682 1, 034, 759 3, 921 5.06 00700 OPERATION OF PLANT 5, 515, 088 1, 145, 163 690, 764 7.00 7.00 146, 438 2,706 00800 LAUNDRY & LINEN SERVICE 40, 238 4, 433 89, 330 8.00 396, 169 387 8.00 00900 HOUSEKEEPI NG 446, 046 9 00 1, 573, 853 29, 947 15, 698 497 9 00 10.00 01000 DI ETARY 422, 918 51, 336 19, 409 90, 859 994 10.00 01100 CAFETERI A 11.00 1, 709, 132 44, 286 394, 301 11.00 01300 NURSING ADMINISTRATION 62, 912 7. 180 222, 779 2, 485 13.00 13.00 663.525 14.00 01400 CENTRAL SERVICE & SUPPLY 272 966 10, 682 51, 351 87 906 Ω 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 01700 SOCIAL SERVICE 17.00 370, 231 125, 427 17.00 11, 425 0 884 01900 NONPHYSICIAN ANESTHETISTS O 19.00 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 04400 SKILLED NURSING FACILITY 44.00 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 05100 RECOVERY ROOM 345, 585 114, 291 51.00 10,826 2, 282 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 233, 855 15, 329 3, 990 74, 650 166 52.00 05300 ANESTHESI OLOGY 227, 749 186, 451 31.146 53.00 6, 770 1.270 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 785, 270 81, 403 476, 242 560, 207 2, 761 54.00 05500 RADIOLOGY - THERAPEUTIC 489, 993 120, 710 55.00 31, 265 521, 045 607 55.00 05600 RADI OI SOTOPE 316, 188 47, 391 56.00 3.465 56.00 0 3, 824 05700 CT SCAN 0 198, 528 57.00 1, 189, 123 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (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 1, 104 06500 RESPIRATORY THERAPY 33, 157 341, 225 65 00 1 575 580 114 021 65 00 06600 PHYSI CAL THERAPY 66.00 2, 901, 821 102, 017 15, 357 937, 702 3, 313 66.00 1, 764 67.00 06700 OCCUPATIONAL THERAPY 1, 105, 399 36, 981 335, 034 442 67.00 68.00 06800 SPEECH PATHOLOGY 359, 081 998 2, 192 123, 548 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 392, 380 71 00 O 71 00 C 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 465, 098 C 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 6, 126, 680 0 0 0 73.00 73.00 74.00 07400 RENAL DIALYSIS 210, 828 7, 377 2.128 67,647 0 74.00 03950 DIABETIC EDUCATION 76.00 3, 864 272, 142 406 93.758 0 76.00 76. 97 07697 CARDIAC REHABILITATION 136, 666 22, 387 13,072 44, 934 221 76.97 07698 HYPERBARIC OXYGEN THERAPY 19, 232 76.98 96,005 9,708 45, 995 0 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 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 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 104, 218, 112 3, 060, 137 3, 204, 891 13, 724, 555 50, 310 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190.00 7.601 192.00 19200 PHYSICIANS PRIVATE OFFICES 194, 786 35, 831 3, 435 63, 519 1, 491 192. 00

194.00|07950|RENTED SPACE 0 194.00 0 125, 282 0 194. 01 07951 PASSAVANT FOUNDATION 1, 325 0 0 0 194. 01 0 194. 02 07952 COMMUNITY BENEFIT & RELATIONS 0 131, 435 3.681 0 110 194. 02 194. 03 07953 HEALTHY JACKSONVILLE 0 0 194. 03 95, 128 3, 233 31, 590 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 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

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

2/28/2024 8:49 am Cost Center Description DATA PURCHASI NG ADMITTI NG CASHI ERI NG/ACC Subtotal PROCESSI NG RECEIVING AND **OUNTS STORES** RECEI VABLE 5. 02 5. 04 5A. 05 5.03 5.05 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.01 00540 NONPATIENT TELEPHONES 5.01 00550 DATA PROCESSING 5, 071, 664 5.02 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 57.680 315, 338 5.03 00570 ADMITTING 5.04 288, 180 9, 962 1, 363, 521 5 04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 288, 180 1, 159 2, 268, 094 5.05 5.06 00590 OTHER ADMIN & GENERAL 345, 860 10, 766 0 0 15, 084, 238 5.06 00700 OPERATION OF PLANT 7, 535, 940 7.00 35, 781 0 7.00 0 0 00800 LAUNDRY & LINEN SERVICE 0 8.00 0 10, 391 0 540, 948 8.00 9.00 00900 HOUSEKEEPING 38, 389 0 0 2, 104, 430 9.00 10.00 01000 DI ETARY 172, 821 79, 988 0 0 838, 325 10.00 01100 CAFETERIA 0 2, 147, 719 11.00 11.00 C 01300 NURSING ADMINISTRATION 13.00 288, 180 2, 575 0 1, 249, 636 13.00 14.00 01400 CENTRAL SERVICE & SUPPLY 1,037 0 423, 942 14.00 15.00 01500 PHARMACY 115, 359 7, 947 0 2, 080, 872 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16,00 230, 501 818 1, 439, 173 16,00 17.00 01700 SOCIAL SERVICE 57,680 2, 335 0 0 567, 982 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 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 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 259 8, 244 13, 715 495, 202 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 597 2, 837 4,720 336, 144 52.00 53.00 05300 ANESTHESI OLOGY 0 1,898 15, 493 25, 773 496, 550 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 576, 357 2, 691 77, 225 128, 471 4, 690, 627 54.00 55 00 05500 RADI OLOGY - THERAPEUTI C 574 46 166 76 802 1, 287, 162 55 00 0 05600 RADI OI SOTOPE 56.00 0 1,870 13,064 21, 733 403, 711 56.00 05700 CT SCAN 0 43 202, 342 336, 367 1, 930, 227 57.00 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 15 39, 479 65, 677 674, 766 58.00 06000 LABORATORY 288 180 5 938 163, 965 6, 781, 671 60 00 272, 770 60 00 2, 423, 068 65.00 06500 RESPIRATORY THERAPY 172,821 2, 248 68, 671 114, 241 65.00 4, 604, 237 06600 PHYSI CAL THERAPY 2,065 67, 939 113, 022 66.00 461,001 66.00 67.00 06700 OCCUPATIONAL THERAPY 9, 111 26, 160 43, 519 1, 558, 410 67.00 0 06800 SPEECH PATHOLOGY 0 493, 259 68.00 57 2.772 4.611 68 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 27, 574 45, 872 1, 465, 826 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 28, 092 46, 733 1, 539, 923 72.00 0 07300 DRUGS CHARGED TO PATIENTS 111, 899 6, 424, 733 73.00 186, 154 73.00 3, 951 300, 970 74.00 07400 RENAL DIALYSIS 2.466 6.573 74 00 76.00 03950 DIABETIC EDUCATION 0 1, 291 222 370 372, 053 76.00 76. 97 07697 CARDIAC REHABILITATION 0 2, 137 3, 555 224, 140 76. 97 1, 168 07698 HYPERBARIC OXYGEN THERAPY 76. 98 76.98 0 72 1,966 3, 271 176, 249 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 61, 275 2, 292, 511 2,710 36, 833 90.00 91.00 09100 EMERGENCY 461,001 9, 788 163, 512 272, 018 7, 508, 098 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 279, 696 1, 363, 521 2, 268, 094 103, 674, 871 118. 00 118.00 4, 841, 163 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 7, 601 190. 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 572 0 299, 634 192. 00 194, 00 07950 RENTED SPACE C 0 0 125, 282 194. 00 194. 01 07951 PASSAVANT FOUNDATION 230, 501 r 0 0 231, 826 194. 01 169, 865 194. 02 194. 02 07952 COMMUNITY BENEFIT & RELATIONS 34, 639 0 0 o 194. 03 07953 HEALTHY JACKSONVILLE 0 0 130, 382 194. 03 431 Cross Foot Adjustments 0 200, 00 200.00 201.00 Negative Cost Centers 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

In Lieu of Form CMS-2552-10

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

				''	0 09/30/2023	2/28/2024 8: 4	
	Cost Center Description	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5. 06	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
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 CASHI ERI NG/ACCOUNTS RECEI VABLE						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 9. 00	00800 LAUNDRY & LINEN SERVICE	91, 115	195, 711				8. 00 9. 00
10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	354, 460 141, 203	145, 657 249, 687		2, 609, 267 73, 635	1, 306, 371	10.00
11. 00	01100 CAFETERI A	361, 751	215, 399			1, 300, 371	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	210, 482	305, 993		_	0	13. 00
14.00	01400 CENTRAL SERVICE & SUPPLY	71, 407	51, 957			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	16. 00
17. 00	01700 SOCIAL SERVICE	95, 668	55, 568			0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS I NPATIENT ROUTINE SERVICE COST CENTERS	U U	0	0	0	0	19. 00
30. 00	03000 ADULTS & PEDIATRICS	1, 762, 359	1, 061, 384	175, 687	655, 458	978, 166	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	511, 546	167, 675			55, 840	
43.00	04300 NURSERY	50, 569	41, 822			0	43.00
44.00	04400 SKILLED NURSING FACILITY	314, 482	333, 291			189, 382	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 265, 730	1, 218, 342		259, 842	82, 983	50.00
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	83, 409 56, 618	52, 656 74, 557			0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	83, 636	32, 929		17, 299	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	790, 066	395, 927		112, 975	0	54. 00
55.00	05500 RADI OLOGY - THERAPEUTI C	216, 803	152, 064			0	55. 00
56.00	05600 RADI OI SOTOPE	67, 999	16, 853	0	0	0	56. 00
57. 00	05700 CT SCAN	325, 118	18, 600		_	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	113, 654	65, 936		_	0	58. 00
60.00	06000 LABORATORY	1, 142, 271	350, 028			0	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	408, 129 775, 515	161, 268 496, 190			0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	262, 491	179, 868			0	67. 00
68. 00	06800 SPEECH PATHOLOGY	83, 082	4, 854			0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	246, 896	0			0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	259, 377	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 082, 150	0			0	73. 00
74. 00	07400 RENAL DI ALYSI S	50, 694	35, 880			0	74.00
76. 00 76. 97	03950  DI ABETI C EDUCATION   07697  CARDI AC REHABI LI TATION	62, 667 37, 753	18, 794 108, 884		"	0	76. 00 76. 97
	07698 HYPERBARI C OXYGEN THERAPY	29, 687	47, 219			0	
70.70	OUTPATIENT SERVICE COST CENTERS	27,007	17,217	1,021	17,021		70.70
90.00	09000 CLI NI C	386, 139	408, 702			0	90. 00
91. 00	09100 EMERGENCY	1, 264, 626	933, 744	175, 997	594, 934	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
112 00	SPECIAL PURPOSE COST CENTERS			I			112 00
113.00	11300 INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)	14, 921, 767	7, 944, 593	822, 257	2, 605, 333	1, 306, 371	113.00
110.00	NONREI MBURSABLE COST CENTERS	14, 721, 707	7, 744, 575	022, 237	2, 000, 333	1, 300, 371	110.00
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	1, 280	36, 968	0	0	0	190. 00
	19200 PHYSICIANS PRIVATE OFFICES	50, 469	174, 276		3, 934		192. 00
	07950 RENTED SPACE	21, 102	609, 345	0	0		194. 00
	07951 PASSAVANT FOUNDATION	39, 048	6, 446		0		194. 01
	07952 COMMUNITY BENEFIT & RELATIONS	28, 611	17, 901		0		194. 02
	07953 HEALTHY JACKSONVILLE	21, 961	15, 727	0	0	0	194. 03 200. 00
200. 00 201. 00			0	0		Ω	200. 00
201.00		15, 084, 238	8, 805, 256		2, 609, 267	1, 306, 371	
50	, , , , , , , , , , , , , , , , , , ,		.,, _00		,	,,	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1352

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

2/28/2024 8:49 am Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL RECORDS & SERVICE & ADMI NI STRATI ON **SUPPLY** LI BRARY 11. 00 13.00 15.00 14.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00540 NONPATIENT TELEPHONES 5.01 00550 DATA PROCESSING 5.02 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 5.03 00570 ADMITTING 5.04 5 04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.06 00590 OTHER ADMIN & GENERAL 5.06 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERIA 2, 724, 869 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 46, 615 1,886,361 13.00 14.00 01400 CENTRAL SERVICE & SUPPLY 38, 879 591, 481 14.00 15.00 01500 PHARMACY 78, 029 2, 694, 783 15.00 C 0 01600 MEDICAL RECORDS & LIBRARY 2, 021, 981 16,00 107.826 0 16,00 17.00 01700 SOCIAL SERVICE 30, 440 46,086 0 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 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 43.00 116, 968 44 00 04400 SKILLED NURSING FACILITY 169, 804 0 0 44 00 26, 283 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 273, 639 368, 440 0 0 199, 375 50.00 0 0 51.00 05100 RECOVERY ROOM 19, 198 28, 462 12, 227 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 13, 974 21, 419 4, 207 52.00 53.00 05300 ANESTHESI OLOGY 22, 977 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 148, 915 0 0 114, 531 54.00 55 00 05500 RADI OLOGY - THERAPEUTI C 28 682 Ω 0 68 468 55 00 0 05600 RADI OI SOTOPE 56.00 7,926 0 19, 375 56.00 57.00 05700 CT SCAN 47, 489 0 299, 861 57.00 0 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 26, 241 58, 551 58.00 06000 LABORATORY 0 60 00 237, 453 243, 172 60 00 102, 632 0 65.00 06500 RESPIRATORY THERAPY 122, 869 101, 845 65.00 06600 PHYSI CAL THERAPY 0 100, 758 66.00 226, 201 66.00 67.00 06700 OCCUPATIONAL THERAPY 71, 710 0 0 0 38, 797 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 23, 398 Ω 4, 110 68 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 288, 214 0 40, 895 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 303, 267 41,662 72.00 07300 DRUGS CHARGED TO PATIENTS 2, 693, 788 73.00 165, 955 73.00 0 0 C 07400 RENAL DIALYSIS 74.00 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 3, 170 76. 97 07698 HYPERBARIC OXYGEN THERAPY 5, 998 76. 98 76.98 0 0 2<u>,</u> 916 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 109,022 0 0 54,626 90.00 91.00 09100 EMERGENCY 291, 311 392, 977 0 242, 502 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 693, 788 2, 696, 187 1,886,361 591, 481 2, 021, 981 118. 00 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190. 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 15, 220 0 995 0 192.00 194.00|07950|RENTED SPACE 0 0 0 0 0 194, 00 194. 01 07951 PASSAVANT FOUNDATION 0 C 0 0 0 194. 01 194. 02 07952 COMMUNITY BENEFIT & RELATIONS 0 0 0 194. 02 194. 03 07953 HEALTHY JACKSONVILLE C 0 0 0 194. 03 13, 462 Cross Foot Adjustments 200.00 lann nn 201.00 Negative Cost Centers 0 201.00 2, 021, 981 202. 00 202.00 TOTAL (sum lines 118 through 201) 2, 724, 869 1, 886, 361 591, 481 2, 694, 783

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1352 Peri od: Worksheet B From 10/01/2022 Part I Date/Time Prepared: 09/30/2023 2/28/2024 8:49 am Cost Center Description SOCIAL SERVICE NONPHYSICIAN Intern & Subtotal Total **ANESTHETISTS** Residents Cost & Post Stendown Adjustments 19.00 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 00550 DATA PROCESSING 5.02 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 00590 OTHER ADMIN & GENERAL 5 06 5 06 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI FTARY 10 00 10 00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICE & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 801,040 17.00 01900 NONPHYSICIAN ANESTHETISTS 19 00 19 00 INPATIENT ROUTINE SERVICE COST CENTERS 17, 057, 896 30.00 03000 ADULTS & PEDIATRICS 16, 803, 637 254, 259 486, 325 30.00 31.00 03100 INTENSIVE CARE UNIT 69.818 0 4, 146, 723 -217, 260 3, 929, 463 31.00 04300 NURSERY 46.723 492 653 489, 159 43 00 43 00 0 -3,49444.00 04400 SKILLED NURSING FACILITY 198, 174 0 3, 429, 907 3, 429, 907 44.00 ANCILLARY SERVICE COST CENTERS 11, 344, 897 11, 344, 897 05000 OPERATING ROOM 50.00 50.00 0 05100 RECOVERY ROOM 0 0 51.00 703, 620 703, 620 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 525, 776 0 525, 776 52.00 0000000000000000000 05300 ANESTHESI OLOGY 0 53 00 636, 092 636, 092 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 6, 349, 386 0 0 0 0 0 6, 349, 386 54.00 05500 RADI OLOGY - THERAPEUTI C 55 00 Ω 1, 809, 183 1, 809, 183 55 00 05600 RADI OI SOTOPE 515, 864 515, 864 56.00 56.00 57.00 05700 CT SCAN 2, 621, 295 2, 621, 295 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 939, 148 939, 148 58.00 58.00 0 60.00 06000 LABORATORY 8, 836, 553 8, 836, 553 60.00 65.00 06500 RESPIRATORY THERAPY 3, 376, 077 0 0 3, 376, 077 65.00 06600 PHYSI CAL THERAPY 66.00 6, 363, 104 6.363.104 66.00 06700 OCCUPATIONAL THERAPY 2, 145, 622 0 2, 145, 622 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 648, 042 0 0 0 648, 042 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 041, 831 2, 041, 831 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 144, 229 2, 144, 229 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 10, 366, 626 10, 366, 626 73.00 74.00 07400 RENAL DIALYSIS 403, 450 0 403, 450 74.00 0 03950 DIABETIC EDUCATION 0 492, 231 492, 231 76.00 76.00 07697 CARDIAC REHABILITATION 76.97 412.343 0 C 412, 343 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 282, 911 282, 911 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 3, 377, 220 3, 377, 220 90.00 09100 EMERGENCY 91.00 0 11, 404, 189 -33, 505 11, 370, 684 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS 113 00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 801,040 0 102, 612, 609 0 102, 612, 609 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 45, 849 45, 849 190. 00 0 192. 00 19200 PHYSICIANS PRIVATE OFFICES 550, 045 192. 00 0 0 550, 045 0 194.00 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 0 194. 02 07952 COMMUNITY BENEFIT & RELATIONS 0 0 216.377 216, 377 194. 02 181, 532 194. 03 194. 03 07953 HEALTHY JACKSONVILLE 0 0 181, 532 0 200.00 Cross Foot Adjustments 0 0 200.00 C 0 201.00 Negative Cost Centers 0 201.00 104, 639, 461 202.00 TOTAL (sum lines 118 through 201) 801, 040 104, 639, 461 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1352

				10	09/30/2023	2/28/2024 8: 4	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	U	1.00	2.00	Zn	4.00	
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 NONPATI ENT TELEPHONES	0	1, 940		1, 940	0	5. 01
5. 02	00550 DATA PROCESSING	0	87, 151	296, 407	383, 558	235	
5. 03	00560 PURCHASING RECEIVING AND STORES	0	47, 943		47, 943	0	5. 03
5. 04 5. 05	00570   ADMITTI NG   00580   CASHI ERI NG/ACCOUNTS   RECEI VABLE	0	12, 463 15, 010		13, 815 15, 010	169 148	5. 04 5. 05
5.06	00590 OTHER ADMIN & GENERAL	0	108, 125		539, 807	668	5. 06
7. 00	00700 OPERATION OF PLANT	0	1, 145, 163		1, 291, 601	446	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	40, 238		44, 671	58	8. 00
9.00	00900 HOUSEKEEPI NG	0	29, 947	15, 698	45, 645	288	9. 00
10.00	01000 DI ETARY	0	51, 336	19, 409	70, 745	59	10.00
11. 00	01100 CAFETERI A	0	44, 286		44, 286	255	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	62, 912		70, 092	144	1
14.00	01400 CENTRAL SERVI CE & SUPPLY 01500 PHARMACY	0	10, 682		62, 033	57	14.00
15. 00 16. 00	01600 MEDICAL RECORDS & LIBRARY	88, 885 0	26, 762 44, 614		124, 124 58, 271	263 186	1
17. 00	01700 SOCIAL SERVICE	0	11, 425		11, 425	81	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	o	0	1	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1			<u>'</u>		
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		102, 921	190	1
43. 00	04300 NURSERY	0	8, 599		12, 241	44	1
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	4, 350	68, 525	7, 553	80, 428	265	44. 00
50. 00	05000 OPERATING ROOM	5, 758	250, 492	415, 468	671, 718	620	50.00
51. 00	05100 RECOVERY ROOM	0,700	10, 826	·	13, 108	74	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	15, 329		19, 319	48	52.00
53.00	05300 ANESTHESI OLOGY	28	6, 770	186, 451	193, 249	20	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	81, 403		557, 645	362	1
55. 00	05500 RADI OLOGY - THERAPEUTI C	0	31, 265		552, 310	78	55. 00
56. 00	05600 RADI 0I SOTOPE	0	3, 465		3, 465	31	1
57. 00 58. 00	05700 CT SCAN   05800 MAGNETIC RESONANCE I MAGING (MRI)	9, 068	3, 824 13, 557		3, 824 22, 625	128 72	57. 00 58. 00
60.00	06000 LABORATORY	9,000	71, 966		152, 986	460	1
65. 00	06500 RESPI RATORY THERAPY	1, 683	33, 157		148, 861	220	1
66.00	06600 PHYSI CAL THERAPY	0	102, 017		117, 374	605	1
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	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	O O	0	72. 00 73. 00
74.00	07400 RENAL DIALYSIS	0	7, 377	_	9, 505	44	
76. 00	03950 DI ABETI C EDUCATI ON	0	3, 864		4, 270	61	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	372	22, 387		35, 831	29	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	9, 708		55, 703	12	76. 98
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	84, 030		120, 215	291	90.00
91.00	09100 EMERGENCY	2, 277	191, 979	81, 945	276, 201	751	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS				υĮ		92.00
113. 00	11300   INTEREST EXPENSE						113. 00
118. 00		191, 420	3, 060, 137	3, 204, 891	6, 456, 448	8, 865	118. 00
	NONREI MBURSABLE COST CENTERS					·	
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	7, 601		7, 601		190. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	35, 831		39, 266		192. 00
	07950 RENTED SPACE	0	125, 282		125, 282		194. 00
	07951   PASSAVANT FOUNDATION   07952   COMMUNITY BENEFIT & RELATIONS	0	1, 325 3, 681		1, 325 3, 681		194. 01 194. 02
	307953 HEALTHY JACKSONVILLE	0	3, 681		3, 081		194. 02
200.00			3, 233		3, 233 N	20	200.00
201.00			0	o	ő		201. 00
202.00		191, 420	3, 237, 090	3, 208, 326	6, 636, 836		202. 00

| Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS JACKSONVILLE MEMORIAL HOSPITAL Provider CCN: 14-1352

					То	09/30/2023	Date/Time Prep 2/28/2024 8:49	
		Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	alli
			TELEPHONES	PROCESSI NG	RECEIVING AND		OUNTS	
			F 01	F 02	STORES	F 04	RECEI VABLE	
	GENER	AL SERVICE COST CENTERS	5. 01	5. 02	5. 03	5. 04	5. 05	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 5. 02	1	NONPATI ENT TELEPHONES DATA PROCESSI NG	1, 940 126	383, 919				5. 01 5. 02
5. 02		PURCHASING RECEIVING AND STORES	21	4, 366	1			5. 02
5. 04	1	ADMITTING	47	21, 815		37, 499		5. 04
5.05		CASHI ERI NG/ACCOUNTS RECEI VABLE	33	21, 815	1	0	37, 198	5. 05
5.06		OTHER ADMIN & GENERAL	147	26, 181		0	0	5. 06
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	101 14	0	·	0	0	7. 00 8. 00
9. 00		HOUSEKEEPING	19	0		0	0	9. 00
10.00		DI ETARY	37	13, 082		0	0	10.00
11. 00		CAFETERI A	0	0	-	0	0	11. 00
13.00		NURSING ADMINISTRATION	93	21, 815		0	0	13.00
14. 00 15. 00		CENTRAL SERVICE & SUPPLY PHARMACY	27	0 8. 733		0	0	14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	29	17, 449	, - 1	0	Ö	16. 00
17. 00	1	SOCIAL SERVICE	33	4, 366	1	0	0	17. 00
19. 00		NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
30. 00		I ENT ROUTI NE SERVI CE COST CENTERS ADULTS & PEDI ATRI CS	157	39, 264	1, 522	2, 191	2, 191	30. 00
31.00		INTENSIVE CARE UNIT	54	26, 181		2, 191 507	507	31. 00
43. 00		NURSERY	4	20, 101		59	59	43. 00
44.00		SKILLED NURSING FACILITY	19	0	209	485	485	44.00
FO 00		LARY SERVICE COST CENTERS	222	12 002	2 52/	2 /77	2 /77	FO 00
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	232	13, 082 0		3, 677 225	3, 677 225	50. 00 51. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	6	0		78	78	52. 00
53.00	1	ANESTHESI OLOGY	47	0	315	424	424	53.00
54.00		RADI OLOGY - DI AGNOSTI C	103	43, 630	1	2, 112	2, 112	54.00
55. 00 56. 00		RADI OLOGY - THERAPEUTI C RADI OI SOTOPE	23	0		1, 263 357	1, 263 357	55. 00 56. 00
57. 00		CT SCAN	0	0		5, 742	5, 441	57. 00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	O	0		1, 080	1, 080	58. 00
60.00	1	LABORATORY	95	21, 815	1	4, 485	4, 485	
65. 00		RESPI RATORY THERAPY	41	13, 082	1	1, 878	1, 878	65. 00
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	124 17	34, 897 0		1, 858 715	1, 858 715	66. 00 67. 00
68. 00	1	SPEECH PATHOLOGY	0	0		76	76	68. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	754	754	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	768	768	72. 00
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0	0	0 409	3, 060 108	3, 060 108	73. 00 74. 00
76.00		DI ABETIC EDUCATION	0	0		6	6	76. 00
		CARDIAC REHABILITATION	8	0	404	58		
	07698	HYPERBARI C OXYGEN THERAPY	0	0	12	54	54	76. 98
00 00		TIENT SERVICE COST CENTERS CLINIC	70		150	1 007	1 007	00.00
90. 00 91. 00	1	EMERGENCY	72 151	0 34, 897		1, 007 4, 472	1, 007 4, 472	90. 00 91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	101	01,077	1,021	1, 172	1, 1, 2	92. 00
	SPECI.	AL PURPOSE COST CENTERS						
	1	I NTEREST EXPENSE						113. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)   IMBURSABLE COST CENTERS	1, 880	366, 470	46, 416	37, 499	37, 198	118.00
190. 00		GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
		PHYSICIANS PRIVATE OFFICES	56	0		0		192. 00
		RENTED SPACE	o	0		0		194. 00
		PASSAVANT FOUNDATION	0	17, 449		0		194. 01
		COMMUNITY BENEFIT & RELATIONS HEALTHY JACKSONVILLE	4	0	5, 748 71	0		194. 02 194. 03
200.00		Cross Foot Adjustments	٩	O	''	O		200. 00
201.00		Negative Cost Centers	О	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

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1352

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: | 2/28/2024 8:49 am

						2/28/2024 8: 4	9 am
	Cost Center Description	OTHER ADMIN &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		GENERAL	PLANT	LINEN SERVICE			
	Ta	5. 06	7. 00	8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS			T	T		
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 NONPATI ENT TELEPHONES						5. 01
5.02	00550 DATA PROCESSING						5. 02
5.03	00560 PURCHASING RECEIVING AND STORES						5. 03
5.04	00570 ADMI TTI NG						5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						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
		1					8.00
8.00	00800 LAUNDRY & LINEN SERVICE	3, 434	29, 916		00 404		
9.00	00900 HOUSEKEEPI NG	13, 361	22, 265			440 504	9. 00
10.00	01000 DI ETARY	5, 323	38, 166		2, 495	143, 524	10.00
11. 00	01100 CAFETERI A	13, 636	32, 925		0	0	11. 00
13. 00	01300 NURSI NG ADMINISTRATION	7, 934	46, 773		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	ol	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   NTENSI VE CARE UNI T	19, 282	25, 630			6, 135	1
43. 00	04300 NURSERY	1, 906	6, 393		535	0, 133	43. 00
							1
44. 00	04400 SKILLED NURSING FACILITY	11, 854	50, 945	9, 273	4, 007	20, 806	44. 00
F0 00	ANCILLARY SERVICE COST CENTERS	47.744	407 000	1 45 (44	0.004	0.447	F0 00
50. 00	05000 OPERATING ROOM	47, 711	186, 229		8, 804	9, 117	50. 00
51. 00	05100 RECOVERY ROOM	3, 144	8, 049		0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 134	11, 396		586	0	52. 00
53. 00	05300 ANESTHESI OLOGY	3, 153	5, 033	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	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 RADI OI SOTOPE	2, 563	2, 576	0	o	0	56.00
57.00	05700 CT SCAN	12, 255	2, 843		ol	0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	4, 284	10, 079		0	0	58. 00
60. 00	06000 LABORATORY	43, 057	53, 504		2, 760	0	60.00
65. 00	06500 RESPI RATORY THERAPY	15, 384	24, 651			0	65. 00
		1				0	•
66. 00	06600 PHYSI CAL THERAPY	29, 232	75, 845				66.00
67. 00	06700 OCCUPATI ONAL THERAPY	9, 894	27, 494		1, 164	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	3, 132	742	1	1, 333	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 307	0	0	0	0	71. 00
72. 00	07200 I MPL. 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 CARDI AC REHABI LI TATI ON	1, 423	16, 643	22	940	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	1, 119	7, 218	98	672	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	14, 555	62, 472	13	4, 272	0	90.00
91. 00	09100 EMERGENCY	47, 669	142, 728		20, 157	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	17,007	112,720	10, 771	20, 107	Ŭ	92.00
72.00	SPECIAL PURPOSE COST CENTERS			l.	l		72.00
112 0	11300   INTEREST EXPENSE						113. 00
		E(2,4/7	1 214 275	70 205	00 271	142 524	
118. 00		562, 467	1, 214, 375	79, 285	88, 271	143, 524	1118.00
400.0	NONREI MBURSABLE COST CENTERS		E (E4	_	ما		
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	48	5, 651				190. 00
	19200 PHYSICIANS PRIVATE OFFICES	1, 902	26, 639		133		192. 00
	07950 RENTED SPACE	795	93, 142		0		194. 00
	07951 PASSAVANT FOUNDATION	1, 472	985	0	0		194. 01
194. 02	07952 COMMUNITY BENEFIT & RELATIONS	1, 078	2, 736	0	0		194. 02
194. 03	07953 HEALTHY JACKSONVILLE	828	2, 404	0	ol	0	194. 03
200.00			,	1	]		200. 00
201.00		0	n	n	n	n	201. 00
202.00		568, 590	1, 345, 932	79, 817	88, 404	143, 524	202, 00
232.00	1.0 (3a 1.1.35 110 till 3agil 201)	000,070	.,010,732	, ,, 517	33, 104	110,024	1-02.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1352

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

2/28/2024 8:49 am Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL RECORDS & SERVICE & ADMI NI STRATI ON **SUPPLY** LI BRARY 11. 00 13.00 15.00 14.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00540 NONPATIENT TELEPHONES 5.01 00550 DATA PROCESSING 5.02 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 5.03 00570 ADMITTING 5.04 5 04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.06 00590 OTHER ADMIN & GENERAL 5.06 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERIA 11.00 91.102 11.00 01300 NURSING ADMINISTRATION 13.00 1,558 151, 331 13.00 14.00 01400 CENTRAL SERVICE & SUPPLY 1,300 14.00 74, 375 15.00 01500 PHARMACY 2,609 172, 053 15.00 C C 01600 MEDICAL RECORDS & LIBRARY 122, 509 16,00 3.605 0 16,00 17.00 01700 SOCIAL SERVICE 1,018 3, 697 0 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 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 0 51.00 05100 RECOVERY ROOM 642 2, 283 0 741 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 467 1, 718 255 52.00 53.00 05300 ANESTHESI OLOGY 0 1, 393 53.00 05400 RADI OLOGY-DI AGNOSTI C 4, 979 0 54.00 0 0 6, 944 54.00 55 00 05500 RADI OLOGY - THERAPEUTI C 959 Ω 0 4 151 55 00 0 05600 RADI OI SOTOPE 56.00 265 0 1, 175 56.00 57.00 05700 CT SCAN 1,588 0 0 0 0 0 18, 102 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 877 0 3, 550 58.00 06000 LABORATORY 7 939 0 60 00 14, 743 60 00 C 0 65.00 06500 RESPIRATORY THERAPY 3, 431 9,857 6, 175 65.00 06600 PHYSI CAL THERAPY 7,563 0 6, 109 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 2,398 0 0 0 2, 352 67.00 06800 SPEECH PATHOLOGY 0 68.00 782 Ω 0 249 68 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 36, 241 0 2, 479 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 38. 134 0 2,526 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 171, 989 73.00 0 0 C 10.061 07400 RENAL DIALYSIS 74.00 336 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 0 192 76. 97 07698 HYPERBARIC OXYGEN THERAPY 76.98 201 0 0 76.98 0 177 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 3, 312 90.00 3,645 0 0 09100 EMERGENCY 91.00 9,740 31, 526 0 14, 702 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 171, 989 90, 143 151, 331 74, 375 122, 509 118. 00 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190. 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 509 0 0 192.00 0 64 194.00|07950|RENTED SPACE 0 0 0 0 0 194, 00 194. 01 07951 PASSAVANT FOUNDATION 0 C 0 0 0 194. 01 194. 02 07952 COMMUNITY BENEFIT & RELATIONS 0 0 0 0 194. 02 194. 03 07953 HEALTHY JACKSONVILLE C 0 0 0 194. 03 450 Cross Foot Adjustments 200.00 200. 00 201.00 Negative Cost Centers 0 201.00 122, 509 202. 00 202.00 TOTAL (sum lines 118 through 201) 91, 102 151, 331 74, 375 172, 053

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1352 Peri od: Worksheet B From 10/01/2022 Part II Date/Time Prepared: 09/30/2023 2/28/2024 8:49 am Cost Center Description SOCIAL SERVICE NONPHYSICIAN Intern & Subtotal Total **ANESTHETISTS** Residents Cost & Post Stepdown Adjustments 19.00 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 00550 DATA PROCESSING 5.02 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 5.03 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 00590 OTHER ADMIN & GENERAL 5 06 5 06 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI FTARY 10 00 10 00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICE & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 33, 286 17.00 01900 NONPHYSICIAN ANESTHETISTS 19 00 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 20, 208 941, 982 941, 982 30.00 31.00 03100 INTENSIVE CARE UNIT 2,901 200, 984 0 200, 984 31.00 04300 NURSERY 1,942 25, 635 0 25, 635 43 00 43 00 44.00 04400 SKILLED NURSING FACILITY 8, 235 206, 137 206, 137 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 014, 799 1, 014, 799 50.00 0 0 05100 RECOVERY ROOM 51.00 29, 736 29, 736 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 36, 334 36, 334 52.00 0000000000000000000 0 0 0 05300 ANESTHESI OLOGY 53 00 204, 058 204, 058 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 721, 753 721, 753 54.00 05500 RADI OLOGY - THERAPEUTI C 55 00 593.677 593, 677 55 00 11, 099 05600 RADI OI SOTOPE 11,099 0 0 0 56.00 56.00 57.00 05700 CT SCAN 49, 930 49, 930 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 43, 649 43, 649 58.00 60.00 06000 LABORATORY 307, 363 307, 363 60.00 65.00 06500 RESPIRATORY THERAPY 227, 976 0 0 227, 976 65.00 06600 PHYSI CAL THERAPY 285, 329 285, 329 66.00 66.00 06700 OCCUPATIONAL THERAPY 85, 222 85, 222 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 9, 669 0 0 0 9,669 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 49, 535 49, 535 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 51, 973 51, 973 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 228, 961 228, 961 73.00 74.00 07400 RENAL DIALYSIS 18, 261 0 18, 261 74.00 76.00 03950 DIABETIC EDUCATION 11, 095 76.00 11,095 07697 CARDIAC REHABILITATION 76.97 55, 747 55, 747 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 65, 320 65, 320 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 211, 311 0 211, 311 91.00 09100 EMERGENCY 0 606, 061 0 606, 061 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS 113 00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 33, 286 118.00 0 6, 293, 596 0 6, 293, 596 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 13, 300 13, 300 190. 00 0 192. 00 19200 PHYSICIANS PRIVATE OFFICES 69, 237 192. 00 0 69, 237 0 0 0 194.00 07950 RENTED SPACE 219, 219 219, 219 194. 00 194. 01 07951 PASSAVANT FOUNDATION 0 0 21, 231 194. 01 21, 231 0 194. 02 07952 COMMUNITY BENEFIT & RELATIONS 0 13. 247 13, 247 194. 02 194. 03 07953 HEALTHY JACKSONVILLE 7, 006 194. 03 0 7,006 0 200.00 Cross Foot Adjustments 0 200.00 C 0 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 33, 286 6, 636, 836 6, 636, 836 202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1352 Peri od: Worksheet B-1 From 10/01/2022 09/30/2023 Date/Time Prepared: 2/28/2024 8:49 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** NONPATI ENT DATA (SQUARE FEET) (DOLLAR VALUE) PROCESSI NG BENEFITS TELEPHONES DEPARTMENT (NUMBER OF (DEPT TIME) (GROSS PHONES) SALARI ES) 1.00 2.00 5. 01 5. 02 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 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 39, 474, 775 4.00 00540 NONPATI ENT TELEPHONES 5 01 940 5 01 243 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 1, 446 10 265 5.03 1, 479 5.04 00570 ADMITTING 1,561 747, 452 23 1, 324 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 1 880 652.847 5 05 5 05 16 1.324 5.06 00590 OTHER ADMIN & GENERAL 13, 543 472, 093 2, 955, 711 71 1,589 5.06 00700 OPERATION OF PLANT 1, 973, 114 7.00 143, 436 160, 146 49 0 7.00 00800 LAUNDRY & LINEN SERVICE 5,040 4, 848 8.00 255, 165 7 8.00 0 9 3, 751 9 00 00900 HOUSEKEEPI NG 17, 167 1, 274, 098 0 9 00 10.00 01000 DI ETARY 6,430 21, 226 259, 533 18 794 10.00 01100 CAFETERI A 11.00 5,547 1, 126, 291 0 11.00 01300 NURSING ADMINISTRATION 7,880 7.852 45 13.00 636, 351 1, 324 13.00 14.00 01400 CENTRAL SERVICE & SUPPLY 1.338 56, 158 251, 097 0 Ω 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 01700 SOCIAL SERVICE 358, 272 16 17.00 17.00 1, 431 265 01900 NONPHYSICIAN ANESTHETISTS 19.00 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 03100 INTENSIVE CARE UNIT 1, 589 31.00 4, 318 59, 443 840.847 31.00 26 43.00 04300 NURSERY 1,077 3, 983 194, 642 2 Ω 43.00 04400 SKILLED NURSING FACILITY 9 44.00 8,583 8, 260 1, 171, 138 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 31, 375 454, 361 2, 744, 055 113 794 50.00 2, 496 05100 RECOVERY ROOM 51.00 1, 356 326, 464 0 51.00 3 52.00 05200 DELIVERY ROOM & LABOR ROOM 1,920 4, 364 213, 231 0 52.00 05300 ANESTHESI OLOGY 203.905 88.966 53.00 848 23 Λ 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 10, 196 520, 825 1,600,189 50 2, 648 54.00 05500 RADIOLOGY - THERAPEUTIC 344, 800 55.00 3, 916 569, 820 11 0 55.00 05600 RADI OI SOTOPE 135, 370 56.00 434 0 56.00 0 0 05700 CT SCAN 567, 080 57.00 479 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1,698 319, 601 0 0 58.00 60.00 06000 LABORATORY 9,014 88, 605 2, 036, 978 46 1, 324 60.00 06500 RESPIRATORY THERAPY 20 65 00 4 153 124 695 974, 684 794 65 00 06600 PHYSI CAL THERAPY 66.00 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 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 71 00 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 0 0 0 2, 327 74.00 07400 RENAL DIALYSIS 924 193, 228 0 74.00 03950 DIABETIC EDUCATION 76.00 484 444 267, 812 0 76.00 76. 97 07697 CARDIAC REHABILITATION 2,804 14, 296 128, 350 4 0 76.97 07698 HYPERBARIC OXYGEN THERAPY 76.98 1, 216 50, 301 54, 935 0 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 10.525 39, 572 1, 289, 394 90.00 09000 CLI NI C 35 0 91.00 09100 EMERGENCY 24, 046 89, 616 3, 322, 422 73 2, 118 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 383, 293 3, 504, 911 39, 203, 101 911 22, 242 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190.00 952 192.00 19200 PHYSICIANS PRIVATE OFFICES 4, 488 3, 757 181, 438 27 0 192.00 194.00 07950 RENTED SPACE 15, 692 C 0 0 194.00 194. 01 07951 PASSAVANT FOUNDATION 0 1, 059 194. 01 C 166 1 194. 02 07952 COMMUNITY BENEFIT & RELATIONS 2 461 C  $\Gamma$ 0 194. 02 194. 03 07953 HEALTHY JACKSONVILLE 90, 235 0 194. 03 405 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, 3, 237, 090 3, 208, 326 13, 819, 664 51, 911 5, 071, 664 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 7. 983806 0.914400 0.350088 55. 224468 217. 658641 203. 00 8 926 1, 940 383, 919 204. 00 204 00 Cost to be allocated (per Wkst. B, Part II)

Heal th Finar	ncial Systems J	ACKSONVILLE MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS	Provider CCN: 14-135			Peri od: From 10/01/2022	Worksheet B-1	
					To 09/30/2023		
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	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			0. 00022	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

Health Financial Systems JACKSONVILLE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1352 Peri od: Worksheet B-1 From 10/01/2022 09/30/2023 Date/Time Prepared: 2/28/2024 8:49 am Cost Center Description PURCHASI NG ADMI TTI NG CASHIERING/ACC Reconciliation OTHER ADMIN & RECEIVING AND (GROSS OUNTS **GENERAL** CHARGES) RECEI VABLE (ACCUM. COST) **STORES** (COST OF (GROSS SUPPLI ES) CHARGES) 5.03 5.04 5A. 06 5.06 5.05 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 00550 DATA PROCESSING 5.02 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 CASHI ERI NG/ACCOUNTS RECEI VABLE 3,888 466, 135, 793 5.05 00590 OTHER ADMIN & GENERAL 36, 108 -15, 084, 238 89, 555, 223 5 06 0 5 06 00700 OPERATION OF PLANT 7.00 120,007 0 0 7, 535, 940 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 34, 850 540, 948 8.00 9.00 00900 HOUSEKEEPI NG 128, 753 0 2, 104, 430 9.00 0 0 01000 DI FTARY 10 00 838.325 10 00 268, 274 11.00 01100 CAFETERI A 0 2, 147, 719 11.00 01300 NURSING ADMINISTRATION 0 13.00 8,636 0 1, 249, 636 13.00 01400 CENTRAL SERVICE & SUPPLY 0 14 00 3 479 Ω 423, 942 14 00 0 15.00 01500 PHARMACY 26, 655 0 2, 080, 872 15.00 01600 MEDICAL RECORDS & LIBRARY 2,743 0 0 0 1, 439, 173 16.00 16.00 0 17.00 01700 SOCIAL SERVICE 0 567, 982 17.00 7,831 01900 NONPHYSICIAN ANESTHETISTS O 19 00 19.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 27, 393, 236 30.00 03000 ADULTS & PEDIATRICS 30, 769 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 04300 NURSERY 734, 726 734 726 0 300, 230 43 00 43 00 1.827 44.00 04400 SKILLED NURSING FACILITY 4, 225 6, 058, 800 6, 058, 800 1, 867, 082 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 45, 960, 154 45, 960, 154 0 7, 514, 649 50.00 71, 268 50.00 05100 RECOVERY ROOM 2.818.587 51.00 868 2, 818, 587 495, 202 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 2,002 969, 905 969, 905 0 336, 144 52.00 05300 ANESTHESI OLOGY 53.00 6, 367 5, 296, 629 5, 296, 629 0 0 0 0 0 0 0 0 496, 550 53 00 26, 401, 847 54.00 05400 RADI OLOGY-DI AGNOSTI C 9.026 26, 401, 847 4, 690, 627 54.00 05500 RADI OLOGY - THERAPEUTI C 55 00 1.924 15, 783, 398 15, 783, 398 1, 287, 162 55 00 6, 273 05600 RADI OI SOTOPE 4, 466, 372 4, 466, 372 403, 711 56.00 56.00 57.00 05700 CT SCAN 145 69, 150, 817 69, 150, 817 1, 930, 227 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 13, 497, 160 58.00 13, 497, 160 674, 766 49 58, 00 60.00 06000 LABORATORY 19, 916 56, 056, 351 56, 056, 351 6, 781, 671 60.00 65.00 06500 RESPIRATORY THERAPY 7.538 23, 477, 299 23, 477, 299 2, 423, 068 65.00 06600 PHYSI CAL THERAPY 6, 927 23, 226, 866 23, 226, 866 4, 604, 237 66.00 66.00 06700 OCCUPATIONAL THERAPY 30, 556 8, 943, 587 8, 943, 587 1, 558, 410 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 192 947, 532 947, 532 0 0 0 493, 259 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 9, 427, 135 9, 427, 135 1, 465, 826 71.00 9, 604, 007 1, 539, 923 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 9, 604, 007 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 38, 256, 069 38, 256, 069 6, 424, 733 73.00 74.00 07400 RENAL DIALYSIS 8, 271 1, 350, 897 1, 350, 897 300, 970 74.00 0 03950 DIABETIC EDUCATION 76, 017 76, 017 372, 053 76.00 4.330 76.00 07697 CARDIAC REHABILITATION 76.97 224, 140 3, 917 730, 637 730, 637 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 241 672, 144 672, 144 176, 249 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 9, 090 90.00 12, 592, 421 12, 592, 421 0 2, 292, 511 91.00 09100 EMERGENCY 32, 827 55, 901, 684 55, 901, 684 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 SUBTOTALS (SUM OF LINES 1 through 117) 466, 135, 793 -15, 084, 238 118.00 938, 075 466, 135, 793 88, 590, 633 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 7, 601 190. 00 C 192.00 19200 PHYSICIANS PRIVATE OFFICES 1, 917 0 0 299, 634 192. 00 Ω 0 194.00 07950 RENTED SPACE 0 0 125, 282 194. 00 194. 01 07951 PASSAVANT FOUNDATION 0 0 0 231, 826 194. 01 194. 02 07952 COMMUNITY BENEFIT & RELATIONS 116, 177 0 0 0 169, 865 194. 02 1,444 O 130, 382 194. 03 194. 03 07953 HEALTHY JACKSONVILLE Ω 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 15, 084, 238 202. 00 315, 338 1, 363, 521 2, 268, 094 Part I) 0. 168435 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 0. 298160 0.002925 0.004866

52, 330

0.049479

37, 499

0.000080

37, 198

0.000080

568, 590 204. 00

0.006349 205.00

Part II)

111)

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

204.00

205.00

Health Fina	ncial Systems JA	ACKSONVILLE MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS					Period: From 10/01/2022	Worksheet B-1	
					To 09/30/2023	Date/Time Pre 2/28/2024 8:4	
	Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	CReconciliation	OTHER ADMIN &	
		RECEIVING AND	(GROSS	OUNTS		GENERAL	
		STORES	CHARGES)	RECEI VABLE		(ACCUM. COST)	
		(COST OF		(GROSS			
		SUPPLI ES)		CHARGES)			
		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

In Lieu of Form CMS-2552-10 Health Financial Systems JACKSONVILLE MEMORIAL HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1352 Peri od: Worksheet B-1 From 10/01/2022 09/30/2023 Date/Time Prepared: 2/28/2024 8:49 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A PLANT LINEN SERVICE (HOURS OF (MEALS SERVED) (MEALS SERVED) (SQUARE FEET) SERVICE) (POUNDS OF LAUNDRY) 7.00 9.00 10.00 11.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.01 00540 NONPATIENT TELEPHONES 5.01 00550 DATA PROCESSING 5. 02 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 00570 ADMITTING 5.04 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.06 00590 OTHER ADMIN & GENERAL 5.06 00700 OPERATION OF PLANT 7.00 226, 755 7.00 00800 LAUNDRY & LINEN SERVICE 574, 852 8.00 5,040 8.00 9.00 00900 HOUSEKEEPI NG 3, 751 3, 278 51, 735 9.00 10.00 01000 DI ETARY 6, 430 2, 445 63, 821 10.00 1, 460 01100 CAFETERI A 5, 547 271, 233 11.00 C 0 11.00 13.00 | 01300 | NURSI NG ADMINISTRATION 7,880 0 1, 460 0 4, 640 13.00 01400 CENTRAL SERVICE & SUPPLY 1, 338 0 0 3, 870 14.00 105 14.00 15. 00 01500 PHARMACY 0 1,095 7, 767 15.00 3 352 0 01600 MEDICAL RECORDS & LIBRARY 5, 588 16.00 0 309 10, 733 16.00 17.00 01700 SOCIAL SERVICE 1, 431 0 105 0 3, 030 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 27, 333 122,007 12, 996 47, 787 47,652 30.00 03100 INTENSIVE CARE UNIT 4, 318 12, 352 31.00 1, 460 2, 728 9, 264 31.00 1,077 43.00 04300 NURSERY 988 313 1, 293 43.00 04400 SKILLED NURSING FACILITY 9, 252 44.00 8, 583 66, 786 2, 345 11, 643 44.00 ANCILLARY SERVICE COST CENTERS 27, 238 50. 00 50.00 05000 OPERATING ROOM 31, 375 112, 430 5, 152 4,054

51 00	05100 RECOVERY ROOM	1, 356	8, 657	0	0	1, 911	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	1, 920	1, 082	343	ol	1, 391	
	05300 ANESTHESI OLOGY	848	0	0	ol	0	1
	05400 RADI OLOGY-DI AGNOSTI C	10, 196	66, 907	2, 240	ol	14, 823	1
	05500 RADI OLOGY - THERAPEUTI C	3, 916	2, 466	1, 040	ol	2, 855	
	05600 RADI OI SOTOPE	434	-,	0	ol	789	1
	05700 CT SCAN	479	ol	0	ol	4, 727	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 698	o	Ō	ol	2, 612	
	06000 LABORATORY	9, 014	351	1, 615	ol	23, 636	
	06500 RESPI RATORY THERAPY	4, 153	2, 648	1, 040	ol	10, 216	1
	06600 PHYSI CAL THERAPY	12, 778	45, 442	1, 879	ol	22, 516	
	06700 OCCUPATI ONAL THERAPY	4, 632	.0,2	681	o	7, 138	
	06800 SPEECH PATHOLOGY	125	o	780	Ö	2, 329	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö	0	Ö	2, 327	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	o o	o	0	0	0	1
	07300 DRUGS CHARGED TO PATIENTS	l o	0	0	0	0	73. 00
	07400 RENAL DIALYSIS	924	Ö	0	0	1, 000	
	03950 DIABETIC EDUCATION	484	0	0		3, 821	1
	07697 CARDI AC REHABI LI TATI ON	2, 804	159	550	0	1, 038	1
	07698 HYPERBARI C OXYGEN THERAPY	1, 216	709	393	o	597	1
70. 90	OUTPATIENT SERVICE COST CENTERS	1,210	709	393	U U	397	70.90
90. 00	09000 CLINIC	10, 525	92	2, 500	O	10, 852	90.00
	09100 EMERGENCY	24, 046	122, 222	11, 796	O O	28, 997	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	24, 040	122, 222	11, 790	۷	20, 997	92.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
112 00	11300 INTEREST EXPENSE						113. 00
118.00		204, 591	571, 021	51, 657	63, 821	268, 378	
	NONREIMBURSABLE COST CENTERS	204, 591	5/1,021	51,057	03, 821	208, 378	1118.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	952	ام	0	ام		190. 00
	19200 PHYSICIANS PRIVATE OFFICES	4, 488	3, 831	78	O O		190.00
	07950 RENTED SPACE		3, 031	70	0		194. 00
	07951 PASSAVANT FOUNDATION	15, 692	U O	0	U O		194. 00
		166	O O	0	0		
	07952 COMMUNITY BENEFIT & RELATIONS	461	U O	0	U O		194. 02
	07953 HEALTHY JACKSONVILLE	405	O	0	O		194. 03
200.00							200.00
201.00		0.005.05/		0 (00 0(7	4 00/ 074		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		5. 935622	0. 138848	1. 708785	2. 248852	0. 335881	205 00
_00.00	II)	0. 700022	0. 1000 10	1. 700700	2.210002	0. 000001	
	17	ı I	ı	I	ı		1

Health Financial Systems JA		ACKSONVILLE MEN	MORIAL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS					Period: From 10/01/2022	Worksheet B-1		
					Γο 09/30/2023			
Cost Center Descrip	otion	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A		
		PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	(MEALS SERVED)		
		(SQUARE FEET)	(POUNDS OF	SERVI CE)				
			LAUNDRY)					
		7.00	8. 00	9. 00	10.00	11. 00		
206.00 NAHE adjustment amo	ount to be allocated						206. 00	
(per Wkst. B-2)								
207.00 NAHE unit cost mult	tiplier (Wkst. D,						207. 00	
Parts III and IV)								

	NA CONTROL OTATIOTICAL BACKS	JACKSUNVILLE MEMO				u of form CMS	
COST	ALLOCATION - STATISTICAL BASIS		Provi der CCI		Period: From 10/01/2022 Fo 09/30/2023	Worksheet B-1 Date/Time Pre 2/28/2024 8:4	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG	CENTRAL SERVI CE & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	RECORDS & LI BRARY (GROSS	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		HRS) 13. 00	REQUIS. ) 14. 00	15. 00	CHARGES) 16. 00	17. 00	
	GENERAL SERVICE COST CENTERS	15.00	14.00	13.00	10.00	17.00	
1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00	OO100 CAP REL COSTS-BLDG & FIXT OO200 CAP REL COSTS-BLDG & FIXT OO400 EMPLOYEE BENEFITS DEPARTMENT OO540 NONPATIENT TELEPHONES OO550 DATA PROCESSING OO560 PURCHASING RECEIVING AND STORES OO570 ADMITTING OO580 CASHIERING/ACCOUNTS RECEIVABLE OO590 OTHER ADMIN & GENERAL OO700 OPERATION OF PLANT OO800 LAUNDRY & LINEN SERVICE OO900 HOUSEKEEPING O1100 DIETARY O1100 CAFETERIA O1300 NURSING ADMINISTRATION O1400 CENTRAL SERVICE & SUPPLY	408, 457 0	2, 857, 478				1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00
15. 00 16. 00 17. 00 19. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0 0 9,979 0	0 0 0 0	6, 141, 58 <sup>-</sup> ( (	466, 135, 793 0 0	12, 001 0	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS	135, 026	0		27, 393, 236		
43. 00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	20, 093 4, 314	0		6, 341, 516 734, 726		1
44. 00	04400 SKILLED NURSING FACILITY	36, 768	o		6, 058, 800		1
	ANCILLARY SERVICE COST CENTERS		- 1			,	
50.00	05000 OPERATING ROOM	79, 779	0		45, 960, 154	0	
51. 00 52. 00	O5100 RECOVERY ROOM   O5200 DELIVERY ROOM & LABOR ROOM	6, 163	0	(	2, 818, 587 969, 905	0	
53. 00	05300 ANESTHESI OLOGY	4, 638	ol Ol		5, 296, 629	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	Ö	(		0	
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0	(	15, 783, 398		
56.00	05600 RADI OI SOTOPE	0	0	(	4, 466, 372	0	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)		0	(	07, 100, 017	0	
60.00	06000 LABORATORY		Ö	Č	56, 056, 351	0	
65.00	06500 RESPIRATORY THERAPY	26, 605	0	(	23, 477, 299	0	
66.00	06600 PHYSI CAL THERAPY	0	0	(	23, 226, 866		
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		8, 943, 587 947, 532	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1, 392, 380		9, 427, 135		
	07200 IMPL. DEV. CHARGED TO PATIENTS	o	1, 465, 098	(	9, 604, 007	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	6, 139, 320			•
74. 00 76. 00	07400 RENAL DIALYSIS 03950 DIABETIC EDUCATION	0	0	(	1, 350, 897 76, 017	0	
76. 00	07697 CARDIAC REHABILITATION		0	(	730, 637	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	O	(	672, 144		
	OUTPATIENT SERVICE COST CENTERS				10.500.404		
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	85, 092	0		12, 592, 421 55, 901, 684	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	65, 042	O	,	33, 701, 084	J	92.00
	SPECIAL PURPOSE COST CENTERS	1					]
	11300 INTEREST EXPENSE						113. 00
118.00		408, 457	2, 857, 478	6, 139, 320	466, 135, 793	12, 001	1118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	O	٥		0	0	] 190. 00
	19200 PHYSICIANS PRIVATE OFFICES	O	Ö	2, 26	-		192. 00
	07950 RENTED SPACE	0	0	(	0		194. 00
	O7951 PASSAVANT FOUNDATION  2O7952 COMMUNITY BENEFIT & RELATIONS	0	0	(	0		194. 01 194. 02
	3 07953 HEALTHY JACKSONVILLE		0	(			194. 02
200.00							200. 00
201.00							201. 00
202.00	***	1, 886, 361	591, 481	2, 694, 783	2, 021, 981	801, 040	202. 00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	4. 618261	0. 206994	0. 438776	0. 004338	66. 747771	203 00
203.00		151, 331	74, 375	172, 05			204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 370494	0. 026028	0. 028014	0.000263	2. 773602	205.00
200.00			l l				

Heal th Fi	nancial Systems Ja	ACKSONVILLE MEMO	ORIAL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALL	OCATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1		
					From 10/01/2022			
					To 09/30/2023			
						2/28/2024 8: 4	9 am	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
		ADMI NI STRATI ON	SERVICE &	(COSTED	RECORDS &			
			SUPPLY	REQUIS.)	LI BRARY	(TOTAL PATIENT		
		(DIRECT NRSING	(COSTED		(GROSS	DAYS)		
		HRS)	REQUIS.)		CHARGES)			
		13.00	14.00	15. 00	16.00	17. 00		
206.00	NAHE adjustment amount to be allocated						206. 00	
	(per Wkst. B-2)							
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00	
	Parts III and IV)							

In Lieu of Form CMS-2552-10 Health Financial Systems JACKSONVILLE MEMORIAL HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1352 Peri od: Worksheet B-1 From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/28/2024 8:49 am Cost Center Description NONPHYSI CI AN **ANESTHETI STS** (ASSI GNED TIME) 19.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.01 00540 NONPATIENT TELEPHONES 5.01 00550 DATA PROCESSING 5.02 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 00570 ADMITTING 5.04 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 00590 OTHER ADMIN & GENERAL 5.06 5.06 7. 00 7 00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 13. 00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICE & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 17.00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 0 31.00 03100 INTENSIVE CARE UNIT 31.00 0 43 00 04300 NURSERY 43 00 04400 SKILLED NURSING FACILITY 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 00000000000000000000 05100 RECOVERY ROOM 51 00 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 05300 ANESTHESI OLOGY 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 55 00 56.00 05600 RADI OI SOTOPE 56.00 05700 CT SCAN 57.00 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 06000 LABORATORY 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 74.00 07400 RENAL DIALYSIS 74.00 76.00 03950 DIABETIC EDUCATION 76.00 76. 97 07697 CARDIAC REHABILITATION 76. 97 07698 HYPERBARI C OXYGEN THERAPY 0 76.98 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09100 EMERGENCY 91.00 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 190.00 192. 00 19200 PHYSICIANS PRIVATE OFFICES 0 192.00 194.00 07950 RENTED SPACE 194.00 194. 01 07951 PASSAVANT FOUNDATION 194. 01 194. 02 07952 COMMUNITY BENEFIT & RELATIONS 0 194.02 0 194. 03 07953 HEALTHY JACKSONVILLE 194 03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 202.00 0 202.00 Part I) 203.00 l203. 00 Unit cost multiplier (Wkst. B, Part I) 0.000000 Cost to be allocated (per Wkst. B, 204. 00 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 205.00 11)

Heal th Finar	ncial Systems JA	ACKSONVILLE MEMO	RLAL HOSPITAL	In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provider CCN: 14-1352	Peri od:	Worksheet B-1	
				From 10/01/2022 To 09/30/2023	Date/Time Pre 2/28/2024 8:4	
	Cost Center Description	NONPHYSI CI AN				
		ANESTHETI STS				
		(ASSI GNED				
		TIME)				
		19. 00				
206.00	NAHE adjustment amount to be allocated					206. 00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,					207. 00
	Parts III and IV)					

JACKSONVILLE MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10
Worksheet B-2

Health Financial Systems
POST STEPDOWN ADJUSTMENTS

Health Financial Systems JA	ACKSONVILLE MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10			
POST STEPDOWN ADJUSTMENTS	Provider Co		Peri od:	Worksheet B-2	
			From 10/01/2022 To 09/30/2023		
		Wor	ksheet		
	Description	CODE	Li ne No.	Amount	
	1. 00	2.00	3. 00	4. 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
	ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1 74.00	0	3. 00
	ADJ FOR ARANESP COSTS IN HOME PROGRAM		1 94.00	0	4. 00
	ADJ FOR ESA COSTS IN RENAL DIALYSIS		1 74.00	0	5. 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	l CU		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

COMPUT	FATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od: From 10/01/2022 To 09/30/2023	Worksheet C Part I Date/Time Pre 2/28/2024 8:4	pared: 9 am
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description		Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30.00	03000 ADULTS & PEDIATRICS	17, 057, 896		17, 057, 8	96 0	17, 057, 896	30.00
31. 00	03100 INTENSIVE CARE UNIT	3, 929, 463		3, 929, 4		3, 929, 463	
43. 00		489, 159		489, 1		489, 159	
44. 00	· ·	3, 429, 907		3, 429, 9		3, 429, 907	
	ANCILLARY SERVICE COST CENTERS				- ,		
50.00		11, 344, 897		11, 344, 8	97 0	11, 344, 897	50.00
51.00	05100 RECOVERY ROOM	703, 620		703, 6	20 0	703, 620	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	525, 776		525, 7	76 0	525, 776	52.00
53.00	05300 ANESTHESI OLOGY	636, 092		636, 0	92 0	636, 092	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 349, 386		6, 349, 3	86 0	6, 349, 386	54. 00
55.00	05500 RADI OLOGY - THERAPEUTI C	1, 809, 183		1, 809, 1	83 0	1, 809, 183	55. 00
56.00	05600 RADI OI SOTOPE	515, 864		515, 8		515, 864	
57. 00	05700 CT SCAN	2, 621, 295		2, 621, 2		2, 621, 295	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	939, 148		939, 1		939, 148	
60.00	06000 LABORATORY	8, 836, 553		8, 836, 5		8, 836, 553	
65. 00	06500 RESPI RATORY THERAPY	3, 376, 077	0			3, 376, 077	65. 00
66. 00	06600 PHYSI CAL THERAPY	6, 363, 104	0			6, 363, 104	
67. 00	06700 OCCUPATI ONAL THERAPY	2, 145, 622	0	2, 145, 6		2, 145, 622	1
68. 00	06800 SPEECH PATHOLOGY	648, 042	0	648, 0		648, 042	68. 00
71. 00		2, 041, 831		2, 041, 8		2, 041, 831	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 144, 229		2, 144, 2		2, 144, 229	
73.00	07300 DRUGS CHARGED TO PATIENTS	10, 366, 626		10, 366, 6		10, 366, 626	
74. 00 76. 00	07400 RENAL DIALYSIS 03950 DIABETIC EDUCATION	403, 450 492, 231		403, 4		403, 450 492, 231	
76. 00 76. 97	07697 CARDIAC REHABILITATION	412, 343		492, 2 412, 3		492, 231	1
76. 97	07698 HYPERBARI C OXYGEN THERAPY	282, 911		282, 9		282, 911	
70. 90	OUTPATIENT SERVICE COST CENTERS	202, 911		202, 9	111 0	202, 911	70.90
90 00	09000 CLINIC	3, 377, 220		3, 377, 2	20 0	3, 377, 220	90.00
91. 00	09100 EMERGENCY	11, 370, 684		11, 370, 6		11, 370, 684	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 958, 844		3, 958, 8		3, 958, 844	
	SPECIAL PURPOSE COST CENTERS			-,, -		27.1227.2.1.	
113.00	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	106, 571, 453	0	106, 571, 4	53 0	106, 571, 453	200. 00
201.00	Less Observation Beds	3, 958, 844		3, 958, 8	44	3, 958, 844	201. 00
202.00	Total (see instructions)	102, 612, 609	0	102, 612, 6	09 0	102, 612, 609	202. 00

Hear th	Financial Systems J	ACKSUNVILLE MEMO	DRIAL HUSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provider Co		Peri od: From 10/01/2022	Worksheet C Part I	
					To 09/30/2023	Date/Time Pre	
			Ti +Lo	: XVIII	Hospi tal	2/28/2024 8: 4 Cost	9 am
			Charges	: AVIII	nospi tai	COST	
	Cost Center Description	Inpatient	Outpati ent	Total (col.	Cost or Other	TEFRA	
	·	'	'	+ col. 7)	Rati o	Inpati ent	
				·		Ratio	
	T	6. 00	7. 00	8. 00	9. 00	10. 00	
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	04 050 005		04 050 00	.el		00.00
30.00	03000 ADULTS & PEDIATRICS	21, 952, 825		21, 952, 82			30.00
31.00	03100   NTENSI VE CARE UNI T	6, 341, 516		6, 341, 51			31.00
43.00	04300 NURSERY	734, 726		734, 72			43. 00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	6, 058, 800		6, 058, 80	0		44. 00
50. 00	05000 OPERATING ROOM	8, 410, 513	37, 549, 641	45, 960, 15	0. 246842	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	797, 734	2, 020, 853			l e	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	613, 259	356, 646				1
53. 00	05300 ANESTHESI OLOGY	1, 076, 231	4, 220, 398			l e	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 994, 541	24, 407, 306				1
55. 00	05500 RADI OLOGY - THERAPEUTI C	1, 7,4, 541	15, 783, 398				
56. 00	05600 RADI OI SOTOPE	121, 976	4, 344, 396				
57. 00	05700 CT SCAN	7, 247, 628	61, 903, 189				
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	765, 816	12, 731, 344			0.000000	1
60.00	06000 LABORATORY	14, 288, 616	41, 767, 735	56, 056, 35	0. 157637	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	7, 628, 426	15, 848, 873	23, 477, 29	9 0. 143802	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	2, 239, 680	20, 987, 186	23, 226, 86	6 0. 273954	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	2, 208, 027	6, 735, 560	8, 943, 58	7 0. 239906	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	225, 221	722, 311				
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 889, 672	6, 537, 463			0.000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 268, 884	7, 335, 123				
73. 00	07300 DRUGS CHARGED TO PATIENTS	8, 628, 754	29, 627, 315				1
74. 00	07400 RENAL DI ALYSI S	1, 099, 774	251, 123				1
76. 00	03950 DI ABETI C EDUCATI ON	752	75, 265	·			
76. 97	07697 CARDI AC REHABI LI TATI ON	209	730, 428			0.000000	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	672, 144	672, 14	0. 420908	0.000000	76. 98
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	592, 787	11, 999, 634	12, 592, 42	0. 268195	0. 000000	90.00
90.00	09100 EMERGENCY	6, 836, 379	49, 065, 305				
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 044, 569	4, 395, 842				
72.00	SPECIAL PURPOSE COST CENTERS	1,044,307	4, 373, 042	3, 440, 41	0.727074	0.000000	72.00
113.00	11300 I NTEREST EXPENSE						113. 00
200.00		106, 067, 315	360, 068, 478	466, 135, 79	3		200.00
201.00			, , . , . ,				201. 00
202.00	1 1	106, 067, 315	360, 068, 478	466, 135, 79	3	1	202. 00
				•			•

			To 09/30/2023	Date/Time Prepar 2/28/2024 8:49 a	red: am
		Title XVIII	Hospi tal	Cost	<u> </u>
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					0. 00
31.00 03100 INTENSIVE CARE UNIT				1	1. 00
43. 00   04300   NURSERY					3.00
44.00 04400 SKILLED NURSING FACILITY				44	4. 00
ANCILLARY SERVICE COST CENTERS					
50.00   05000   OPERATING ROOM	0. 246842				0. 00
51.00   05100   RECOVERY ROOM	0. 249636				1. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 542090				2. 00
53. 00   05300   ANESTHESI OLOGY	0. 120094				3. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 240490				4. 00
55. 00   05500   RADI OLOGY - THERAPEUTI C	0. 114626				5. 00
56. 00   05600   RADI 0I SOTOPE	0. 115500				6. 00
57.00  05700 CT SCAN	0. 037907				7. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 069581				8. 00
60. 00   06000   LABORATORY	0. 157637				0.00
65. 00   06500   RESPI RATORY THERAPY	0. 143802				5.00
66. 00  06600 PHYSI CAL THERAPY	0. 273954				6. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0. 239906			6	7.00
68.00   06800   SPEECH PATHOLOGY	0. 683926			68	8. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 216591			7	1.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 223264			72	2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 270980			7:	3.00
74.00   07400   RENAL DI ALYSI S	0. 298653			7.	4. 00
76.00 03950 DIABETIC EDUCATION	6. 475275			7.0	6. 00
76. 97   07697   CARDIAC REHABILITATION	0. 564361			7.0	6. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 420908			70	6. 98
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 268195				0.00
91. 00   09100   EMERGENCY	0. 203405				1.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 727674			92	2. 00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 I NTEREST EXPENSE					3.00
200.00 Subtotal (see instructions)					0.00
201.00 Less Observation Beds					1.00
202.00 Total (see instructions)				202	2.00

Health Financial Systems	JACKSONVILLE MEN	MORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	TAL COSTS	Provi der C		Peri od: From 10/01/2022 To 09/30/2023	Worksheet D Part II Date/Time Pre 2/28/2024 8:4	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col . 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	1, 014, 799		1		36, 610	
51.00   05100   RECOVERY ROOM	29, 736				2, 720	
52.00   05200   DELIVERY ROOM & LABOR ROOM	36, 334		1		0	52. 00
53. 00   05300   ANESTHESI OLOGY	204, 058				7, 292	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	721, 753		1		16, 954	54.00
55. 00   05500   RADI OLOGY - THERAPEUTI C	593, 677				0	55. 00
56. 00   05600   RADI 0I SOTOPE	11, 099				116	56. 00
57.00  05700 CT SCAN	49, 930				756	
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	43, 649					58. 00
60. 00   06000   LABORATORY	307, 363					60.00
65. 00   06500   RESPI RATORY THERAPY	227, 976	23, 477, 299	0. 00971	0 3, 000, 049	29, 130	65. 00
66. 00   06600 PHYSI CAL THERAPY	285, 329	23, 226, 866	0. 01228	522, 762	6, 422	66. 00
67. 00   06700 OCCUPATI ONAL THERAPY	85, 222	8, 943, 587	0.00952	9 586, 627	5, 590	67. 00
68.00 06800 SPEECH PATHOLOGY	9, 669	947, 532	0. 01020	116, 567	1, 189	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	49, 535	9, 427, 135	0.00525	5 837, 037	4, 399	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	51, 973	9, 604, 007	0. 00541	2 777, 298	4, 207	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	228, 961	38, 256, 069	0. 00598	2, 608, 245	15, 610	73. 00
74.00   07400   RENAL DIALYSIS	18, 261	1, 350, 897	0. 01351	8 547, 391	7, 400	74. 00
76.00 03950 DIABETIC EDUCATION	11, 095	76, 017	0. 14595	4 0	0	76. 00
76. 97 07697 CARDIAC REHABILITATION	55, 747	730, 637	0. 07629	9 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	65, 320	672, 144	0. 09718	2 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	211, 311	12, 592, 421	0. 01678	85, 624	1, 437	90.00
91. 00 09100 EMERGENCY	606, 061	55, 901, 684	0. 01084	2 43, 922	476	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	218, 619	5, 440, 411	0. 04018	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

Health Financial Systems	JACKSONVILLE MEMOR	IAL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIE	NT ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-1352	Peri od:	Worksheet D
TUDOUGU COCTO			From 10/01/2022	Dart IV

THROUGH COSTS	RVICE UTHER PAS	S Provider C		From 10/01/2022 To 09/30/2023	Part IV Date/Time Pre 2/28/2024 8:4	
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS		1		1		
50. 00   05000   OPERATING ROOM	0	0		0	0	50.00
51. 00 05100 RECOVERY ROOM	0	0		0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY - DI AGNOSTI C	0	0		0	0	53. 00 54. 00
55. 00   05500   RADI OLOGY - DI AGNOSTI C	0	0		0	0	55.00
56. 00   05600   RADI OI SOTOPE				0	0	56.00
57. 00   05700 CT SCAN	0			0 0	0	57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	o o	58.00
60. 00   06000   LABORATORY	o o	ĺ		o o	Ö	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL 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	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
74. 00   07400   RENAL DI ALYSI S	0	0		0	0	74. 00
76. 00 03950 DI ABETI C EDUCATI ON	0	0		0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC		0		0 0	0	90.00
91. 00   09100  EMERGENCY				0 0	0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		١		o o	0	1
200.00 Total (lines 50 through 199)	0	0		0 0	-	200. 00

Health Financial Systems	JACKSONVILLE MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1352	Period: Worksheet D From 10/01/2022 Part IV To 09/30/2023 Date/Time Prepared:
		2/29/2024 9: 40 am

THROUGH COSTS				From 10/01/2022 To 09/30/2023		
			XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
				7.00	instructions)	
ANOULL ADV. CEDVI OF COCT OFNITEDS	4.00	5. 00	6. 00	7. 00	8. 00	
ANCI LLARY SERVI CE COST CENTERS  50.00   05000   0PERATI NG ROOM			J ,	AE 0/0 1E4	0.000000	50.00
51. 00   05100   OPERATING ROOM 51. 00   05100   RECOVERY ROOM	0			45, 960, 154		50.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0			2, 818, 587 969, 905		
53. 00   05300   ANESTHESI OLOGY	0			5, 296, 629		
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0			26, 401, 847	l	
55. 00   05500   RADI OLOGY - THERAPEUTI C	0		)	15, 783, 398	l .	1
56. 00   05600   RADI 01 SOTOPE			)	4, 466, 372	1	56.00
57. 00  05700  CT SCAN	0		)	69, 150, 817	l	
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)	0			13, 497, 160	l	1
60. 00   06000   LABORATORY	0			56, 056, 351	0.000000	
65. 00 06500 RESPIRATORY THERAPY	0		]	23, 477, 299	l e	1
66. 00   06600 PHYSI CAL THERAPY	0	Ö		23, 226, 866	l e	
67. 00 06700 OCCUPATI ONAL THERAPY	0	Ö		8, 943, 587	l e	1
68. 00   06800   SPEECH PATHOLOGY	0	Ö		947, 532	l e	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö		9, 427, 135		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	O		9, 604, 007	l e	1
73.00 07300 DRUGS CHARGED TO PATIENTS	0	o	) (	38, 256, 069	0.000000	73. 00
74. 00 07400 RENAL DIALYSIS	0	Ö	) (	1, 350, 897	0.000000	74. 00
76. 00 03950 DIABETIC EDUCATION	0	Ö	) (	76, 017	0.000000	76. 00
76. 97 07697 CARDIAC REHABILITATION	0	0	) (	730, 637	0.000000	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	) (	672, 144	0.000000	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	(	12, 592, 421	0.000000	90. 00
91. 00 09100 EMERGENCY	0	0		55, 901, 684	•	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		5, 440, 411		1
200.00   Total (lines 50 through 199)	0	0	(	431, 047, 926		200. 00

Health Financial Systems	JACKSONVILLE MEMORI	AL HOSPITAL		In Lieu of Form CMS-2552-10
ADDODTI ONMENT OF INDATIENT (OUTDATIENT	ANCILLARY SERVICE OTHER DASS	Dravidor CCN: 14 1252	Dori od:	Workshoot D

Period: From 10/01/2022 To 09/30/2023 Part IV THROUGH COSTS Date/Time Prepared: 2/28/2024 8:49 am Title XVIII Hospi tal Cost Outpati ent Cost Center Description Outpati ent Inpatient Inpati ent Outpati ent Program Ratio of Cost Program Program Program Pass-Through Pass-Through to Charges Charges Charges Costs (col. (col. 6 ÷ col Costs (col. 8 x col . 12) 13.00 7) x col. 10) 11.00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 1, 658, 057 0 0 50.00 0 05100 RECOVERY ROOM 51.00 0.000000 257, 788 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 52.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 05300 ANESTHESI OLOGY 0.000000 189, 274 0 53.00 53.00 0 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.000000 620, 197 54.00 0 0 55.00 05500 RADI OLOGY - THERAPEUTI C 0.000000 0 55.00 56.00 05600 RADI OI SOTOPE 0.000000 46, 822 0 0 56.00 0 57.00 05700 CT SCAN 0.000000 1,047,432 57.00 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0.000000 246, 476 0 58.00 60.00 06000 LABORATORY 0.000000 3, 581, 824 0 60.00 06500 RESPIRATORY THERAPY 0.000000 3,000,049 0 65.00 0 65.00 0 06600 PHYSI CAL THERAPY 0.000000 522, 762 66.00 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 586, 627 0 67.00 06800 SPEECH PATHOLOGY 0.000000 116, 567 0 68.00 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71 00 0.000000 837, 037 0 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 777, 298 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 2, 608, 245 0 0 73.00 07400 RENAL DIALYSIS 0 74.00 0.000000 547, 391 0 74.00 03950 DIABETIC EDUCATION 0 76.00 0.000000 76.00 C Ω 0 76.97 07697 CARDIAC REHABILITATION 0.000000 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 0 0 76. 98 OUTPATIENT SERVICE COST CENTERS 90.00 90. 00 09000 CLI NI C 0.000000 0 0 0 85, 624 0 91. 00 09100 EMERGENCY 0.000000 43, 922 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 12, 480 0 0 0 92.00

16, 785, 872

0

0 200.00

Total (lines 50 through 199)

200.00

Health Financial Systems	JACKSONVILLE MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1352	Peri od:	Worksheet D

From 10/01/2022 Part V To 09/30/2023 Date/Time Prepared: 2/28/2024 8:49 am Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 246842 10, 215, 474 0 50.00 51.00 05100 RECOVERY ROOM 0. 249636 368, 172 0 0 0 0 0 0 0 0 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.542090 0 52 00 52 00 0 53.00 05300 ANESTHESI OLOGY 0.120094 0 978, 380 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 240490 6, 291, 769 0 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 0.114626 0 5. 423. 383 55.00 0 05600 RADI OI SOTOPE 0.115500 56.00 1, 718, 934 0 56.00 57.00 05700 CT SCAN 0.037907 19, 273, 930 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0.069581 3, 264, 681 0 58.00 06000 LABORATORY 0. 157637 9, 860, 853 60 00 60 00 0 06500 RESPIRATORY THERAPY 65.00 0.143802 4, 753, 121 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 273954 5, 663, 979 0 66.00 06700 OCCUPATIONAL THERAPY 1, 023, 861 67.00 0. 239906 67.00 0 68.00 06800 SPEECH PATHOLOGY 77, 159 0.683926 0 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 216591 0 1, 776, 543 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 223264 2, 489, 496 0 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 270980 8, 246, 247 0 73.00 3, 945 07400 RENAL DIALYSIS 0.298653 74.00 74 00 0 3, 350 0 0 76.00 03950 DIABETIC EDUCATION 6. 475275 0 0 76.00 07697 CARDIAC REHABILITATION 0 270, 075 0 76. 97 76.97 0.564361 0 07698 HYPERBARI C OXYGEN THERAPY 76.98 0.420908 0 0 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 268195 3, 410, 265 8, 755 0 90.00 09100 EMERGENCY 0. 203405 12, 231, 032 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.727674 92.00 0 1, 407, 215 0 200.00 Subtotal (see instructions) Ω 98, 747, 919 12, 700 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges Net Charges (line 200 - line 201) 202.00 ol 98, 747, 919 0 202. 00 12, 700

From 10/01/2022 To 09/30/2023 Part V Date/Time Prepared: 2/28/2024 8:49 am Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 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 52 00 05300 ANESTHESI OLOGY 0 53.00 117, 498 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 513, 108 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 621, 661 0 55.00 05600 RADI OI SOTOPE 0 56.00 198, 537 56.00 57. 00 05700 CT SCAN 730, 617 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 227, 160 58.00 06000 LABORATORY 60 00 60 00 1, 554, 435 65.00 06500 RESPIRATORY THERAPY 683, 508 0 65.00 66.00 06600 PHYSI CAL THERAPY 1, 551, 670 66.00 06700 OCCUPATIONAL THERAPY 67.00 245, 630 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 52, 771 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 384, 783 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 555, 815 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 234, 568 73.00 1.069 07400 RENAL DIALYSIS 74.00 1,000 0 74.00 76.00 03950 DIABETIC EDUCATION 0 76.00 76. 97 07697 CARDIAC REHABILITATION 76. 97 152, 420 0 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76.98 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 914, 616 2, 348 90.00 09100 EMERGENCY 2, 487, 853 91.00 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1,023,994 92.00 200.00 Subtotal (see instructions) 17, 865, 161 3, 417 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00

17, 865, 161

3, 417

202.00

Only Charges

Net Charges (line 200 - line 201)

202.00

	Financial Systems J. TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	ACKSONVILLE MEN			Peri od:	worksheet D	2552-10
	TONMENT OF INPATTENT/OUTPATTENT ANCILLARY SER SH COSTS	WICE UTHER PAS	5 Provider C	CIN: 14-1352	From 10/01/2022		
11111000	11 00313		Component	CCN: 14-5951	To 09/30/2023		
			Ti +Lo	e XVIII	Skilled Nursing	2/28/2024 8: 4 PPS	<u>9 am</u>
			11 11 6	: AVIII	Facility	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	<b>'</b>	Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2. 00	3A	3. 00	
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	)	0	0	00.00
51. 00	05100 RECOVERY ROOM	0	0	)	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	)	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	)	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	)	0	0	54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0	)	0	0	55. 00
56.00	05600 RADI 0I SOTOPE	0	0	)	0	0	56. 00
57. 00	05700 CT SCAN	0	0	)	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	)	0	0	58. 00
60.00	06000 LABORATORY	0	0	)	0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	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	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
74.00	07400 RENAL DIALYSIS	0	0	1	0 0	0	74. 00
76. 00	03950 DI ABETI C EDUCATI ON	0	0	1	0 0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	1	0 0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	1	0 0	0	76. 98

0 0 0

0

0

0 0 0

0

0 92.00 0 200.00

90. 00 91. 00

91. 00 09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLINIC

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50 through 199)

Heal th	Financial Systems J	ACKSONVILLE MEN	ORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUG	SH COSTS		Component	CCN: 14-5951	From 10/01/2022 To 09/30/2023		nanad.
			Component	CCN: 14-5951	To 09/30/2023	Date/Time Pre 2/28/2024 8:4	pareu: 9 am
-			Ti tl e	XVIII	Skilled Nursing	PPS	
					<u>Facility</u>		
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col . 5 ÷ col .	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	F 00	( 00	7.00	instructions)	
	ANGLILADY CEDVICE COCT CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
50. 00	ANCILLARY SERVICE COST CENTERS    O5000   OPERATING ROOM	0	0	ı	0 45, 960, 154	0. 000000	50.00
51.00	05100 RECOVERY ROOM			l .	0 45, 960, 154	l e	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0			0 969, 905	l e	
53. 00	05300 ANESTHESI OLOGY	0			0 5, 296, 629		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	Ĭ		0 26, 401, 847	l e	
55. 00	05500 RADI OLOGY - THERAPEUTI C	0	Ö		0 15, 783, 398		
56. 00	05600 RADI OI SOTOPE	0			0 4, 466, 372		
57. 00	05700 CT SCAN	0	l o	,	0 69, 150, 817		
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	l o	,	0 13, 497, 160	l e	
60.00	06000 LABORATORY	0	l c	,	0 56, 056, 351	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	0	l o	1	0 23, 477, 299	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	)	0 23, 226, 866	0.000000	66. 00
67.00	06700 OCCUPATI ONAL 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	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	)	0 9, 604, 007		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0 38, 256, 069		
74.00	07400 RENAL DI ALYSI S	0	0	)	0 1, 350, 897	l .	
76.00	03950 DI ABETI C EDUCATI ON	0	0	)	0 76, 017		
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	1	0 730, 637	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 672, 144	0.000000	76. 98
	OUTPATIENT SERVICE COST CENTERS			1			
90.00	09000 CLI NI C	0		1	0 12, 592, 421	l e	
91.00	09100 EMERGENCY	0	1		0 55, 901, 684		
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		1	0 5, 440, 411	l e	
200.00	Total (lines 50 through 199)	0	0	1	0 431, 047, 926		200. 00

Health Financial Systems	ACKSON/ATTE WEWO	DIAI HOSDITAI		In Lia	u of Form CMS	neen 10
Health Financial Systems JA APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	ACKSONVILLE MEMOR VICE OTHER PASS	Provi der Co		Period: From 10/01/2022 To 09/30/2023	w of Form CMS-2 Worksheet D Part IV Date/Time Pre	pared:
		Title	XVIII	Skilled Nursing Facility	2/28/2024 8: 4 PPS	9 am
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
3350 331101 B3501 F11011	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	9	Pass-Through	
	(col . 6 ÷ col .	orial ges	Costs (col.		Costs (col. 9	
	7)		x col . 10)		x col . 12)	
	9, 00	10.00	11.00	12.00	13. 00	
ANCI LLARY SERVI CE 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	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	249		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	35, 931		0	0	54.00
55. 00   05500   RADI OLOGY - THERAPEUTI C	0. 000000	00, 701		0 0	0	55.00
56. 00   05600   RADI OI SOTOPE	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	Ö	
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 PHYSI CAL THERAPY	0. 000000	776, 093		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	695, 314		0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	27, 084		0 0	0	
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 DI ALYSI S	0. 000000	390		0 0	0	
76. 00 03950 DI ABETI C EDUCATI ON	0. 000000	0		0 0	Ō	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS	2. 222300					1
90. 00 09000 CLINIC	0. 000000	21, 712		0 0	0	90.00
91. 00   09100   EMERGENCY	0. 000000	173		0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	1
200.00 Total (lines 50 through 199)		2, 532, 098		0 0	0	200.00
, , ,	1		1	1	•	•

Health Financial Systems	JACKSONVILLE MEMORIAL HOSPITAL	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-1352	From 10/01/2022	Worksheet D-1 Date/Time Prep 2/28/2024 8:49	
	Title XVIII	Hospi tal	Cost	
Cost Center Description				

1. Injestient days (including private room days, sexulating sating-bed and newborn days) (and on the complete this line. 2. On Private room days (excluding saving-bed and observation bed days). If you have only private room days. (and on on complete this line. 3. On Private room days (excluding saving-bed and observation bed days). If you have only private room days. (3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3. 0. 3					2/28/2024 8: 4	9 am	
PART   - ALL PROVIDER COMPONENTS	Title XVIII Hospital						
RRATT TO MON   RRATT TO MON	Cost Center Description						
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1.00 Inpatient days (including private room days, excluding newborn) 9, 488 1, 0.0 Inpatient days (including private room days, excluding saling-bed and newborn days) 9, 488 2, 0.0 Inpatient days (including private room days) 1.7 you have only private room days (9, 488 2, 0.0 Sing-bed saling private room days) 1.7 you have only private room days (9, 488 2, 0.0 Sing-bed SRF type inpatient days (including private room days) 1.7 you have only private room days (10 SRF type inpatient days (including private room days) 1.7 you have only private room days) 1.7 you have only private room days (including private room days) 1.7 you have only private room days) 1.7 you have only private room days (including private room days) 1.7 you have only private room days) 1.7 you have only private room days (including private room days) 1.7 you have only 1.7 you have reporting period (including private room days) 1.7 you have private room days (including private room days) 1.7 you have reporting period (including private room days) 1.7 you have reporting period (including private room days) 1.7 you have reporting period (including private room days) 1.7 you have reporting period (including private room days) 1.7 you have reporting period (including private room days) 1.7 you have reporting period (including private room days) 1.7 you have reporting period (including private room days) 1.7 you have reporting period (including private room days) 1.7 you have reporting period (including private room days) 1.7 you have reporting 1.7 you have reporting period (including private room days) 1.7 you have reporting 1.7 you have repor		PART I - ALL PROVIDER COMPONENTS					
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Private room days (excluding swing-bed and observation bed days). If you have only private room days.  do not complete this line.  4.00 Seel : private room days. (excluding swing-bed and observation bed days).  5.01 Total swing-bed SWF type inpatient days. (including private room days) through December 31 of the cost reporting period (if callender year, enter 0 on this line).  7.00 Total swing-bed SWF type inpatient days. (including private room days) through December 31 of the cost reporting period (if callender year, enter 0 on this line).  7.00 Total swing-bed WF type inpatient days. (including private room days) after December 31 of the cost reporting period.  8.00 Total swing-bed WF type inpatient days. (including private room days) after December 31 of the cost reporting period.  9.00 Total inpatient days (including private room days) after December 31 of the cost	1.00				·	1.00	
do not complete this line.  1. Ose Semi-private room days (excluding swing-bed and observation bod days)  1. Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1. Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1. Total swing-bed FY type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1. Total swing-bed FY type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1. Total inpatient days including private room days applicable to the Program (excluding swing-bed and loss inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1. Total inpatient days including private room days applicable to the program (excluding swing-bed and loss inpatient days applicable to title WIII only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1. Do Swing-bed SWF type inpatient days applicable to title WIII only (including private room days)  1. Do Swing-bed SWF type inpatient days applicable to titles VI arX XI only (including private room days)  1. Do Swing-bed SWF type inpatient days applicable to titles VI arX XI only (including private room days)  1. Do Swing-bed SWF type inpatient days applicable to titles VI arX XI only (including private room days)  1. Do Swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed days)  1. Do Swing-bed SWF type inpatient days applicable to services through December 31 of the cost reporting period (including type type type type type type type type	2.00	Inpatient days (including private room days, excluding swing-b	ped and newborn days)		9, 488	2.00	
Semi-perivate room days (excluding swing-bed and observation bed days)  5. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period of the swing-bed SNF type inpatient days (including private room days) after December 31 of the cost swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting December 31 of the cost after December 31 of the cost applicable to SPK services applicable to services after December 31 of the cost applicable 31 of December 31 of the	3.00	Private room days (excluding swing-bed and observation bed day	rs). If you have only pri	vate room days,	0	3.00	
10tal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost roporting period (if cal endar year, enter 0 on this line)   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00		do not complete this line.					
reporting period (if calendar year, enter 0 on this line)  7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.00 Total inpatient days including private room days after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see Instructions)  10.00 Swing-bed SNF type inpatient days applicable to tille XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  10.00 Swing-bed SNF type inpatient days applicable to tille XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  10.00 Swing-bed SNF type inpatient days applicable to tille XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  10.00 Swing-bed SNF type inpatient days applicable to tille XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10.00 Swing-bed NF type inpatient days applicable to tille XVIII only (including private room days)  10.10 Modically inaccessary private room days applicable to the Program (excluding swing-bed days)  10.10 Modically inaccessary private room days applicable to services through December 31 of the cost reporting period (in calendar year, enter 0 on this line)  10.00 Modically inaccessary private room days applicable to services after December 31 of the cost reporting period (in calendar year, enter 0 on this line)  10.00 Modical processary private room days applicable to services after December 31 of the cost reporting period (in period year)  10.00 Modical properiod	4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		7, 286	4.00	
10tal saving-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal ender year, enter 0 on this line)   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00	5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	r 31 of the cost	0	5.00	
reporting period (if calendar year, enter 0 on this line)   7.00		reporting period					
Total swing-bed NF type inpatient days (including private room days) shrough December 31 of the cost reporting period   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)   Total inpatient days including private room days applicable to the Program (excluding swing-bed and support of the cost reporting period (if calendar year, enter 0 on this line)   Total inpatient days including private room days applicable to the Program (excluding swing-bed and support of the cost reporting period (see instructions)   Total inpatient days applicable to the Ital XIV and (including private room days)   Total period (see instructions)   Total inpatient days applicable to title XV in Ital (including private room days)   Total Program (excluding private room days)   Total Virough December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total Virough December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total Virough December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total Virough December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total Virough December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total Virough December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total Virough December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total Virough December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total Virough December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total Virough December 31 of the cost reporting period (if period year)   Total Virough December 31 of the cost reporting period (if period year)   Total Virough December 31 of the cost reporting period (if period year)   Total Virough December 31 of the cost reporting period (if period year)   T	6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December :	31 of the cost	0	6.00	
reporting period   reporting period   0   8.00   7   7   7   7   7   7   7   7   7		reporting period (if calendar year, enter 0 on this line)					
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reporting period (if cal endar year, enter 0 on this line) 10.00 10.00 Simplebed Sim Industrial days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Simplebed Sim Type Inpatient days applicable to title XVIII only (including private room days) 11.00 Simplebed Sim Type Inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 10.00 Simplebed Ni Type Inpatient days applicable to title V or XIX only (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 10.00 Simplebed Ni Type Inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 11.00 Simplebed Ni Type Inpatient days applicable to titles V or XIX only (including private room days) after 14.00 arter December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 11.00 Total nursery days (title V or XIX only) 11.00 Narsery							
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newborn days) (see instructions)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through becember 31 of the cost reporting period (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after through becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary privates reporting period (if calendar year, enter 0 on this line)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to the Program (excluding swing-bed days)  18.00 Medicare rate for swing-bed SNF services applicable to services through becember 31 of the cost reporting period (including swing-bed swing-bed swing-bed swing-bed NF services applicable to services after December 31 of the cost reporting period (including swing-bed swing-bed swing-bed NF services applicable to services after December 31 of the cost reporting period (including swing-bed swing-bed NF services applicable to services after December 31 of the cost reporting period (including swing-bed swing-bed NF services applicable to services after December 31 of the cost reporting period (including swing-bed cost reporting period (line 8 x x iinc 20)  28.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 x x iinc 20)  28.00 S					· '		
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after brown becember 31 of the cost reporting period (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  17.00 Swing-bed Swing-bed SNF services applicable to services through December 31 of the cost reporting period (incer rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (incer rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (incer capter for swing-bed NF services applicable to services after December 31 of the cost reporting period (incer period	9. 00		the Program (excluding	swing-bed and	3, 158	9. 00	
through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to fittle XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.01 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.02 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 8 x 1 in							
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  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)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  16.00 Nursery days (title V or XIX only)  17.00 Medical unserved days (title V or XIX only)  18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (inc or pepting period (inc or pep	10. 00			oom days)	01	10.00	
December 31 of the cost reporting period (if calendar year, enter 0 on this line)							
12.00 Swing-bed NF type inpatient days applicable to it tiles V or XIX only (including private room days) or through December 31 of the cost reporting period (if call endarry sar, enter 0 on this line) of the cost reporting period (if call endarry sar, enter 0 on this line) of the cost reporting period (if call endarry sar, enda	11. 00			oom days) after	01	11. 00	
through December 31 of the cost reporting period  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)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 12)  23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 Compared line 10 NF type services after December 31 of the cost reporting period (line 8 x line 20)  28.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  29.00 Private room charges (excluding swing-bed cost (line 21 minus line 26)  29.00 Private room charges (excluding swing-bed cost (line 22 minus line 26)  29.00 Private room charges (excluding swing-bed cost applicable and the cost reporti					_ '		
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 called and year, enter 0 on this line)   14.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00	12. 00		( only (including private	e room days)	01	12. 00	
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   14.00   15.00   15.00   15.10   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15					_ '		
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00	13. 00				01	13.00	
15.00   Total nursery days (title V or XIX only)   0   15.00   0   16.00   0   16.00   0   16.00   0   16.00   0   16.00   0   16.00   0   16.00   0   16.00   0   16.00   0   16.00   0   16.00   0   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00							
16.00   Nursery days (title v or XIX only)   0   16.00			am (excluding swing-bed	days)	-		
SWING BED ADJUSTMENT  17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period (line gorting period reporting period (line gorting period reporting period (line gorting gorting gorting (line gorting gorting gorting gorting gorting gorting gorting gorting (line gorting gor							
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18)  10. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  10. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  10. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  10. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 31)  10. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 31)  10. 01 Swing-bed cost applicable to NF type service cost (line 21 minus line 26)  10. 01 Swing-bed cost applicable to NF type service safter December 31 of the cost reportin	16.00				0	16.00	
reporting period  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (19. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (11. 00 Total general inpatient routine service cost (see instructions) (22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (11. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (11. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11. 00 Swing-bed Cost applicable to NF type services after December 31 of the cost reporting period (11. 00 Swing-bed Cost applicable to NF type service after Decembe	47.00						
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (10.00 Total general inpatient routine service cost (see instructions)  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (11ne 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (11ne 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (11ne 6 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11ne 6 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11ne 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.01 Swing-bed cost (see instructions)  28.00 General inpatient routine service cost net of swing-bed cost (11ne 21 minus line 26)  28.00 General inpatient routine service cost net of swing-bed and observation bed charges)  28.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average perione private room perione charge (11ne 29 + line 3)  30.00 Average perione private room charge differential (11ne 32 minus line 33) (see instructions)  30.00 Average perione private room charge differential (11ne 32 minus line 33) (see instructions)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (11ne 3 x line 35)  30.00 Average perione private room charge differential (11ne 32 minus line 33) (see instructions)  30.00 General inpatient routine service cost perione (swing-be	17.00		es through December 31 o	t the cost		17.00	
reporting period  Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost cost (according to the cost reporting period (line services applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20)  26.00 To x line 19)  26.00 Total swing-bed cost (see instructions)  27.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  28.00 Total swing-bed cost (see instructions)  29.00 Private room charges (excluding swing-bed charges)  29.00 Dotal swing-bed charges (see see see see seed some service cost (see seed some service seed seed seed seed seed seed seed se	10.00		CI D I 01 C			40.00	
19.00   Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period   17,057,896   21.00   21.00   Total general inpatient routine service cost (see instructions)   17,057,896   22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   26.00   27.00   Swing-bed cost (see instructions)   0.00   26.00   27.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.	18.00		es after December 31 of	tne cost		18.00	
reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (20.00 Medicaid rate for swing-bed NF services ost (see instructions)  17, 057, 896  17, 057, 896  17, 057, 896  21. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  32. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service cost net of swing-bed and observation bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Office of the cost reporting period (line 27 minus line 26)  30. 00 Semi-private room charges (excluding swing-bed cost (line 21 minus line 26)  30. 00 Semi-private room charges (excluding swing-bed cost (line 27 minus line 26)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room cost differential (line 27 minus line 28)  30. 00 Average perion deminus deminus deminus line 29  30. 00 Average perion deminus deminus deminus line 29  30. 00 Average perion deminus deminus line 29  30. 00 Average perion deminus deminus line 20  30. 00 Average perion deminus deminus line 20  30. 00 Average perion deminus line 20  30. 00 Average perion deminus line 20  30. 00	10.00				0.00	40.00	
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reporting period  Total general inpatient routine service cost (see instructions)  22.00  Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  33.00  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  Private Room DIFFERENTIAL ADJUSTMENT  28.00  General inpatient routine service cost net of swing-bed and observation bed charges)  General inpatient routine service cost (excluding swing-bed and observation bed charges)  O 22.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Total swing-bed cost applicable to NF type service after December 31 of the cost reporting period (line 8 x line 20)  Total swing-bed cost applicable to NF type service after December 31 of the cost reporting period (line 8 x line 20)  Total swing-bed cost applicable to NF type service after December 31 of the cost reporting period (line 9 x line 20)  Total swing-bed cost applicable to NF type service after December 31 of the cost r	20.00		after December 21 of the	20 000+	0.00	20.00	
21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 General inpatient routine service cost net of swing-bed and observation bed charges) 28.00 Semi-private room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average per diem private room per diem charge (line 30 + line 4) 33.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 34.00 Average per diem private room cost differential (line 32 minus line 33) 35.00 Average per diem private room cost differential (line 32 minus line 33) 36.00 Private room cost differential (line 32 minus line 33) 37.00 Private room cost differential (line 32 minus line 31) 38.00 Average per diem private room cost differential (line 32 minus line 35) 38.00 Average per diem private room cost differential (line 32 minus line 35) 38.00 Average per diem private room cost differential (line 32 minus line 35) 38.00 Average per diem private room cost differential (line 32 minus line 35) 38.00 Average per diem private room cost differential (line 32 minus line 35) 38.00 Average per diem private room cost differential (line 32 minus line 36) 38.00 Average per diem private room	20.00		s arter becember 31 or th	ie cost	0.00	20.00	
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23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 Private room charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 * line 3)  30.00 Average private room per diem charge (line 29 * line 3)  30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 35 x line 35)  30.00 Average per diem private room cost differential (line 35 x line 35)  30.00 Average smilline 36)	22.00		or or the cost report	ing period (init	١	22.00	
x line 18)  24.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00  Total swing-bed cost (see instructions)  Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Semi-private room charges (excluding swing-bed charges)  Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges)  Semi-private room charges (excluding swing-bed charges)  Ceneral inpatient routine service cost/charge ratio (line 27 ± line 28)  Ceneral inpatient routine service cost/charge ratio (line 27 ± line 28)  Ceneral inpatient routine service cost/charge ratio (line 27 ± line 28)  Ceneral inpatient routine service cost/charge ratio (line 27 ± line 28)  Ceneral inpatient routine service cost full (line 30 ± line 4)  Ceneral inpatient routine service cost differential (line 32 minus line 33)(see instructions)  Ceneral inpatient routine service cost differential (line 34 x line 31)  Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 057, 896)  PRIVATE ROOM DIFFERNTIAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Ceneral inpatient routine service cost per diem (see instructions)  Ceneral inpatient routine service cost per diem (see instructions)  Ceneral inpatient routine service cost per diem (see instructions)  Ceneral inpatient routine service cost per diem (see instructions)  Ceneral inpatient routine service cost (line 9 x line 38)  Ceneral inpatient routine service cost (line 9 x line 38)  Ceneral inpatient routine service cost (line 9 x line 38)	23 00		31 of the cost reporting	n period (line 6	0	23 00	
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7 x line 19)  25. 00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00  Private room charges (excluding swing-bed charges)  9. 01  30. 00  Semi-private room charges (excluding swing-bed charges)  9. 00  30. 00  31. 00  General inpatient routine service cost/charge ratio (line 27 + line 28)  31. 00  Average private room per diem charge (line 29 + line 3)  32. 00  33. 00  34. 00  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35. 00  36. 00  37. 00  General inpatient routine service cost/charge ratio (line 32 minus line 33) (see instructions)  38. 00  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  37. 00  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17,057,896)  38. 00  Average per diem private room cost differential (line 3 x line 35)  39. 00  PRIVATE ROOM DIFFERENTIAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  10. 00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  10. 04. 06  Medically necessary private room cost applicable to the Program (line 14 x line 35)  17. 07, 57, 579  18. 00  Adverage per diem provent room cost applicable to the Program (line 14 x line 35)	24.00		31 of the cost reporti	na period (line	0	24.00	
25. 00  26. 00  26. 00  27. 00  28. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00				.g p (	- 1		
x line 20) Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charges) Ceneral inpatient routine service cost/charge ratio (line 27 + line 28) Ceneral inpatient routine service cost/charge ratio (line 27 + line 28) Ceneral inpatient routine service cost/charge ratio (line 27 + line 28) Ceneral inpatient routine service cost/charge ratio (line 28 + line 28) Ceneral inpatient routine service cost (line 29 + line 3) Ceneral inpatient routine service cost differential (line 30 + line 4) Ceneral inpatient routine service cost differential (line 32 minus line 33) (see instructions) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 34 × line 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 31 × line 35) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 31 × line 35) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost (line 9 × line 38) Ceneral inpatient routine service cost (line 9 × line 38) Ceneral inpatient routine service cost (line 9 × line 38) Ceneral inpatient routine service cost (line 9 × line 38) Ceneral inpatient routine service cost (line 9 × line 38) Ceneral inpatient routine service cost (line 9 × line 38) Ceneral inpatient routine service cost (line 9 × line 38) Ceneral inpatient routine	25.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25.00	
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRI VATE ROOM DIFFERENTI AL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00 Pri vate room charges (excluding swing-bed charges)  10 Semi-pri vate room charges (excluding swing-bed charges)  11. 00 General inpatient routine service cost/charge ratio (line 27 ± line 28)  12. 00 Average pri vate room per diem charge (line 29 + line 3)  13. 00 Average semi-pri vate room per diem charge (line 30 ± line 4)  13. 00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  13. 00 Average per diem pri vate room cost differential (line 34 x line 31)  13. 00 Average per diem pri vate room cost differential (line 34 x line 31)  13. 00 Average per diem pri vate room cost differential (line 3 x line 35)  13. 00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  13. 00 Adjusted general inpatient routine service cost (line 9 x line 38)  14. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  15. 07. 07. 99. 040. 00		x line 20)					
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Pri vate room charges (excluding swing-bed charges)  30.00 Semi-pri vate room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average pri vate room per diem charge (line 29 ÷ line 3)  33.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4)  34.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem pri vate room cost differential (line 34 x line 31)  36.00 Pri vate room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17,057,896)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  39.00 Program general inpatient routine service cost (line 9 x line 38)  5,677,579  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	26.00	Total swing-bed cost (see instructions)			0	26.00	
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17,057,896)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  28.00 Adjusted general inpatient routine service cost (line 9 x line 38)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	27.00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		17, 057, 896	27.00	
29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 29 ÷ line 3)  34.00 Average per diem private room charge differential (line 30 ± line 4)  35.00 Average per diem private room cost differential (line 32 ± line 33) (see instructions)  36.00 Private room cost differential (line 34 ± line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17,057,896)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Medically necessary private room cost applicable to the Program (line 14 ± line 35)  0 29.00  30.00  30.00  31.00  31.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00		PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost (line 9 x line 38)  Description of the cost and private room cost differential (line 27 minus line 36)  Program general inpatient routine service cost per diem (see instructions)  Description of the cost and private room cost differential (line 27 minus line 36)  Adjusted general inpatient routine service cost per diem (see instructions)  Description of the cost and private room cost differential (line 27 minus line 36)  Description of the cost and private room cost differential (line 27 minus line 36)  Description of the cost and private room cost differential (line 37 minus line 36)  Description of the cost and private room cost differential (line 38 minus line 39)  Description of the cost and private room cost differential (line 38 minus line 39)  Description of the cost and private room cost differential (line 38 minus line 39)  Description of the cost and private room cost differential (line 38 minus line 39)  Description of the cost and private room cost differential (line 38 minus line 39)  Description of the cost and private room cost differential (line 38 minus line 39)  Description of the cost and private room cost differential (line 38 minus l	28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00	
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 in inus line 36)  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)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  5.00 Oncood 32.00  32.00 Oncood 32.00  32.00 Oncood 32.00  33.00 Oncood 32.00  34.00 Oncood 32.00  35.00 Oncood 32.00  36.00 Oncood 32.00  37.00 Oncood 32.00  38.00 Oncood 32.00  39.00 Oncood 32.00  39.00 Oncood 32.00  39.00 Oncood 32.00  30.00	29. 00	Private room charges (excluding swing-bed charges)			0	29. 00	
32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17,057,896)  27 minus line 36)  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)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  5.677,579  40.00	30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00	
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17,057,896)  27 minus line 36)  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)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 33.00 34.00 34.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 3	31.00	General inpatient routine service cost/charge ratio (line 27 -	- line 28)		0. 000000	31.00	
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17,057,896)  27 minus line 36)  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)  70.00 Program general inpatient routine service cost (line 9 x line 38)  71.797.84 Service cost (line 9 x line 38)  72.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00	
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  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)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	33.00					33.00	
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  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)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 37.00 17, 057, 896  17, 057, 896  17, 057, 896  17, 057, 896  17, 057, 896  17, 057, 896  17, 057, 896  17, 057, 896  18, 00  19, 00  10, 00  10, 00  10, 00  10, 00  11, 00  11, 00  12, 00  13, 00  13, 00  14, 00  15, 677, 579  16, 00  17, 057, 896  17, 057, 896  17, 057, 896  18, 00  19, 00  10, 00  10, 00  10, 00  11, 00  11, 00  12, 00  13, 00  13, 00  14, 00  15, 00  16, 00  17, 057, 896  17, 057, 896  17, 057, 896  17, 057, 896  17, 057, 896  18, 00  19, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 00  10, 0	34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34.00	
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) 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)  9.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00  40.00 40.00	35.00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	35. 00	
27 minus line 36) 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 Program general inpatient routine service cost (line 9 x line 38) 5,677,579 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	36.00	0   Private room cost differential adjustment (line 3 x line 35)				36. 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 Program general inpatient routine service cost (line 9 x line 38)  5,677,579 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	17, 057, 896	37. 00	
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 Program general inpatient routine service cost (line 9 x line 38)  5,677,579 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00							
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,797.84 38.00 Program general inpatient routine service cost (line 9 x line 38)  5,677,579 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY					
39.00 Program general inpatient routine service cost (line 9 x line 38)  5,677,579 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS				
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	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	
41.00   Total Program general inpatient routine service cost (line 39 + line 40) 5,677,579   41.00	40.00	Medically necessary private room cost applicable to the Progra	am (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	

		CKSONVILLE MEMOR				u of Form CMS-2	<u> 2552-10</u>
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CC	CN: 14-1352	Peri od: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prep 2/28/2024 8:4	
	Cost Center Description	Total npatient Costlr	Total			Cost Program Cost (col. 3 x col.	7 4111
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	00 0	0	42. 00
43. 00	INTENSIVE CARE UNIT	3, 929, 463	1, 046	3, 756.	56 347	1, 303, 561	43. 00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wks					3, 333, 567	48. 00
48. 01 49. 00	Program inpatient cellular therapy acquisitio Total Program inpatient costs (sum of lines 4	•			column I)	0 10, 314, 707	
	PASS THROUGH COST ADJUSTMENTS		•	,			
50. 00	Pass through costs applicable to Program inpa	tient routine s	ervices (from	Wkst. D, sun	n of Parts I and	0	50. 00
51.00	Pass through costs applicable to Program inpa	tient ancillary	services (fr	om Wkst. D, s	sum of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines 5	) and 51)				0	52. 00
53. 00	Total Program inpatient operating cost exclud	ing capital rela	ated, non-phy	sician anesth	netist, and	0	
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	2)					
	Program di scharges						54. 00
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge						55. 00 55. 01
55. 02	, , ,	se only)					55. 02
56.00	Target amount (line 54 x sum of lines 55, 55.		ast smount (1	ino E/ minuo	Line E2)	0	
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ig cost and targ	get amount (i	THE SO IIITIUS	111le 53)	0	57. 00 58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54, o	r line 55 from	the cost repo	rting period	endi ng 1996,	0. 00	59. 00
60. 00	updated and compounded by the market basket)  00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the						60. 00
61. 00	market basket) Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less					0	61. 00
62. 00	53) are less than expected costs (lines 54 x enter zero. (see instructions) Relief payment (see instructions)	60), or 1 % of <sup>-</sup>	the target am	ount (line 56	o), otherwise	0	62. 00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63. 00
64. 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					0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost</pre>	s after Decembei	r 31 of the c	ost reportino	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin</pre>	e costs (line 64	4 plus line 6	5)(title XVII	I only); for	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routine	costs through [	December 31 o	f the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19)	· ·					68. 00
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient r			•	or tring period		69. 00
09.00	PART III - SKILLED NURSING FACILITY, OTHER NU					0	09.00
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co						70. 00 71. 00
72. 00	Program routine service cost (line 9 x line 7		10 70 . TITIE .	2)			72.00
73. 00 74. 00	Medically necessary private room cost applica Total Program general inpatient routine servi		•	ne 35)			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient r	•		orksheet B, F	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	a 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00 79. 00	,		avidor record	6)			78. 00 79. 00
80.00							80.00
81. 00 82. 00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li						81. 00 82. 00
82.00	1 .		)				83.00
84.00	Program inpatient ancillary services (see ins	tructions)					84. 00
85. 00 86. 00							85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS		<u> </u>			2 222	
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per d	em (line 27 ÷ l	line 2)			2, 202 1, 797. 84	87. 00 88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	instructions)				3, 958, 844	89. 00

Health Financial Systems JA	ACKSONVILLE MEM	IORI AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2022 To 09/30/2023	Date/Time Prep 2/28/2024 8:49	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	941, 982	17, 057, 896	0. 05522	3, 958, 844	218, 619	90. 00
91.00 Nursing Program cost	0	17, 057, 896	0.00000	3, 958, 844	0	91.00
92.00 Allied health cost	0	17, 057, 896	0.00000	3, 958, 844	0	92. 00
93.00 All other Medical Education	0	17, 057, 896	0. 00000	3, 958, 844	0	93. 00

Health Financial Systems	JACKSONVILLE MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1352	Peri od: From 10/01/2022	Worksheet D-1
	Component CCN: 14-5951		Date/Time Prepared: 2/28/2024 8:49 am
	Title XVIII	Skilled Nursing	PPS

		litle XVIII	Facility	PPS		
	Cost Center Description					
	PART I - ALL PROVIDER COMPONENTS			1. 00		
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days			2, 969	1. 00	
2.00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day		ivata maam daya	2, 969	2.00	
3.00	do not complete this line.	ys). It you have only pr	ivate room days,	0	3. 00	
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 969	4. 00	
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00	
	reporting period	om dava) after December	21 of the cost	0	4 00	
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) arter becember	31 Of the Cost	U	6. 00	
7.00	Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	0	7. 00	
	reporting period			_		
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	m days) after December 3	1 of the cost	0	8. 00	
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 863	9. 00	
	newborn days) (see instructions)					
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00	
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00	
	December 31 of the cost reporting period (if calendar year, en					
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	K only (including privat	e room days)	0	12. 00	
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	/ only (including privat	o room days)	0	13. 00	
13.00	after December 31 of the cost reporting period (if calendar ye			O	13.00	
14. 00	Medically necessary private room days applicable to the Progra	am (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 XLX only) SWING BED ADJUSTMENT			0	16. 00	
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00	
	reporting period					
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00	
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00	
17.00	reporting period	3 through becomber 31 or	the cost	0.00	17.00	
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0. 00	20. 00	
21. 00	reporting period Total general inpatient routine service cost (see instructions	-)		3, 429, 907	21. 00	
21.00	Swing-bed cost applicable to SNF type services through December		ing period (line	3, 429, 907	21.00	
	5 x line 17)					
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00	
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	- 31 of the cost reporti	ng period (line	0	24. 00	
24.00	7 x line 19)	or the cost reporti	ing period (inite	Ö	24.00	
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00	
26 00	x line 20) 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		
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0		
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00	
31. 00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0. 000000		
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	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 min	, ,	tions)	0.00	•	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	le 31)		0. 00 0	35. 00 36. 00	
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	3, 429, 907	37. 00	
	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY					
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see				38. 00	
39. 00	Program general inpatient routine service cost per drem (see				39. 00	
40.00	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)			40. 00	
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)	l		41. 00	

	Financial Systems JA ATION OF INPATIENT OPERATING COST	ACKSONVILLE MEM		CN: 14-1352	In Lie Period:	u of Form CMS-: Worksheet D-1	
OWPUT	ATTON OF INPATTENT OPERATING COST			CCN: 14-1352 CCN: 14-5951	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/28/2024 8:4	pared:
			Title	e XVIII	Skilled Nursing Facility	PPS	· 7 aiii
	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)	
	AND SERVICE AND	1.00	2.00	3.00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
3. 00	INTENSIVE CARE UNIT						43.00
1. 00	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45. 0
	SURGICAL INTENSIVE CARE UNIT						46.0
7.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 0
	cost center bescription					1. 00	
8. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	l, line 200)				48. 0
	Program inpatient cellular therapy acquisition				column 1)		48. 0
9. 00	Total Program inpatient costs (sum of lines	41 through 48.0	01)(see instruc	ctions)			49. 0
0. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpa	ationt routing	corvices (from	wkst D su	m of Darts I and		50. O
). 00	Tass through costs appricable to Frogram The	attent routine	services (IIIII	ii wkst. D, Sui	II OI FAILS I AIIU		30.0
. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II		51.0
	and IV)						
2. 00	Total Program excludable cost (sum of lines!	,					52. 0
3. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		erated, non-pny	/sician anesti	netist, and		53. C
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
4. 00	Program di scharges						54.0
	Target amount per discharge						55.0
	Permanent adjustment amount per discharge						55. (
	Adjustment amount per discharge (contractor of						55. (
	Target amount (line 54 x sum of lines 55, 55. Difference between adjusted inpatient operati			ine 56 minus	line 53)		56. 0 57. 0
	Bonus payment (see instructions)	ring cost and ta	irget amount (i	THE 30 III HUS	11116 33)		58.0
9. 00	Trended costs (lesser of line 53 ÷ line 54, o	or line 55 from	the cost repo	orting period	endi ng 1996,		59.0
	updated and compounded by the market basket)				-		
0. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	om prior year o	cost report, i	updated by the		60.0
1. 00	Continuous improvement bonus payment (if line						61.0
	55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)	00), 01 1 % 01	the target an	ilouit (Trie 3	o), Otherwise		
	Relief payment (see instructions)						62.0
3. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ıcti ons)				63.0
4 00	PROGRAM INPATIENT ROUTINE SWING BED COST	ts through Doss	mbor 21 of the	act reporti	ng poriod (Soc		64.0
54. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	amber at Of the	cost reporti	ing period (see		04.0
55. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the o	cost reporting	g period (See		65. 0
, 66	instructions)(title XVIII only)			· => /			,
6. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	ob)(title XVI	i only); for		66. C
7. 00	CAH, see instructions  Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 d	of the cost re	eportina period		67.0
	(line 12 x line 19)				,		
58. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period		68. 0
59. 00	(line 13 x line 20)	couting costs (	lino 47 : lino	. 40)			69. 0
9. 00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU						J 69. U
0. 00	Skilled nursing facility/other nursing facili				)	3, 429, 907	70.0
	Adjusted general inpatient routine service co					1, 155. 24	1
	Program routine service cost (line 9 x line					2, 152, 212	1
	Medically necessary private room cost applica		•	•		0	
4. 00 5. 00	Total Program general inpatient routine servi	•			Part II column	2, 152, 212	1
J. UU	Capital-related cost allocated to inpatient ( 26, line 45)	outine service	COSIS (110111 V	IOI KSHEEL B, I	artii, COTUIIII	0	/3.0
6. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)				0.00	76.0
	Program capital-related costs (line 9 x line					0	1
78.00	,					0	
79.00	Aggregate charges to beneficiaries for excess				aug Lino 70)	0	1
30. 00 31. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		ost iiiii tatior	ı (ııne /8 mli	ius IIIle /9)	0 00	80.0

594, 335

0 2, 152, 212

0 2, 746, 547

82.00

84. 00 85. 00

86.00

0 87.00 0.00 88.00

84.00

85.00

86.00

81.00 Inpatient routine service cost per diem limitation

87.00 Total observation bed days (see instructions)

82.00 Inpatient routine service cost limitation (line 9 x line 81)

83.00 Reasonable inpatient routine service costs (see instructions)

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

Program inpatient ancillary services (see instructions)
Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)

Health Financial Systems Ja	ACKSONVILLE MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1			
		Component (		From 10/01/2022 To 09/30/2023	Date/Time Pre 2/28/2024 8:4			
		Title	XVIII	Skilled Nursing	PPS			
				Facility -				
Cost Center Description								
					1. 00			
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				0	89. 00		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on			
		(from line 21)	column 2	Observati on	Bed Pass			
				Bed Cost (from	Through Cost			
				line 89)	(col. 3 x col.			
					4) (see			
					instructions)			
	1.00	2.00	3.00	4. 00	5. 00			
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00 Capital -related cost	0	0	0.00000	0 0	0	90. 00		
91.00 Nursing Program cost	0	0	0. 00000	0 0	0	91.00		
92.00 Allied health cost	0	0	0. 00000	0 0	0	92.00		
93.00 All other Medical Education	0	0	0. 00000	0 0	0	93. 00		

Heal th Financial Systems						
NPATIENT ROUTINE SERVICE COST CENTERS   NAME   NA	Health Financial Systems					
To 09/30/2023   Date/Time Prepared: 2/28/7024 8: 49 am	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C			Worksheet D-3	
Title XVIII					Data/Tima Dra	narod:
Title XVIII				10 09/30/2023		
Name   Program		Ti tl e	e XVIII	Hospi tal		, u
NPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.	Cost Center Description					
INPATI ENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00						
NPATI ENT ROUTINE SERVICE COST CENTERS   9, 178, 245   30. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 00   3. 0				Charges	(col. 1 x col.	
NPATI ENT ROUTINE SERVICE COST CENTERS   9, 178, 245   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00   30. 00				ŭ .	2)	
30. 00   03000   ADULTS & PEDI ATRI CS   9,178, 245   30. 00   03100   INTENSI VE CARE UNIT   31. 00   04300   INTENSI VE CARE UNIT   31. 00   04300   INTENSI VE CASE UNIT   31. 00   04300   INTENSI VE CASE UNIT   31. 00   04300   INTENSI VE CASE UNIT   32. 00   32. 00   04300   INTENSI VE CASE UNIT   32. 00   33. 00   04300   INTENSI VE CASE UNIT   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00   34. 00			1. 00	2. 00	3. 00	
31. 00   03100   NTENSI VE CARE UNI T   2, 221, 511   31. 00   43. 00   NURSERY   20. 00   05000   OPERATI NG ROOM   0. 246842   1, 658, 057   409, 278   50. 00   05000   OPERATI NG ROOM   0. 246936   257, 788   64, 353   51. 00   52. 00   05200   DELI VERY ROOM   0. 542090   0   0   52. 00   05200   DELI VERY ROOM   0. 542090   0   0   52. 00   05200   DELI VERY ROOM   0. 542090   0   0   52. 00   05300   ANESTHESI OLOGY   0. 120094   189, 274   22, 731   53. 00   05300   ANESTHESI OLOGY   0. 120094   189, 274   22, 731   54. 00   05400   RADI OLOGY-DI AGNOSTI C   0. 114626   0   0   0   55. 00   05500   RADI OLOGY-DI AGNOSTI C   0. 114626   0   0   0   05500   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 000   0. 00						
43. 00   0.4300   NURSERY   ANCILLARY SERVICE COST CENTERS						
ANCILLARY SERVICE COST CENTERS	31.00   03100   INTENSIVE CARE UNIT			2, 221, 511		31. 00
50. 00     05000     OPERATI ING ROOM   0.246842   1,658,057   409,278   50. 00   51. 00   05100     RECOVERY ROOM   0.249636   257,788   64,353   51. 00   05200   DELI VERY ROOM & LABOR ROOM   0.542090   0   0.522.00   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200	43. 00 04300 NURSERY					43. 00
51. 00       05100 RECOVERY ROOM       0. 249636       257, 788       64, 353       51. 00         52. 00       05200 DELI VERY ROOM & LABOR ROOM       0. 542090       0       0. 52. 00         53. 00       05300 ANESTHESI OLOGY       0. 120094       189, 274       22, 731       53. 00         54. 00       05400 RADI OLOGY - DI AGNOSTI C       0. 240490       620, 197       149, 151       54. 00         55. 00       05500 RADI OLOGY - THERAPEUTI C       0. 114626       0       0       55. 00         56. 00       05600 RADI OLOGY - THERAPEUTI C       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 MAGNETI C RESONANCE I MAGI NG (MRI)       0. 069581       246, 476       17, 150       58. 00         60. 00       06500 RESPI RATORY THERAPY       0. 157637       3, 581, 824       564, 628       60. 00         65. 00       06600 PHYSI CAL THERAPY       0. 273954       522, 762       143, 213       66. 00         66. 00       06600 SPECH PATHOLOGY       0. 239906       586, 627       140, 735       67. 00         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0. 223264						
52. 00         05200         DELIVERY ROOM & LABOR ROOM         0.542090         0         0.52.00           53. 00         05300         ANESTHESI OLOGY         0.120094         189, 274         22, 731         53.00           54. 00         05400         RADI OLOGY - DIA GROSTI C         0.240490         620, 197         149, 151         54.00           55. 00         05500         RADI OLOGY - THERAPEUTI C         0.114626         0         0         55.00           56. 00         05600         RADI OLOGY - THERAPEUTI C         0.115500         46, 822         5, 408         56.00           57. 00         05500         RADI OLOGY - THERAPEUTI C         0.037907         1, 047, 432         39, 705         57.00           58. 00         05600         RADI OLOGY - THERAPEUTI C         0.037907         1, 047, 432         39, 705         57.00           58. 00         05500         MAGNETI C RESONANCE I MAGI NG (MRI)         0.06991         0.069581         246, 476         17, 150         58.00           60. 00         06600         LABORATORY         0.06901         LABORATORY         431, 413         65.00           65. 00         06500         RESPI RATORY THERAPY         0.143802         3,000, 049         431, 413         65						
53. 00       05300       ANESTHESI OLOGY       0. 120094       189, 274       22, 731       53. 00         54. 00       05400       RADI OLOGY - DI AGNOSTI C       0. 240490       620, 197       149, 151       54. 00         55. 00       05500       RADI OLOGY - THERAPEUTI C       0. 1115500       46, 822       5, 408       56. 00         57. 00       05600       RADI OLOGY - THERAPEUTI C       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       MAGNETI C RESONANCE I MAGI NG (MRI)       0. 069581       246, 476       17, 150       58. 00         60. 00       06000       LABORATORY       0. 157637       3, 581, 824       564, 628       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       60. 00       6			1		64, 353	
54. 00       05400       RADI OLOGY - DI AGNOSTI C       0. 240490       620, 197       149, 151       54. 00         55. 00       05500       RADI OLOGY - THERAPEUTI C       0. 114626       0       0       55. 00         56. 00       05600       RADI OLOGY - THERAPEUTI C       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       MAGNETI C RESONANCE I MAGI NG (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       RESPI RATORY THERAPY       0. 143802       3, 000, 049       431, 413       65. 00         66. 00       06700       DORTON OCCUPATI LONAL THERAPY       0. 23996       586, 627       140, 735       67. 00         67. 00       06700       DOCUPATI LONAL THERAPY       0. 23996       586, 627       140, 735       67. 00         71. 00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0. 23996       586, 627       140, 79, 723       68. 00         72. 00       07200       IMPL. DEV. CHARG						
55.00       05500 RADI OLOGY - THERAPEUTI C       0.114626       0       0       55.00         56.00       05600 RADI OLOGY - THERAPEUTI C       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 MAGNETI C RESONANCE I MAGI NG (MRI)       0.069881       246,476       17,150       58.00         60.00       06000 LABORATORY       0.157637       3,581,824       564,628       60.00         65.00       06500 RESPI RATORY THERAPY       0.143802       3,000,049       431,413       65.00         66.00       06600 PHYSI CAL THERAPY       0.273954       522,762       143,213       66.00         67.00       06700 OCCUPATI ONAL THERAPY       0.239906       586,627       140,735       67.00         68.00       PEECH PATHOLOGY       0.683926       116,567       79,723       68.00         71.00       O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.216591       837,037       181,295       71.00         73.00       07200 IMPL DEV. CHARGED TO PATI ENTS       0.223264       777,298       173,543       72.00         74.00       07400 RENAL DI ALYSI S       0.026805       547,391       1			1			
56.00   05600   RADIOI SOTOPE   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   MAGNETI C RESONANCE I MAGI NG (MRI )   0. 069581   246, 476   17, 150   58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0. 069581   246, 476   17, 150   58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0. 069581   246, 476   17, 150   58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0. 069581   246, 476   17, 150   58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0. 05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0. 069581   246, 476   17, 150   58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0. 0659581   246, 476   17, 150   58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0. 074300   A581, 824   564, 628   60.00   0. 069580   A581, 824   564, 628   60.00   0. 06500   RESPI RATORY THERAPY   0. 239954   522, 762   143, 213   66.00   06.00   06000   PHYSI CAL THERAPY   0. 239906   586, 627   140, 735   67.00   06800   SPEECH PATHOLOGY   0. 683926   116, 567   79, 723   68.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 216591   837, 037   181, 295   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENT   0. 223264   777, 298   173, 543   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   0. 223264   777, 298   173, 543   72.00   74.00   07400   RENAL DI ALYSI S   0. 298653   547, 391   163, 480   74.00   76.97   07697   CARDI AC REHABI LITATI ON   0. 564361   0   0. 76.97   07698   NOR SERVITOR   0. 0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0			1		149, 151	
57. 00       05700 CT SCAN       0.037907 D58.00       1,047,432 D58.00       39,705 D58.00       57. 00         58. 00       05800 MAGNETI C RESONANCE I MAGI NG (MRI )       0.069581 D46,476       17,150 D58.00       60.00       60.00 LABORATORY       0.157637 B58.02       3,581,824 B56,628 B60.00       60.00 LABORATORY       0.143802 B58.00       3,000,049 B51,810 B58.00       431,413 B55.00       66.00 C60.00 C60.00       66.00 PHYSI CAL THERAPY       0.273954 B52,762 B52,76	l l		1		1	
58. 00       05800 MAGNETI C RESONANCE I MAGI NG (MRI)       0.069581 246, 476 17, 150 58. 00       17, 150 58. 00         60. 00       06000 LABORATORY       0.157637 3, 581, 824 564, 628 60. 00       60. 00         65. 00       06500 RESPI RATORY THERAPY       0.143802 3, 000, 049 431, 413 65. 00         66. 00       06600 PHYSI CAL THERAPY       0. 273954 522, 762 143, 213 66. 00         67. 00       06700 OCCUPATI ONAL 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 MEDI CAL SUPPLIES CHARGED TO PATI ENT       0. 216591 837, 037 181, 295 71. 00         72. 00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0. 223264 777, 298 173, 543 72. 00         73. 00       07300 DRUGS CHARGED TO PATI ENTS       0. 270980 2, 608, 245 706, 782 73. 00         74. 00       07400 RENAL DI ALYSI S       0. 270980 2, 608, 245 706, 782 73. 00         76. 00       03950 DI ABETTI C EDUCATI ON       6. 475275 0       0       0       76. 97         76. 97       07697 CARDI AC REHABI LI TATI ON       0. 564361 0       0       0       0       76. 98         0UTPATI ENT SERVI CE COST CENTERS       0. 203405 43, 922 8, 934 91. 00       90. 00       90000 CLI NI C       0. 203405 43, 922 8, 934 91. 00       90. 00       90. 00			1			
60. 00       06000 LABORATORY       0. 157637       3, 581, 824       564, 628 do. 00         65. 00       06500 RESPIRATORY THERAPY       0. 143802       3, 000, 049 do. 00       431, 413 do. 00         66. 00       06600 PHYSI CAL THERAPY       0. 273954 do. 239906       586, 627 do. 143, 213 do. 00       67. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0. 239906 do. 683026 do. 00       586, 627 do. 00       140, 735 do. 00         68. 00       06800 SPEECH PATHOLOGY       0. 683926 do. 00       116, 567 do. 79, 723 do. 00       68. 00         71. 00       07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0. 216591 do. 00       837, 037 do. 00       181, 295 do. 00         73. 00       07300 DRUGS CHARGED TO PATI ENTS       0. 223264 do. 00       777, 298 do. 00       173, 543 do. 00         74. 00       07400 RENAL DI ALYSI S       0. 270980 do. 2, 608, 245 do. 00       706, 782 do. 00         76. 97       07697 CARDI AC REHABI LI TATI ON       0. 298653 do. 00       547, 391 do. 00       76. 97         76. 98       07698 HYPERBARI C OXYGEN THERAPY       0. 420908 do. 0       0       0       76. 98         00 09000 CLI NI C       0. 268195 do. 00       85, 624 do. 00       22, 964 do. 00       90. 00         91. 00       09100 BMERGENCY       0. 203405 do. 43, 922 do. 00						
65. 00   06500   RESPIRATORY THERAPY   0. 143802   3, 000, 049   431, 413   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 273954   522, 762   143, 213   66. 00   67. 00   06700   0CCUPATI ONAL 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   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 216591   837, 037   181, 295   71. 00   72. 00   72. 00   TMPL. DEV. CHARGED TO PATI ENTS   0. 223264   777, 298   173, 543   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 270980   2, 608, 245   706, 782   73. 00   74. 00   74. 00   RENAL DI ALYSIS   0. 298653   547, 391   163, 480   74. 00   76. 97   76. 97   07697   CARDI AC REHABI LI TATI ON   0. 564361   0   0   76. 97   76. 98   PHYPERBARI C OXYGEN THERAPY   0. 420908   0   0   0   76. 98   000   0000   CLI NI C   0. 0000   0000   0000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   000000			1			
66. 00   06600   PHYSI CAL THERAPY   0. 273954   522, 762   143, 213   66. 00   67. 00   06700   0CCUPATI ONAL 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   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 216591   837, 037   181, 295   71. 00   72. 00   72. 00   73. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 223264   777, 298   173, 543   72. 00   73. 00   07400   RENAL DI ALYSI S   0. 270980   2, 608, 245   706, 782   73. 00   76. 00   76. 00   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 97   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76. 98   76.	l l		1			
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 75. 00 07400 RENAL DI ALYSI S 76. 00 07500 DI ABETI C EDUCATI ON 76. 00 07697 CARDI AC REHABI LI TATI ON 76. 00 07698 HYPERBARI C OXYGEN THERAPY 77. 00 07500 DOUTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 90. 00 09100 EMERGENCY 90. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 90. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						
68. 00   06800   SPEECH PATHOLOGY   0. 683926   116, 567   79, 723   68. 00   71. 00   07100   MEDI CAL 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 DI ALYSIS   0. 298653   547, 391   163, 480   74. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 97   07697   CARDI AC REHABI LI TATI ON   0. 564361   0   0   0   76. 97   07698   HYPERBARI C OXYGEN THERAPY   0. 420908   0   0   0   76. 98   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000						
71. 00   07100   MEDI CAL 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 DI ALYSIS   0. 298653   547, 391   163, 480   74. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76. 00   76						
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 0 76. 00 76. 00 76. 97 07697 CARDIAC REHABILITATION 0. 564361 0 0 76. 97 076. 98 HYPERBARIC OXYGEN THERAPY 0. 420908 0 0 0 76. 98 00 00 00 00 00 00 00 00 00 00 00 00 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   0   0   0   0   0   0   0			1			
74. 00 07400 RENAL DIALYSIS 0. 298653 547, 391 163, 480 74. 00 76. 00 03950 DIABETIC EDUCATION 6. 475275 0 0 0 76. 00 76. 97 07697 CARDIAC REHABILITATION 0. 564361 0 0 0 76. 97 07698 HYPERBARIC OXYGEN THERAPY 0. 420908 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	l l					
76. 00 03950 DI ABETI C EDUCATI ON 6. 475275 0 0 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 564361 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 420908 0 0 76. 98 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0. 268195 85, 624 22, 964 90. 00 91. 00 09100 EMERGENCY 0. 203405 43, 922 8, 934 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 727674 12, 480 9, 081 92. 00			1			
76. 97   07697   CARDI AC REHABI LI TATI ON   0. 564361   0   0. 76. 97   07698   HYPERBARI C OXYGEN THERAPY   0. 420908   0   0   0   0   0   0   0   0   0						
76. 98   07698   HYPERBARI C OXYGEN THERAPY   0. 420908   0   0   76. 98   0   0   76. 98   0   0   76. 98   0   0   0   0   0   0   0   0   0			1		1	
OUTPATI ENT SERVI CE COST CENTERS           90. 00         09000 CLI NI C         0.268195         85, 624         22, 964         90. 00           91. 00         09100 EMERGENCY         0.203405         43, 922         8, 934         91. 00           92. 00         09200 OBSERVATI ON BEDS (NON-DISTINCT PART         0.727674         12, 480         9, 081         92. 00						
90. 00   09000   CLI NI C   0. 268195   85, 624   22, 964   90. 00   91. 00   09100   EMERGENCY   0. 203405   43, 922   8, 934   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0. 727674   12, 480   9, 081   92. 00   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09200   09			0. 42090	0 8	0	76. 98
91. 00   09100   EMERGENCY   0. 203405   43, 922   8, 934   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   0. 727674   12, 480   9, 081   92. 00						
92. 00   09200   OBSERVATI ON BEDS (NON-DI STINCT PART   0.727674   12, 480   9, 081   92. 00						
				· ·		
	,	1.0(.11	0. 72767			

16, 785, 872 0

16, 785, 872

9, 081 92. 00 3, 333, 567 200. 00 201. 00 202. 00

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

200. 00 201. 00

202.00

Heal th Financial Systems JACKSONVILLE MEMO				eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-1352	Peri od:	Worksheet D-3	
	Component	CCN: 14-5951	From 10/01/2022 To 09/30/2023		
	Ti tl e	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
INDATIENT DOUTINE CEDVICE COST CENTERS		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS				I	30.00
31. 00   03100   NTENSI VE CARE UNI T					31.00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS					1 .0.00
50. 00 05000 OPERATI NG ROOM		0. 2468	42 C	0	50.00
51. 00   05100   RECOVERY ROOM		0. 2496	36 C	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM		0. 5420		0	52. 00
53. 00   05300   ANESTHESI OLOGY		0. 1200			
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 2404			
55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 1146		_	
56. 00   05600   RADI 0I SOTOPE		0. 1155		0	56.00
57.00   05700   CT SCAN 58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)		0. 0379 0. 0695			1
60. 00   06000   LABORATORY		0. 0695	· ·		60.00
65. 00   06500  RESPI RATORY THERAPY		0. 1370			1
66. 00 06600 PHYSI CAL THERAPY		0. 2739	· ·		
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2399			
68. 00 06800 SPEECH PATHOLOGY		0. 6839	· ·		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2165	91 74, 714	16, 182	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2232		0	
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 2709			
74. 00 07400 RENAL DI ALYSI S		0. 2986			1
76. 00 03950 DI ABETI C EDUCATI ON		6. 4752		0	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 5643		0	
76. 98 O7698 HYPERBARI C OXYGEN THERAPY		0. 4209	08 0	0	76. 98
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC		0. 2681	95 21, 712	5, 823	90.00
91. 00   09100   EMERGENCY		0. 2034			1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 7276		0	1
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.7270	2, 532, 098		
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		_,,,	1 ., 555	201. 00
202.00 Net charges (line 200 minus line 201)	. ,	1	2, 532, 098	1	202.00

Health Financial Systems	JACKSONVILLE MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1352	Peri od: From 10/01/2022 To 09/30/2023 Worksheet E Part B Date/Ti me Prepared: 2/28/2024 8:49 am
	T1 11 10 11 1	

Modical and other services (see Instructions)			2/28/2024 8: 4	9 am
Note		Title XVIII Hospital	Cost	
MARIL 9 - MEDICAL AND OFFICE REALITY SERVICES   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.978   17.886.			1 00	
Medical and other services (see instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00   DPS or RIT payment (see Instructions)   0   0   0   0   0   0   0   0   0	1.00		17, 868, 578	1.00
Dutilier payment (see instructions)		· · · · · · · · · · · · · · · · · · ·		2. 00
0		1		
Enter the hospital specific payment to cost ratio (see instructions)   0.000				4. 00 4. 01
Line 2 Times   Line 5			_	1
Sum of Tines 3, 4, and 4, 01, divided by Tine 6   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00				6.00
Ancil lary service other pass through costs from West. D. Pt. IV, col. 13. line 200   0   1.00   1.00   0   1.00   0   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00			0.00	1
10.00   Organ acquisitions   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578   17,869,578				8. 00
10   Total cost (sum of lines 1 and 10) (see instructions)				9. 00
COMPUTATION OF LISSER OF COST OR CHARGES   12.00   Ancil lary service charges   12.00   Ancil lary service charges   13.00   Organ acquisition charges (from Wisst. D-4, Pt. 111, col. 4, line 69)   0.11   14.00   Ditail reasonable charges (sum of lines 12 and 13)   0.11   15.00   Organ acquisition charges (sum of lines 12 and 13)   0.11   16.00   Organ acquisition charges (sum of lines 12 and 13)   0.11   16.00   Organ acquisition charges (sum of lines 12 and 13)   0.11   16.00   Organ acquisition charges (sum of lines 12 and 13)   0.11   17.00   Ratio of line 15 to line 16 (not to exceed 1.0000000)   0.12   17.00   Ratio of line 15 to line 16 (not to exceed 1.0000000)   0.12   17.00   Ratio of line 15 to line 16 (not to exceed 1.0000000)   0.12   17.00   Excess of customary charges (see instructions)   0.10   17.00   Excess of customary charges (see instructions)   0.10   17.00   Excess of customary charges (see instructions)   0.10   17.00   Instructions)   0.12   17.00   Instructions)   0.12   18.00   Organ acquisition charges (see in				10.00
Reasonable charges	11.00		17, 868, 578	11. 00
12.00   Ancillary service charges   0   1				l
13.00   Organ acquisition charges (From Wist. D4, Pt. III., col. 4, Iline 69)   O   1	12. 00		0	12.00
Description   Continue   Contin			0	13.00
15.00   Aggregate amount actually collected from patients   Italia   For payment for services on a charge basis   0   1	14.00	Total reasonable charges (sum of lines 12 and 13)	0	14. 00
16.00   Amounts that would have been realized from patients I lable for payment for services on a chargebasis   0   1   had such payment been made in accordance with 42 CFR \$413.13(e)   0   10   10   10   10   10   10   10				
had such payment been made in accordance with 42 CFR §413.13(e)    10.00 Ratio of line 15 to line 16 (not to exceed 1.000000)   11.00 Ratio of line 15 to line 16 (not to exceed 1.000000)   11.00 DE Access of customary charges (see Instructions)    20.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see				15.00
17.00   Ratio of Line 15 to Line 16 (not to exceed 1.000000)   0.000000   19.00   Excess of customary charges (see instructions)   0.000000   19.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   0.000000   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00	16.00		0	16. 00
18.00   Total customary charges (see instructions)   0   1	17 00		0.000000	17. 00
19.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)   18.047,264   2.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00			l	18.00
Instructions				ı
Instructions    18,047,264   22.00   Interns and residents (see instructions)   18,047,264   22.00   Interns and residents (see instructions)   0.2   23.00   Cost of physic lands' services in a teaching hospital (see instructions)   0.2   24.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   0.2   Computation of physic lands' services in a teaching hospital (see instructions)   0.2   Computation of physic lands' services in a teaching hospital (see instructions)   0.2   Computation of physic lands services and col insurance amounts (for CAH, see instructions)   17,708,658   27,00   Country (lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   17,708,658   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   249,825   24				
18.047,264   2   20.00   Interns and residents (see instructions)   0.23.00   0.55 of physicians' services in a teaching hospital (see instructions)   0.24.00   0.25 of physicians' services in a teaching hospital (see instructions)   0.25 of physicians' services in a teaching hospital (see instructions)   0.25 of physicians' services in a teaching hospital (see instructions)   0.25 of physicians' services in a teaching hospital (see instructions)   0.25 of physicians' services in a teaching hospital (see instructions)   0.25 of physicians' services in a teaching hospital (see instructions)   0.25 of physicians' services in a teaching hospital (see instructions)   0.26 of physicians' services in structions   0.26 of physicians' services   0.27 of physicians' servi	20. 00		0	20. 00
22.00   Interns and residents (see instructions)   0.2	21 00		10 047 264	21.00
23.00   Cost of physicians' services in a teaching hospital (see instructions)   0.2			1	22.00
24.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   COMPUTATION OF REIMBURSEMENT SETTLEMENT		· · · · · · · · · · · · · · · · · · ·		ı
25.00   Deductibles and coinsurance amounts (for CAH, see instructions)   88, 781   226.00   Deductibles and Coinsurance amounts of line 24 (for CAH, see instructions)   17,708,658   2.70.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   0.2   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.49,825   2.4			0	24. 00
26.00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   17, 708, 658   249, 825   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)   0   249, 825   27, 00   28, 50   28, 50   28, 50   28, 50   28, 50   28, 50   28, 50   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29, 60   29				
27. 00   Subtotal   [(I ines 21 and 24 minus the sum of I ines 25 and 26) plus the sum of I ines 22 and 23] (see   249, 825   2				25. 00
Instructions		· · · · · · · · · · · · · · · · · · ·		
28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   2   2   2   2   2   2   2   2   2	27.00		249, 825	27. 00
28.50   REH facility payment amount   ESRD direct medical education costs (from Wkst. E-4, line 36)   0.0   2.29, 20.0   2.49, 825   3.10.0   2.49, 825   3.10.0   2.49, 825   3.10.0   2.49, 825   3.10.0   2.49, 825   3.10.0   2.49, 825   3.10.0   2.49, 825   3.10.0   2.49, 825   3.10.0   2.49, 825   3.10.0   2.49, 825   3.10.0   2.49, 825   3.10.0   2.49, 825   3.10.0   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.49, 827   2.4	28 00		0	28. 00
29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   249.825   33.00   Subtotal (sum of lines 27, 28, 28.50 and 29)   249.825   33.00   Primary payer payments   553   33.00   Primary payer payments   553   33.00   Allowable Ine 30 minus line 31)   249.272   33.00   Composite rate ESRD (from Wkst. I-5, line 11)   34.00   Allowable bad debts (see instructions)   1, 389, 105   34.00   Allowable bad debts (see instructions)   1, 389, 105   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   2, 071, 247   37.00   38.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   2, 071, 247   37.00   39.00   MSP-LCC reconciliation amount from PS&R   0.00   39.90   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0.00   39.90   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0.00   39.90   Ponoestration payment adjustment amount (see instructions)   0.00   39.90   RECOVERY OF ACCELERATED DEPRECIATION   0.00   39.90   RECOVERY OF ACCELERATED DEPRECIATION   0.00   39.90   RECOVERY OF ACCELERATED DEPRECIATION   0.00   39.90   Subtotal (see instructions)   0.00   39.90   Sequestration adjustment amount after sequestration   0.00   39.90   Sequestration adjustment (see instructions)   0.00   39.90   RECOVERY OF ACCELERATED DEPRECIATION   0.00   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90				28. 50
1.00   Primary payer payments   5.53   3   3   3   3   3   3   3   3   3			0	1
32.00   Subtotai (line 30 minus line 31)   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   3.400   Allowable bad debts (see instructions)   1, 389, 105   3.500   Allowable bad debts (see instructions)   2, 137, 085   3.600   Allowable bad debts for dual eligible beneficiaries (see instructions)   2, 071, 247   3.700   Subtotal (see instructions)   1, 638, 377   3.800   MSP-LCC reconciliation amount from PS&R   0   3.900   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   3.900   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   3.900   0   3.900   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900   0   3.900	30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	249, 825	30.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   3.3				
33.00   Composite rate ESRD (from Wist I -5, line 11)	32. 00		249, 272	32.00
34. 10	33 00		1 0	33.00
35. 00				
36.00		· · · · · · · · · · · · · · · · · · ·		1
38.00   MSP-LCC reconciliation amount from PS&R   0   3   3   3   3   0   0   0   0   0	36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		36. 00
39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.75   Ny5 respirator payment adjustment amount (see instructions)   39.75   Demonstration payment adjustment amount before sequestration   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   39.99   RECOVERY OF ACCELERATED DEPRECIATION   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99   39.99	37.00	Subtotal (see instructions)	1, 638, 377	37. 00
39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.75 N95 respirator payment adjustment amount (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement (for contractor use only) 43.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{515.2}{100 BE COMPLETED BY CONTRACTOR}  90.00 Utilier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 92.00 The rate used to calculate the Time Value of Money 93.30 Saguestration adjustment amount (see instructions) 93.37 Aug. 30				38.00
39.75 N95 respirator payment adjustment amount (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment (see instructions) 40.04 Demonstration payment adjustment amount after sequestration 40.05 Sequestration adjustment (see instructions) 40.06 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 42.00 Interim payments 43.00 Balance due provider/program (see instructions) 43.00 Balance due provider/program-PARHM (for contractor use only) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 92.00 The rate used to calculate the Time Value of Money 93.00 Subtotal (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)			0	1
39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 42. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement (for contractor use only) 43. 00 Bal ance due provider/program-PARHM (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115. 2 70 BE COMPLETED BY CONTRACTOR  90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 92. 00 The rate used to calculate the Time Value of Money 93. 30 Subtotal (see instructions) 94. 30 Subtotal (see instructions) 95. 30 Sequestration adjustment amount before sequestration of 30 Sequestration of 32,768 44 94. 00 Justicer reconciliation adjustment amount (see instructions) 95. 30 Sequestration adjustment amount sequestration of 32,768 44 96. 30 Justicer instructions of 32,768 44 97. 30 Justicer instructions of 32,658,418 4 98. 30 Justicer instructions of 32,658,418 4 99. 30 Justicer instru			0	39. 50 39. 75
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 99 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  40. 01 Sequestration adjustment (see instructions)  40. 02 Demonstration payment adjustment amount after sequestration  5 Sequestration adjustment-PARHM pass-throughs  1 Interim payments  1 Interim payments  1 Interim payments-PARHM  1 Interim payments-PARHM  2 Interim payments-PARHM  3 ,658,418  4 1. 01 Tentative settlement (for contractors use only)  4 2. 00 Tentative settlement (for contractor use only)  8 Balance due provider/program (see instructions)  8 Balance due provider/program (see instructions)  9 Balance due provider/program-PARHM (see instructions)  9 To BE COMPLETED BY CONTRACTOR  9 Original outlier amount (see instructions)  1 Original outlier amount (see instructions)  1 Original outlier reconciliation adjustment amount (see instructions)  1 Original outlier reconciliation adjustment amount (see instructions)  1 Original outlier amount (see instructions)  1 Original outlier amount (see instructions)  2 Original outlier amount (see instructions)  3 Original outlier amount (see instructions)  4 Original outlier amount (see instructions)  4 Original outlier amount (see instructions)  4 Original outlier amount (see instructions)  5 Original outlier amount (see instructions)  6 Original outlier amount (see instructions)  7 Original outlier amount (see instructions)  8 Original outlier amount (see instructions)  9 Original outlier amount (see instructions)  9 Original outlier amount (see instructions)				39. 75
39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   30   30   30   30   30   30   30				39. 98
40.00       Subtotal (see instructions)       1,638,377       44         40.01       Sequestration adjustment (see instructions)       32,768       44         40.02       Demonstration payment adjustment amount after sequestration       0       44         40.03       Sequestration adjustment-PARHM pass-throughs       44         41.00       Interim payments       3,658,418       4         41.01       Interim payments-PARHM       4       4         42.00       Tentative settlement (for contractors use only)       0       4         43.00       Bal ance due provider/program (see instructions)       -2,052,809       4         43.01       Bal ance due provider/program-PARHM (see instructions)       -2,052,809       4         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2       0       4         70       BE COMPLETED BY CONTRACTOR       9       9         90.00       Original outlier amount (see instructions)       0       9         91.00       Outlier reconciliation adjustment amount (see instructions)       0       9         92.00       The rate used to calculate the Time Value of Money       0.00       9		· · · · · · · · · · · · · · · · · · ·	•	39. 99
40.02 Demonstration payment adjustment amount after sequestration  40.03 Sequestration adjustment-PARHM pass-throughs  41.00 Interim payments  41.01 Interim payments-PARHM  42.00 Tentative settlement (for contractors use only)  42.01 Tentative settlement-PARHM (for contractor use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, and a secondary of the reconciliation adjustment amount (see instructions)  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  9.00 The rate used to calculate the Time Value of Money  9.00 Demonstration payments and 44  4.00 Application adjustment amount after sequestration and 44  4.00 Application adjustment amount after sequestration and 44  4.00 Application adjustment amount (see instructions)  9.00 Outlier reconciliation adjustment amount (see instructions)  9.00 The rate used to calculate the Time Value of Money			1, 638, 377	•
40. 03		Sequestration adjustment (see instructions)		
41.00			0	40. 02
41.01       Interim payments-PARHM       4         42.00       Tentative settlement (for contractors use only)       0         42.01       Tentative settlement-PARHM (for contractor use only)       4         43.00       Bal ance due provider/program (see instructions)       -2,052,809       4         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2       0       4         90.00       Original outlier amount (see instructions)       0       9         91.00       Outlier reconciliation adjustment amount (see instructions)       0       9         92.00       The rate used to calculate the Time Value of Money       0.00       9			0 /50 //-	40. 03
42.00 Tentative settlement (for contractors use only)  42.01 Tentative settlement-PARHM (for contractor use only)  43.00 Bal ance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, splits. 2  TO BE COMPLETED BY CONTRACTOR  90.00 Outlier reconciliation adjustment amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  10 99.00 Tentative settlement (for contractors use only)  42 42.01 Tentative settlement (for contractors use only)  43.01 Fentative settlement (for contractors use only)  44.02 Fentative settlement (for contractors use only)  45.42 Fentative settlement (for contractors use only)  46.42 Fentative settlement (for contractors use only)  47.42 Fentative settlement (for contractors use only)  48.42 Fentative settlement (for contractors use only)  49.42 Fentative settlement (for contractor use only)  49.42 Fentative settlement (for contractor)  49.42 Fentative settlement (f			3, 658, 418	41. 00 41. 01
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Bal ance due provider/program (see instructions) 43.01 Bal ance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  5115.2  TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions) 0 Utilier reconciliation adjustment amount (see instructions)			0	1
43.00 Bal ance due provider/program (see instructions)  43.01 Bal ance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 4.5 115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 October 15-2, chapter 1, 0 4.5 115-2, ch		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		42. 01
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Balance due provider/program-PARHM (see instructions) 44.00 April 15-2, chapter 1, 94.00 April 15-2, chapter 1, 95.00 April 15-2, chapter 1, 96.00 April 15-2, chapter 1, 97.00 Original outlier amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions) 99.00 The rate used to calculate the Time Value of Money			-2, 052, 809	
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money  93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 The rate used to calculate the Time Value of Money  95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)	43. 01	Balance due provider/program-PARHM (see instructions)		43. 01
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 The rate used to calculate the Time Value of Money  94.00 The rate used to calculate the Time Value of Money	44. 00		0	44. 00
90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  90.00 Original outlier amount (see instructions)  9 90.00 Outlier reconciliation adjustment amount (see instructions)				ļ
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  0.00 93	90 00		0	90.00
92.00 The rate used to calculate the Time Value of Money 0.00 9:		, ,	•	91.00
	93. 00	Time Value of Money (see instructions)	0	93. 00
94.00 Total (sum of lines 91 and 93) 0 9.	94. 00	Total (sum of lines 91 and 93)	0	94.00

Health Financial Systems JACKSONVILLE MEMORIAL HOSPITAL In Lieu					2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN:		4 (0000	Worksheet E	
		From 10/0 To 09/3		Part B   Date/Time Pre	nared.
		10 07/3	07 2023	2/28/2024 8: 4	
	Title XV	III Hospi 1	tal	Cost	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				C	200. 00

Health Financial Systems JACKSON
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 10/01/2022 | Part I | To 09/30/2023 | Date/Time Prepared: Provider CCN: 14-1352

				10 09/30/2023	2/28/2024 8: 49	
		Title	XVIII	Hospi tal	Cost	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	Tabel detector comments and to consider	1. 00	2.00	3. 00	4. 00	1 00
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		8, 541, 47	3	5, 040, 725 0	1. 00 2. 00
2.00	submitted or to be submitted to the contractor for		'	)	ا	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	05/10/2023	1, 142, 50		740, 748	3. 01
3. 02					0	3. 02
3.03				O O	0	3. 03
3. 04 3. 05					0	3. 04 3. 05
3.05	Provider to Program			<u> </u>	U	3. 03
3. 50	ADJUSTMENTS TO PROGRAM	09/25/2023	954, 24	5 05/10/2023	2, 123, 055	3. 50
3. 51	ABSOSTMENTS TO TROOK III	0772072020		0	0	3. 51
3. 52					ol	3. 52
3.53				o l	0	3. 53
3.54				D	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		188, 25	5	-1, 382, 307	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		8, 729, 73	4	3, 658, 418	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider			·		
5. 01	TENTATI VE TO PROVI DER			D	0	5. 01
5.02				D	0	5. 02
5. 03				D	0	5. 03
	Provi der to Program			~I		
5.50	TENTATI VE TO PROGRAM				0	5. 50
5. 51 5. 52					0	5. 51 5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
J. 77	5. 50-5. 98)		'			5. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		602, 36	4	0	6. 01
6.02	SETTLEMENT TO PROGRAM			o l	2, 052, 809	6. 02
7.00	Total Medicare program liability (see instructions)		9, 332, 09		1, 605, 609	7. 00
				Contractor	NPR Date	
		,		Number	(Mo/Day/Yr)	
8. 00	Name of Contractor		)	1. 00	2. 00	8. 00
3.00	Traine of Contractor			I	ı	0.00

Provider CCN: 14-1352 Component CCN: 14-5951 Title XVIII Skilled Nursing

				Skilled Nursing Facility		
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	T	1. 00	2.00	3. 00	4. 00	4 00
1. 00 2. 00	Total interim payments paid to provider 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		913, 679 0		0	1. 00 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)  Program to Provider					3. 00
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) TO BE COMPLETED BY CONTRACTOR		913, 679		0	4. 00
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)  Program to Provider					5. 00
5. 01	TENTATI VE TO PROVI DER		0	1	0	5. 01
5. 02	TENTATIVE TO TROVIDER		Ö		0	5. 02
5. 03			Ö		Ö	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 PROVI DER		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			1		8. 00

Heal th	Financial Systems JACKSONVILLE MEMOR	IAL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 14-1352 Period: Worksheet E-From 10/01/2022 Part II					
			To 09/30/2023	Date/Time Pre 2/28/2024 8:4	
		Title XVIII	Hospi tal	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 I	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00					
10.00					
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
22 00	20 Belones due providen (line 0 (ar line 10) minus line 20 and line 21) (assingtructions)				

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Health Financial Systems	JACKSONVILLE MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1352	From 10/01/2022	Worksheet E-3 Part V Date/Time Prepared: 2/28/2024 8:49 am	
	Ti +L o V/// / /	Hospi tal	Cost	

				2/28/2024 8: 4	9 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 0	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instructions)				2. 00
3.00	Organ acqui si ti on			0	3. 00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4.00	Subtotal (sum of lines 1 through 3.01)			10, 314, 707	4. 00
5.00	Primary payer payments				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 p			0	11. 00
12.00	Amounts that would have been realized from patients liable for	r payment for services o	n a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)	)			
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 onl	y if line 14 exceeds li	ne 6) (see	0	15. 00
	instructions)				
16. 00	Excess of reasonable cost over customary charges (complete onl	y if line 6 exceeds line	e 14) (see	0	16. 00
47.00	instructions)			0	47.00
17. 00					17. 00
10.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	1 1: 10)		0	10.00
18.00	Direct graduate medical education payments (from Worksheet E-4	i, Tine 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	
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	
24. 00	Subtotal (line 22 minus line 23)			9, 437, 554	
25. 00	Allowable bad debts (exclude bad debts for professional services)	ces) (see instructions)		130, 762	
26. 00	Adjusted reimbursable bad debts (see instructions)			84, 995	
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		129, 206	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			9, 522, 549	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	29. 50
29. 98	Recovery of accel erated 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. 02				0	30. 02
30. 03	.				30. 03
31. 00	Interim payments			8, 729, 734	
31. 01					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				602, 364	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, mi				33. 01
34.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	cnapter 1,	0	34. 00
	§115. 2				

	<del></del>		eu of Form CMS-2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1352	Peri od: From 10/01/2022	Worksheet E-3 Part VI	
		Component CCN: 14-5951	To 09/30/2023		
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLE	FMEMENT - ALL OTHER HEALTH SERVICES FOR T	TITLE XVIII PART A		
	SERVI CES				
	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				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 lin	e 1 of W/S E,		5. 00
	Part B. This line is now shaded.)			0	/ 00
6.00	Deducti bl e			07.050	6. 00
7.00	Coi nsurance			97, 953	
8. 00 9. 00	Allowable bad debts (see instructions) Reimbursable bad debts for dual eligible bend	0	8. 00 9. 00		
	Adjusted reimbursable bad debts (see instructions)	0	10.00		
	Utilization review	trons)		0	11.00
	Subtotal (sum of lines 4, 5 minus lines 6 and	d 7 nlue lines 10 and 11)(see instruction	ne)	932, 326	
	Inpatient primary payer payments	a 7, prus rines to and ri)(see riistruction	113)	732, 320	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIF	V)		0	14. 00
	Pioneer ACO demonstration payment adjustment			0	14. 50
	Recovery of accelerated depreciation.	(222		0	14. 98
	Demonstration payment adjustment amount before	re sequestration		0	14. 99
	Subtotal (see instructions	4		932, 326	
	Sequestration adjustment (see instructions)			18, 647	
					45 00

15.02 Demonstration payment adjustment amount after sequestration 15.75 Sequestration for non-claims based amounts (see instructions)

18.00 Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)
19.00 Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1,

16.00 Interim payments
17.00 Tentative settlement (for contractor use only)

§115. 2

0 15. 02 0 15. 75

16. 00 17. 00

913, 679 0

0 18.00 0 19.00 Health Financial Systems

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

Provi der CCN: 14-1352

Peri od: Worksheet G From 10/01/2022 To 09/30/2023 Date/Ti me Prepared: 2/28/2024 8: 49 am

oni y)					2/28/2024 8: 4	9 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1, 965, 000	1	0	0	
2.00	Temporary investments	8, 118, 000	i		1	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	23, 935, 000			0	
5. 00	Other recei vable	23, 733, 000			0	
6. 00	Allowances for uncollectible notes and accounts receivable	Ö		o o	Ö	
7.00	Inventory	1, 799, 000	(	0	0	7. 00
8. 00	Prepai d expenses	1, 179, 000	(	0	0	
9.00	Other current assets	0	(	0	0	
10.00	Due from other funds	97, 000	1	0	0	1
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	37, 093, 000		0	0	11.00
12. 00	Land	730, 500		0	0	12. 00
13. 00	Land improvements	1, 450, 753			1	
14.00	Accumulated depreciation	-811, 910	(	0	0	14. 00
15.00	Bui I di ngs	20, 958, 711	1	0	0	
16. 00	Accumulated depreciation	-4, 630, 425	1	0	0	1
17. 00	Leasehold improvements	0	(	1	0	
18. 00 19. 00	Accumulated depreciation Fixed equipment	28, 007, 853		1	0	
20. 00	Accumulated depreciation	-12, 039, 600	1		0	
21. 00	Automobiles and trucks	12,037,000	1		Ö	
22. 00	Accumulated depreciation	0		o o	Ō	
23.00	Major movable equipment	21, 066, 683	(	0	0	23. 00
24. 00	Accumul ated depreciation	-15, 118, 718	1	0	0	
25. 00	Mi nor equi pment depreci abl e	995, 852	1	1	0	
26. 00	Accumulated depreciation	-591, 075	1	0	0	
27. 00	HIT designated Assets	552, 237	1		0	
28. 00 29. 00	Accumulated depreciation Minor equipment-nondepreciable	-1, 404, 879 21, 205, 867	1		0	
30. 00	Total fixed assets (sum of lines 12-29)	60, 371, 849	1			
00.00	OTHER ASSETS	1 00/07/1/01/		<u>,                                     </u>		1 00.00
31.00	Investments	136, 631, 000	(	0	0	31. 00
32.00	Deposits on leases	0	(	0	1	
33. 00	Due from owners/officers	0		0	0	1
34. 00	Other assets	30, 854, 151	1	1	0	
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	167, 485, 151 264, 950, 000			0	
30.00	CURRENT LIABILITIES	204, 930, 000	1	<u>)</u> 0		30.00
37. 00	Accounts payable	7, 339, 000	(	0	0	37. 00
38. 00	Salaries, wages, and fees payable	4, 737, 000	1	0	0	38. 00
39. 00	Payroll taxes payable	0		0	0	
40.00	Notes and Loans payable (short term)	1, 552, 000	(	0	0	
41.00	Deferred income	0	(	0	0	
42. 00 43. 00	Accel erated payments Due to other funds	506 000	,		0	42. 00 43. 00
44. 00	Other current liabilities	596, 000 10, 285, 000			l	
45. 00	Total current liabilities (sum of lines 37 thru 44)	24, 509, 000	1	o o		
	LONG TERM LIABILITIES			-		1
46.00	Mortgage payable	12, 104, 000	(	0	0	46. 00
47.00	Notes payable	0	(	0		1
48. 00	Unsecured Loans	0	(		1	
49. 00	Other long term liabilities	238, 000	ı	0	1	1
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	12, 342, 000 36, 851, 000	1	0		
51.00	CAPITAL ACCOUNTS	30, 631, 000	1	<u>J</u>	0	31.00
52. 00	General fund balance	228, 099, 000				52. 00
53.00	Specific purpose fund		1			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	1
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	(	o	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	264, 950, 000	l .	o o	Ö	
	59)					

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

18.00

19.00

0

0

STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 14-1352 Peri od: Worksheet G-1 From 10/01/2022 09/30/2023 Date/Time Prepared: 2/28/2024 8:49 am General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 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 Total (sum of line 1 and line 2) 3.00 226, 201, 629 0 3.00 4.00 PPA & CRNA CORPS 1, 795, 492 0 0 4.00 5.00 RESISTRICTED ASSETS 101, 879 0 5.00 6.00 6.00 0 0 7.00 0 7.00 0 8.00 0 8.00 0 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 1, 897, 371 10.00 Subtotal (line 3 plus line 10) 228, 099, 000 11.00 0 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 13.00 0000 13.00 14.00 0 14.00 0 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 228, 099, 000 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 PPA & CRNA CORPS 4.00 4.00 5.00 RESISTRICTED ASSETS 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 11.00 0 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00

0

18.00

19.00

Health Financial Systems JACO STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-1352

				0 09/30/2023	2/28/2024 8:49		
	Cost Center Description		Inpatient	Outpati ent	Total	Zill	
			1. 00	2. 00	3. 00		
	PART I - PATIENT REVENUES	<u>'</u>					
	General Inpatient Routine Services						
1.00	Hospi tal		22, 750, 59!	5	22, 750, 595	1.00	
2.00	SUBPROVI DER - I PF					2.00	
3.00	SUBPROVI DER - I RF					3.00	
4.00	SUBPROVI DER					4.00	
5.00	Swing bed - SNF		(		0	5.00	
6.00	Swing bed - NF		(		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, 39	5	28, 809, 395	10.00	
	Intensive Care Type Inpatient Hospital Services			'			
11.00	INTENSIVE CARE UNIT		6, 373, 69		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 I	i nes	6, 373, 69°		6, 373, 691	16.00	
	11-15)						
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	Outpati ent servi ces		8, 492, 336	66, 270, 726	74, 763, 062	19.00	
20.00	RURAL HEALTH CLINIC		(	o	0	20.00	
21.00	FEDERALLY QUALIFIED HEALTH CENTER		(	o	0	21.00	
22.00	HOME HEALTH AGENCY					22.00	
23.00	AMBULANCE SERVICES					23.00	
24.00	CMHC					24.00	
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00	
26.00	HOSPI CE					26.00	
27. 00	PHYSI CI AN REVENUE		204	493, 880	494, 084	27.00	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	to Wkst.	106, 336, 24	366, 841, 699	473, 177, 944	28.00	
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			117, 638, 692		29. 00	
30. 00	ADD (SPECIFY)		(	1		30.00	
31. 00			(			31.00	
32. 00			(			32. 00	
33. 00			(			33.00	
34.00			(			34.00	
35. 00			(			35. 00	
36. 00	Total additions (sum of lines 30-35)			0		36. 00	
37. 00	DEDUCT (SPECIFY)		(			37. 00	
38. 00			(			38. 00	
39. 00			(			39. 00	
40. 00			(			40. 00	
41. 00			(	)		41. 00	
42.00	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		117, 638, 692		43. 00	
	to Wkst. G-3, line 4)	I					

				eu of Form CMS-2552-10			
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 14-1352 Period:		Worksheet G-3					
			From 10/01/2022	Date/Time Pre	narad.		
	To 09/30/2023						
				2/28/2024 8: 4	, dili		
				1. 00			
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, I	ine 28)		473, 177, 944	1. 00		
2.00	Less contractual allowances and discounts on patients' according	unts		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	e 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 I NCOME						
6.00	Contributions, donations, bequests, etc				6. 00		
7.00	Income from investments				7. 00		
8.00	Revenues from telephone and other miscellaneous communication services				8. 00		
9.00	Revenue from television and radio service				9. 00		
10.00	Purchase di scounts			0	10. 00		
11. 00	Rebates and refunds of expenses			0	11. 00		
	Parking lot receipts			0			
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		
	Revenue from rental of living quarters			0	15. 00		
16. 00	Revenue from sale of medical and surgical supplies to other than patients				16. 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		
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 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	MI SCELLANEOUS I NCOME			1, 345, 163	24. 00		
	340B I NCOME			17, 013	1		
24. 02	INTEREST PENALTY INCOME			19, 459			
04.00	CHANGE IN ENVIOL INTERECT DATE CHAR			252 (25	1 04 00		

350, 695

42, 473

486, 314

991, 020

17, 060

144, 486

25, 972

1, 178, 538 28. 00 37, 933, 719 29. 00

9, 099, 310

1, 229, 302

18, 314, 943

39, 112, 257

24.03

24.04

24.05

24. 06

24.50

25.00

26. 00

27.00

27.01

27. 02

27. 03

24.03 CHANGE IN FMV OF INTEREST RATE SWAP

UNREALIZED GAIN ON INVESTMENTS

Total other income (sum of lines 6-24)
Total (line 5 plus line 25)
REALIZED LOSS ON INVESTMENTS

28.00 Total other expenses (sum of line 27 and subscripts)

29.00 Net income (or loss) for the period (line 26 minus line 28)

24.06 EQUITY INCOME OF AFFILATE

COVI D-19 PHE Funding

DEFERRED TAX BENEFIT

RETIREE BENEFIT ADJUSTMENT

27. 03 LOSS ON DISPOSAL OF FIXED ASSETS

24.04

24.05

24.50

25.00

26.00

27. 00 27. 01

27. 02

**GRANTS**